The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.welcometouhc.com/uhcwest or by calling 1-800-624-8822. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-624-8822 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For participating providers $2,000 individual / $4,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.welcometouhc.com/uhcwest or call 1-800-624-8822 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use a non-participating provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your participating provider might use a non-participating provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, written or oral approval is required, based upon medical policies.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay / office visit and $25 copay / Virtual visits by a designated virtual participating provider	Not covered	If you receive services in addition to office visit, additional copayments or coinsurance may apply.
	Specialist visit	$30 copay / visit	Not covered	Member is required to obtain a referral to specialist or other licensed health care practitioner, except for OB/GYN Physician services, reproductive health care services within the Participating Medical Group and Emergency / Urgently needed services. If you receive services in addition to office visit, additional copayments or coinsurance may apply.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	$50 copay / test	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.welcometouhc.com/uhcwest.	Tier 1	$10 copay / prescription retail $20 copay / prescription mail order	Not covered	Participating Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Mail-Order Specialty Drugs: Up to a 31 day supply. All limits are unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Certain preventive medications (including certain contraceptives) are covered at No charge. Copayment maximum of $250 ("Cap") for up to a 31 day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan.
	Tier 2	$25 copay / prescription retail $50 copay / prescription mail order	Not covered	
	Tier 3	$50 copay / prescription retail $100 copay / prescription mail order	Not covered	
	Tier 4	Not applicable	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay / admit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	$100 copay / visit	$100 copay / visit	Copayment waived if admitted.
	Emergency medical transportation	$50 copay / trip	$50 copay / trip	None
	Urgent care	$30 copay / visit	$100 copay / visit	If you receive services in addition to urgent care, additional copayments or coinsurance may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay / admit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay / office visit and No charge for all other outpatient services	Not covered	Substance abuse outpatient and inpatient services are covered at No charge.
	Inpatient services	$250 copay / admit	Not covered	
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply to certain preventive services. Routine pre-natal care and first postnatal visit is covered at No charge. Depending on the type of services, additional copayments or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$500 copay / admit	Not covered	
If you need help recovering or have other special health needs	Home health care	$10 copay / visit	Not covered	Limited to 100 visits per calendar year.
	Rehabilitation services	$30 copay / visit	Not covered	Coverage is limited to physical, occupational, and speech therapy.
	Habilitative services	$30 copay / visit	Not covered	Coverage is limited to physical, occupational, and speech therapy.
	Skilled nursing care	$500 copay / admit	Not covered	Up to 100 days per benefit period.
	Durable medical equipment	$50 copay / item	Not covered	None
	Hospice services	No charge	Not covered	If inpatient admission, subject to inpatient copayments or coinsurance.
If your child needs dental or eye care	Children's eye exam	$30 copay / visit	Not covered	1 exam per year.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	No coverage for Dental check-ups.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Dental care (Child)	• Non-emergency care when traveling outside the U.S.
• Chiropractic care	• Infertility treatment	• Private-duty nursing
• Cosmetic surgery	• Long-term care	• Routine foot care
• Dental care (Adult)		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Routine eye care (Adult)	• Weight loss programs – Real Appeal
• Hearing aids		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies are: Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.gov., or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace.
For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your human resource department, and the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. Contact Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.gov.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-624-8822.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-8822.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-800-624-8822.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-624-8822.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of participating provider pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) copayment	$500
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$560

Managing Joe's Type 2 Diabetes
(a year of routine participating provider care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) copayment	$500
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visit *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$900

Mia's Simple Fracture
(participating provider emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) copayment	$500
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$500

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-624-8822.

The plan would be responsible for the other costs of these EXAMPLE covered services.

English

IMPORTANT LANGUAGE INFORMATION:

You may be entitled to the rights and services below. You can get an interpreter or translation services at no charge. Written information may also be available in some languages at no charge. To get help in your language, please call your health plan at: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. If you need more help, call HMO Help Line at 1-888-466-2219.

Spanish

INFORMACIÓN IMPORTANTE SOBRE IDIOMAS:

Es probable que usted disponga de los derechos y servicios a continuación. Puede pedir un intérprete o servicios de traducción sin cargo. Es posible que tenga disponible documentación impresa en algunos idiomas sin cargo. Para recibir ayuda en su idioma, llame a su plan de salud de UnitedHealthcare of California al 1-800-624-8822 / TTY: 711. Si necesita más ayuda, llame a la línea de ayuda de la HMO al 1-888-466-2219.

Chinese

重要語言資訊：

您可能有資格享有下列權利並取得下列服務。您可以免費獲取口譯員或翻譯服務。部分語言亦備有免費書面資訊。如需取得您語言的協助，請撥打下列電話與您的健保計畫聯絡：UnitedHealthcare of California 1-800-624-8822 / 聽力語言殘障服務專線 (TTY)：711。若您需要更多協助，請撥打 HMO 協助專線 1-888-466-2219。

Arabic

معلومات مهمة عن اللغة:

ربما تكون مؤهلاً للحصول على الحقوق والخدمات أدناه. فيمكنك الحصول على مترجم فوري أو خدمات الترجمة بدون رسوم. وربما تتوفر أيضًا المعلومات المكتوبة بعدة لغات بدون رسوم. وللحصول على مساعدة بلغتك، يُرجى الاتصال بخطتك الصحية على: UnitedHealthcare of California على الرقم 1-800-624-8822 / TTY: 711. وإذا احتجت لمزيدٍ من المساعدة، يمكنك الاتصال بخط المساعدة التابع لـ HMO على الرقم 1-888-466-2219.

Armenian

ԿԱՐԵՎՈՐ ԼԵԶՎԱԿԱՆ ՏԵՂԵԿՈՒԹՅՈՒՆ՝

Հավանական է, որ Ձեզ հասանելի լինեն հետևյալ իրավունքներն ու ծառայությունները: Կարող եք ստանալ բանավոր թարգմանչի կամ թարգմանության անվճար ծառայություններ: Հնարավոր է, որ մի շարք լեզուներով նաև առկա լինի անվճար գրավոր տեղեկություն: Ձեր լեզվով օգնություն ստանալու համար խնդրում ենք զանգահարել Ձեր առողջապահական ծրագիր՝ UnitedHealthcare of California 1-800-624-8822 / TTY՝ 711 համարով: Հավելյալ օգնության կարիքի դեպքում, զանգահարեք HMO-ի Օգնության հեռախոսագիծ 1-888-466-2219 համարով:

Cambodian

ព័ត៌មានសំខាន់អំពីភាសា៖

អ្នកអាចនឹងមានសិទ្ធិ ចំពោះសិទ្ធិ និងសេវានៅខាងក្រោម។ អ្នកអាចទទួលអ្នកបកប្រែ ឬសេវាការបកប្រែ ដោយឥតគិតថ្លៃ។ **ព័ត៌មានដែលបានសរសេរ ក៏អាចនឹងមានជាភាសាមួយចំនួន ដោយឥតគិតថ្លៃដែរ។** ដើម្បីទទួលជំនួយជាភាសារបស់អ្នក សូមទូរស័ព្ទទៅគម្រោងសុខភាពរបស់អ្នក តាមលេខ៖ UnitedHealthcare of California 1-800-624-8822 / TTY: 711។ បើសិនអ្នកត្រូវការជំនួយថែមទៀត ហៅខ្សែទូរស័ព្ទជំនួយ HMO តាមលេខ 1-888-466-2219។

Farsi

اطلاعات مهم در مورد زبان:

شما ممکن است برای حقوق و خدمات زیر واجد شرایط باشید. می توانید خدمات مترجم شفاهی یا ترجمه را بدون پرداخت هزینهدریافت کنید. اطلاعات کتبی ممکن است بدون پرداخت هزینه به برخی زبان ها موجود باشد. برای دریافت کمک و راهنمایی به زبان خودتان، لطفاً با برنامه درمانی: UnitedHealthcare of California به شماره 1-800-624-8822/TTY: 711. تماس بگیرید. اگر به کمک و راهنمایی بیشتری نیاز دارید، با خط دریافت کمک و راهنمایی HMO به شماره 1-888-466-2219 تماس بگیرید.

Hindi

भाषा-संबंधी महत्वपूर्ण जानकारी:

आप निम्नलिखित अधिकारों और सेवाओं के हकदार हो सकते हैं। आपको मुफ़्त में दुभाषिया या अनुवाद सेवाएँ उपलब्ध कराई जा सकती हैं। कुछ भाषाओं में लिखित जानकारी भी आपको मुफ़्त में उपलब्ध कराई जा सकती हैं। अपनी भाषा में सहायता प्राप्त करने के लिए, कृपया अपने स्वास्थ्य प्लान को यहाँ कॉल करें: UnitedHealthcare of California 1-800-624-8822 / TTY: 711। पर। अतिरिक्त सहायता की आवश्यकता पड़ने पर, HMO Help Line को 1-888-466-2219 पर कॉल करें।

Hmong

COV NTAUB NTAWV LUS TSEEM CEEB:

Tej zaum koj yuav muaj cai rau cov cai pab cuam hauv qab no. Koj tuaj yeem tau txais ib tug kws txhais lus los sis txhais ntawv pub dawb. Cov ntaub ntawv sau no muaj sau ua qee yam ntaub ntawv pub dawb rau sawd daws. Yuav tau txais kev cov ntaub ntawv sau ua koj lus, thov hu rau qhov chaw npaj kho mob rau ntawm: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. Yog koj xav tau kev pab ntxiv, hu rau HMO Help Line ntawm tus xov tooj 1-888-466-2219.

Japanese

言語支援サービスについての重要なお知らせ：

お客様には、以下権利があり、必要なサービスをご利用いただける可能性があります。お客様は、通訳または翻訳のサービスを無料でご利用いただけます。言語によっては、文書化された 情報を無料でご利用できる場合もあります。ご希望の言語による援助をご希望の方は、お客様 の医療保険プランにご連絡ください。 UnitedHealthcare of California 1-800-624-8822 / TTY: 711。この他のサポートが必要な場合には、HMO Help Line に 1-888-466-2219 にてお問い合わせください。

Korean

중요 언어 정보:

귀하는 아래와 같은 권리 및 서비스를 누리실 수 있습니다. 귀하는 통역 혹은 번역 서비스를 비용 부담없이 이용하실 수 있습니다. 일부 언어의 경우 서면 번역 서비스 또한 비용 부담없이 제공될 수도 있습니다. 귀하의 언어 지원 서비스가 필요하시면 귀하의 건강보험에 다음 전화번호로 문의하십시오. UnitedHealthcare of California 1-800-624-8822 / TTY: 711. 더 많은 도움이 필요하신 분은 HMO 헬프 라인(안내번호: 1-888-466-2219)으로 문의하십시오.

Punjabi

ਮਹੱਤਵਪੂਰਨ ਭਾਸ਼ਾ ਦੀ ਜਾਣਕਾਰੀ:

ਤੁਸੀਂ ਹੇਠਾਂ ਦਿੱਤੇ ਅਧਿਕਾਰ ਅਤੇ ਸੇਵਾਵਾਂ ਦੇ ਹੱਕਦਾਰ ਹੋ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਬਿਨਾ ਕਿਸੇ ਲਾਗਤ 'ਤੇ ਦੁਭਾਸ਼ੀਆ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਲਿਖਤੀ ਜਾਣਕਾਰੀ ਕੁਝ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਬਿਨਾ ਕਿਸੇ ਖਰਚੇ ਦੇ ਮਿਲ ਸਕਦੀ ਹੈ। ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਸਹਾਇਤਾ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੀ ਸਿਹਤ ਯੋਜਨਾ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ: UnitedHealthcare of California 1-800-624-8822 / TTY: 711। ਜੇ ਤੁਹਾਨੂੰ ਹੋਰ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ HMO ਹੈਲਪ ਲਾਈਨ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-466-2219।

Russian

ВАЖНАЯ ЯЗЫКОВАЯ ИНФОРМАЦИЯ:

Вам могут полагаться следующие права и услуги. Вы можете получить бесплатную помощь устного переводчика или письменный перевод. Письменная информация может быть также доступна на ряде языков бесплатно. Чтобы получить помощь на вашем языке, пожалуйста, позвоните по номеру вашего плана: UnitedHealthcare of California 1-800-624-8822 / линия TTY: 711. Если вам все еще требуется помощь, позвоните в службу поддержки HMO по телефону 1-888-466-2219.

Tagalog

MAHALAGANG IMPORMASYON SA WIKA:

Maaaring kwalipikado ka sa mga karapatan at serbisyo sa ibaba. Maaari kang kumuha ng interpreter o mga serbisyo sa pagsasalin nang walang bayad. Maaaring may available ding libreng nakasulat na impormasyon sa ilang wika. Upang makatanggap ng tulong sa iyong wika, mangyaring tumawag sa iyong planong pangkalusugan sa: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. Kung kailangan mo ng higit pang tulong, tumawag sa HMO Help Line sa 1-888-466-2219.

Thai

ข้อมูลสำคัญเกี่ยวกับภาษา :

คุณอาจมีสิทธิ์ได้รับสิทธิและบริการต่าง ๆ ด้านล่างนี้ คุณสามารถขอล่ามแปลภาษาหรือบริการแปลภาษาได้โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด นอกจากนี้ ยังอาจมีข้อมูลเป็นลายลักษณ์อักษรบางภาษาให้ด้วย โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด หากต้องการขอความช่วยเหลือเป็นภาษาของคุณ โปรดโทรศัพท์ถึงแผนสุขภาพของคุณที่ : UnitedHealthcare of California 1-800-624-8822 / สำหรับผู้มีความบกพร่องทางการฟัง : 711 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรศัพท์ถึงศูนย์ให้ความช่วยเหลือเกี่ยวกับ HMO ที่หมายเลขโทรศัพท์ 1-888-466-2219

Vietnamese

THÔNG TIN QUAN TRỌNG VỀ NGÔN NGỮ:

Quý vị có thể được hưởng các quyền và dịch vụ dưới đây. Quý vị có thể yêu cầu được cung cấp một thông dịch viên hoặc các dịch vụ dịch thuật miễn phí. Thông tin bằng văn bản cũng có thể sẵn có ở một số ngôn ngữ miễn phí. Để nhận trợ giúp bằng ngôn ngữ của quý vị, vui lòng gọi cho chương trình bảo hiểm y tế của quý vị tại: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. Nếu quý vị cần trợ giúp thêm, xin gọi Đường dây hỗ trợ HMO theo số 1-888-466-2219.

Nondiscrimination Notice and Access to Communication Services

UnitedHealthcare does not exclude, deny Covered Health Care Benefits to, or otherwise discriminate against any Member on the ground of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability for participation in, or receipt of the Covered Health Care Services under, any of its Health Plans, whether carried out by UnitedHealthcare directly or through a Network Medical Group or any other entity with which UnitedHealthcare arranges to carry out Covered Health Care Services under any of its Health Plans.

Free services are available to help you communicate with us such as letters in other languages, or in other formats like large print. Or, you can ask for an interpreter at no charge. To ask for help, please call the toll-free number listed on your health plan ID card.

If you think you weren't treated fairly because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

UnitedHealthcare®

SignatureValue™ HMO
Offered by UnitedHealthcare of California
Pharmacy Schedule of Benefits

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Prescription Drug Products before we begin paying for Prescription Drug Products.	None
Co-payment	
Your Co-payment is determined by the Prescription Drug List (PDL) Management Committee's Tier placement of a Prescription Drug Product.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Co-payment • The Network Pharmacy's retail price for the Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Co-payment. • A Network Pharmacy's retail price for the Prescription Drug Product. See the Co-payments in the Benefit Information table for amounts. You are not responsible for paying a Co-payment for PPACA Zero Cost Share Preventive Care Medications.
Prescription Drug Products from a Network Retail Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. **You are not responsible for paying a Co-payment for PPACA Zero Cost Share Preventive Care Medications.** **A 12-month supply at $0 cost may be provided for FDA-approved, self-administered hormonal contraceptives**. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-	**Tier 1** Prescription Drug Product $10 Co-payment maximum of $250 (“Cap”) for up to a 31 day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form*, Section 10. Definitions*, for the definition of a High Deductible Health Plan. **Tier 2** Prescription Drug Product $25 Co-payment maximum of $250 (“Cap”) for up to a 31 day supply of an orally administered anticancer medication for a plan design not

Payment Term And Description	Amounts
payment that applies will reflect the number of days dispensed.	defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form*, Section 10. Definitions*, for the definition of a High Deductible Health Plan. **Tier 3** Prescription Drug Product $50 Co-payment maximum of $250 (“Cap”) for up to a 31 day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form*, Section 10. Definitions*, for the definition of a High Deductible Health Plan. **All cost sharing applies to the out-of-pocket limit.**
Prescription Drug Products from a Mail Order Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits as written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. You may be required to fill the first Prescription Drug Product order at a retail pharmacy and obtain 2 refills at a retail pharmacy before using a mail order Network Pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Co-payment for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your	For up to a 90-day supply, you pay: **Tier 1** Prescription Drug Product $20 Co-payment maximum of $250 (“Cap”) for up to a 31 day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form*, Section 10. Definitions*, for the definition of a High Deductible Health Plan. **Tier 2** Prescription Drug Product $50 Co-payment maximum of $250 (“Cap”) for up to a 31 day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form*, Section 10. Definitions*, for the definition of a High Deductible Health Plan.

Payment Term And Description	Amounts
Prescription Order or Refill for a 90-day supply, not a 31-day supply with three refills.	**Tier 3** Prescription Drug Product $100 Co-payment maximum of $250 (“Cap”) for up to a 31 day supply of an orally administered anticancer medication for a plan design not defined as a High Deductible Health Plan regardless of any Deductible. For a High Deductible Health Plan, the Deductible must be satisfied before the $250 Cap applies, and if there is a separate prescription drug deductible, the Cap applies once the drug deductible is met. Please refer to the Combined Evidence of Coverage and Disclosure Form*, Section 10. Definitions*, for the definition of a High Deductible Health Plan. **All cost sharing applies to the out-of-pocket limit.**

This *Schedule of Benefits* provides specific details about your Prescription Drug Product benefit, as well as the exclusions and limitations. Together this document and the *Supplement to the Combined Evidence of Coverage and Disclosure Form* as well as the medical *Combined Evidence of Coverage and Disclosure Form* determine the exact terms and conditions of your Prescription Drug Product coverage.

What Do I Pay When I fill a Prescription?

The amount you pay for any of the following under this Pharmacy *Schedule of Benefits* will not be included in calculating any Out-of-Pocket Limit stated in your medical *Schedule of Benefits*:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates will not be available to you.

For Prescription Drug Products at a Network Retail pharmacy, you will pay the lower of the applicable Co-payment for a Prescription Unit, or the Network Pharmacy's retail price for the Prescription Drug Product. For Prescription Drug Products from Mail Order**,** you are responsible for paying the lower of either the applicable Co-payment or a Network Pharmacy's retail price for the Prescription Drug Product.

You will pay only a Co-payment when filling a prescription at a UnitedHealthcare Network Pharmacy. You will pay a Co-payment every time a prescription is filled. Your Co-payments are as shown in the grid above.

NOTE: The Tier status of a prescription drug can change periodically. Tier status changes resulting in higher Co-payments occur twice per calendar year or Contract Year. We will notify you 60 days prior to the change in tiers that will result in a higher co-payment. Tier changes resulting in lower Co-payments may occur at any time but no more frequent than quarterly. When Tier status changes occur, you may pay more or less for a prescription drug depending on the Tier placement. You may access PDL and Specialty Medication, Tier placement and Co-payments by contacting Customer Service Department 1-800-624-8822 or 711 (TTY) or visiting UnitedHealthcare’s Web site at **www.myuhc.com**.

You will receive a written notice 60 days prior to an increase in your Co-payment due to the change in Tier placement to move to a higher Tier. The notice will inform you of the new Tier; and if Prior Authorization must be requested by your Network Physician and determined by UnitedHealthcare to be Medically Necessary for the drug to be covered if not previously obtained.

If A Brand-Name Drug Becomes Available as a Generic

If a Generic drug becomes available for a Brand-name drug, your Brand-name drug's Tier placement may change, and therefore your Co-payment may change. Please refer to "PRIOR AUTHORIZATION" if you are currently taking a prescription drug that requires Prior Authorization under the benefit plan.

Prior Authorization

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

Certain Prescription Drug Products may be subject to prior authorization due to the following:

- They have an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

Prior Authorization and Step Therapy Exception Process

Certain Prescription Drug Products require a Prior Authorization or step therapy exception process using criteria based upon U.S. Food and Drug (FDA) approved indications or medical findings. When Prescription Drug Products are dispensed at a Network Pharmacy, your prescribing provider, or the pharmacist, are responsible for obtaining Prior Authorization from us. Please refer to the Outpatient Prescription Drug Benefit Supplement for additional information.

For a list of the Prescription Drug Products that require UnitedHealthcare's Prior Authorization, please contact UnitedHealthcare's Customer Service department at 1-800-624-8822 or 711 (TTY) or view online at **www.myuhc.com**.

Prescription Drug Products Covered by Your Benefit

When prescribed by your Network Physician as Medically Necessary and filled at a Network Pharmacy, subject to all the other terms and conditions of this outpatient prescription drug benefit, the following medications are covered:

- **Disposable all-in-one pre-filled insulin pens**, insulin cartridges and needles for non-disposable pens devices are covered when Medically Necessary in accordance with UnitedHealthcare's Prior Authorization process.
- **Federal Legend Drugs**: Any medicinal substance which bears the legend**:** "Caution: Federal law prohibits dispensing without a prescription."
- **Generic Drugs**: Comparable Generic drugs may be substituted for Brand-name drugs. For Brand-name drugs that have FDA approved equivalents, a prescription may be filled with a Generic drug unless a specific Brand-name drug is Medically Necessary and Prior Authorized by UnitedHealthcare. Prior Authorization is necessary even if a licensed Physician writes "Dispense as Written" or "Do Not Substitute" on your prescription. If you choose to use a Prescription Drug Product not included on the PDL and not Prior Authorized by UnitedHealthcare, you will be responsible for the full retail price of the medication.
  If the requested drug is Medically Necessary, it may be Prior Authorized by UnitedHealthcare. If it is approved, you will only pay your applicable Tier Co-payment.
- **Miscellaneous Prescription Drug Coverage:** For the purposes of determining coverage, the following items are considered prescription drug benefits and are covered when Medically Necessary: glucagons, insulin, insulin syringes, blood glucose test strips, lancets and lancet devices, inhaler extender devices, urine test strips, ketone testing strips and tablets, and anaphylaxis prevention kits. See the medical *Combined Evidence of Coverage and Disclosure Form* for coverage of other injectable medication and equipment for the treatment of asthma in Section Five under "Your Medical Benefits".
- Oral Contraceptives: All FDA-approved contraceptives, drugs, devices, and products are covered at $0 cost sharing subject to Therapeutic Equivalents that may be prescribed and may be subject to Prior Authorization. A Member may receive a 12-month supply of a FDA-approved, self-administered hormonal contraceptive dispensed or furnished at one time by a provider or from a contracted pharmacy that has agreed to dispense or furnish FDA-approved contraceptives in accordance with state and federal law. Over-the-counter birth control devices require a prescription from your provider. To determine whether the Plan's contracted pharmacy provides for a pharmacist to dispense FDA-approved contraceptives directly, please contact the contracted pharmacy or call the Plan at the number shown on your card. Please refer to the medical Evidence of Coverage and to your Outpatient Prescription Drug Supplement for more information.
- **Sexual Dysfunction Medication**: Outpatient prescription medication prescribed by a Network Physician to treat sexual dysfunction require Prior Authorization by UnitedHealthcare. Prescription medications prescribed for the treatment of sexual dysfunction are limited to eight (8) tablets per month for a Co-payment
- **State Restricted Drugs**: Any medicinal substance that may be dispensed by prescription only according to State law.

Exclusions and Limitations

While the prescription drug benefit covers most Prescription Drug Products, there are some that are not covered or limited. These Prescription Drugs Products are listed below. Some of the following excluded drugs may be covered under your medical benefit. Please refer to Section Five of your medical *Combined Evidence of Coverage* and Disclosure Form entitled "Your Medical Benefits" for more information about medications covered by your medical benefit.

- Administered Prescription Drug Products: Drugs or medicines delivered or administered to the Member by the prescriber or the prescriber's staff are not covered. Injectable drugs are covered under your medical benefit when administered during a Physician's office visit or self-administered pursuant to training by an appropriate health care professional. Refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* titled "Your Medical Benefits" for more information about medications covered under your medical benefit.
- Compounded medication: Any Medicinal substance that has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount. Compounded medications are not covered unless Prior Authorized as Medically Necessary by UnitedHealthcare.
- Diagnostic drugs: Drugs used for diagnostic purposes are not covered. Refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form for information about medications covered for diagnostic tests, services and treatment.
- Dietary or nutritional products and food supplements: Whether prescription or non-prescription, including vitamins (except prenatal), minerals and fluoride supplements, health or beauty aids, herbal supplements and/or alternative medicine are not covered. Phenylketonuria (PKU) testing and treatment is covered under your medical benefit including those formulas and special food products that are a part of a diet prescribed by a Network Physician provided that the diet is Medically Necessary. For additional information, refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form*. This exclusion does not apply to authorized Medically Necessary services to treat Severe Mental Illness (SMI) or Serious Emotional Disturbances of a Child (SED).
- Enhancement medications when prescribed for the following non-medical conditions are not covered: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. This exclusion does not exclude coverage for drugs when Prior Authorized as Medically Necessary to treat morbid obesity or diagnosed medical conditions affecting memory, including but not limited to, Alzheimer's dementia.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition) unless Medically Necessary and Prior Authorized by us.
- Infertility: All forms of Prescription Drug Products when prescribed for the treatment of infertility are not covered. If your employer has purchased coverage for infertility treatment, Prescription Drug Products for the treatment of infertility may be covered under that benefit. Please refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* entitled "Your Medical Benefits" for additional information.
- Injectable medications: Except as described under the section "Medications Covered By Your Benefit", injectable medications including, but not limited to, self-injectables, infusion therapy, allergy serum, immunization agents and blood products are not covered as an outpatient prescription drug benefit. However, these medications are covered under your medical benefit as described in and according to the terms and conditions of your medical *Combined Evidence of Coverage and Disclosure Form*. Outpatient injectable medications administered in the Physician's office (except insulin) are covered as a medical benefit when part of a medical office visit. Injectable medications may be subject to UnitedHealthcare's Prior Authorization requirements. For additional information, refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* under "Your Medical Benefits".
- Inpatient Prescription Drug Products: Medications administered to a Member while an inpatient in a hospital or while receiving Skilled Nursing Care as an inpatient in a Skilled Nursing Facility are not covered under this *Pharmacy Schedule of Benefits*. Please refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* entitled "Your Medical Benefits" for information on coverage of prescription medications while hospitalized or in a Skilled Nursing Facility. Outpatient prescription drugs are covered for Members receiving Custodial Care in a rest home, nursing home, sanitarium, or similar facility if they are obtained from a Network Pharmacy in accordance with all the terms and conditions of coverage set forth in this *Schedule of Benefits* and in the Pharmacy Supplement to the *Combined Evidence of Coverage and Disclosure Form.* When a Member is receiving Custodial Care in any facility, relatives, friends or caregivers may purchase the medication prescribed by a Network Physician at a Network Pharmacy, and pay the applicable Co-payment on behalf of the Member.
- Investigational or Experimental drugs: Medication prescribed for Experimental or Investigational therapies are not covered, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. Further information about Investigational and Experimental procedures and external review by an independent panel can be found in the medical *Combined Evidence of Coverage and Disclosure Form* in Section Five, "Your Medical Benefits" and Section Eight, "Overseeing Your Health Care" for appeal rights.

- New Prescription Drug Products that have not been reviewed for safety, efficacy and cost effectiveness and approved by UnitedHealthcare are not covered unless Prior Authorized by UnitedHealthcare as Medically Necessary. This would include new dosage forms that we determine do not meet the definition of a Covered Health Care Service.
- Non-covered medical condition: Prescription Drug Products for the treatment of a non-covered medical condition are not covered. This exclusion does not exclude Medically Necessary Prescription Drug Products directly related to non-covered services when complications exceed follow-up care, such as life-threatening complications of cosmetic surgery.
- Off-label drug use. Off-label drug use means that the Provider has prescribed a drug approved by the Food and Drug Administration (FDA) for a use that is different than that for which the FDA approved the drug. UnitedHealthcare excludes coverage for Off Label Drug Use, including off label self-injectable drugs, except as described in the medical *Combined Evidence of Coverage and Disclosure Form* and any applicable Attachments. If a drug is prescribed for off-label drug use, the drug and its administration will be covered only if it satisfies the following criteria: (1) The drug is approved by the FDA. (2) The drug is prescribed by a Network licensed health care professional. (3) The drug is Medically Necessary to treat the medical condition. (4) The drug has been recognized for treatment of a medical condition by one of the following: (a) The American Hospital Formulary Service Drug Information, (b) One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapy regimen; (i) The Elsevier Gold Standard's Clinical Pharmacology; (ii) The National Comprehensive Cancer Network Drug and Biologics Compendium; (iii) The Thompson Micromedex DRUGDEX System, or (c) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label drug use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in major peer-reviewed medical journal. Nothing in this section shall prohibit UnitedHealthcare from use of a PDL, Co-payment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA. Denial of a drug as investigational or experimental will allow the Member to use the Independent Review System as defined in the medical *Combined Evidence of Coverage and Disclosure Form*.
- Over-the-Counter Drugs: Drugs available over-the-counter do not require a Prescription Order or Refill by federal or state law before being dispensed. Generally over- the-counter Drugs are excluded whether prescribed or not unless they are on UnitedHealth care's PDL or unless they are FDA-approved tobacco cessation drugs and products, or FDA-approved contraceptives, drugs, devises or other products both of which are provided as preventive benefit at $0 cost sharing subject to certain exception. This exclusion does not apply to prescribed over-the-counter medications that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) when prescribed by a provider for which Benefits are available, without cost sharing, as described under Section *5 of the* Combined *Evidence of Coverage and Disclosure Form*. When determining covered FDA approved contraceptive methods, the Plan will consider Therapeutic Equivalent including dosage form and route of administration strength. For more information regarding coverage of certain over- the- counter drugs on the PDL, please see your Outpatient Prescription Drug Supplement and your *Combined Evidence of Coverage* under Family Planning and Tobacco Screenings. You may also contact UnitedHealthcare's Customer Service Department at 1-800-624-8822 or 711 (TTY) or view online at **www.myuhc.com**.
- Prescription Drug Products that are comprised of active ingredients that are available over-the-counter are not covered except when Medically Necessary. Certain prescription drug products that are Therapeutically Equivalent to over the counter drugs or supplement are not covered unless Medically Necessary and Prior Authorized. This exclusion does not apply to coverage of an entire class of prescription drugs when one drug within that class becomes available over the counter.
- Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit are not covered.
- Prescription Drug Product to the extent payment or benefits are provided by the local, state or federal government except as otherwise provided by law.
- Prescription Drug Products prescribed by a dentist or drugs when prescribed for dental treatment are not covered.
- Prescription Drug Products when prescribed solely for the purpose to shorten the duration of a common cold are not covered.
- Prescription Drug Product when packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment that applies will reflect the number of days dispensed.
- Prescription Drug Products prescribed solely to treat hair loss.
- Prior to Effective Date: Drugs or medicines purchased and received prior to the Member's effective date or subsequent to the Member's termination are not covered.

- Replacement of Prescription Drug Products. Lost, stolen, or destroyed Prescription Drug Products are not covered.
- Saline and irrigation solutions. Saline and irrigation solutions are not covered unless Medically Necessary, depending on the purpose for which they are prescribed, as part of the home health or durable medical equipment benefit. Refer to your medical *Combined Evidence of Coverage and Disclosure Form* Section Five for additional information.
- Smoking cessation products unless they are FDA-approved tobacco cessation drugs and products, both of which are provided as a preventive benefit at $0 cost sharing subject to certain exception. For information on UnitedHealthcare's smoking cessation program, refer to the medical *Combined Evidence of Coverage and Disclosure Form* in Section Five, "Your Medical Benefits, in the section entitled "Outpatient Benefits", under "Health Education Services" or contact Customer Service or visit our web site at **www.myuhc.com**.
- Therapeutic devices or appliances including, but not limited to, support garments and other non-medical substances, insulin pumps and related supplies (these services are provided as durable medical equipment). For further information on certain therapeutic devices and appliances that are covered under your medical benefit, refer to your medical *Combined Evidence of Coverage and Disclosure Form* in Section Five, entitled "Your Medical Benefits" under "Outpatient Benefits" located, for example, in subsections entitled "Diabetic Self-Management", "Durable Medical Equipment", or "Home Health Care and Prosthetics and Corrective Appliances".
- Therapeutically Equivalent: Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available unless Medically Necessary.
- Unit/Convenience Dosage Forms: Unit doses, pre-packaged medications, individual packets etc. are not covered unless available in that form only, prior authorized and medically necessary
- Worker's Compensation: Prescription Drug Products for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the patient is not covered. Further information about Workers Compensation can be found in the medical *Combined Evidence of Coverage and Disclosure Form* in Section Six under "Payment Responsibility".

Questions? Call us at 1-800-624-8822 or 711 (TTY).

P.O. Box 30968
Salt Lake City, UT 84130-0968

Customer Service:
1-800-624-8822
711 (TTY)
www.myuhc.com

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SIERRA VIEW MEDICAL CENTER

UnitedHealthcare®

SignatureValue™ HMO
Offered by UnitedHealthcare of California

HMO Schedule of Benefits

30/500A

These services are covered as indicated when authorized through your Primary Care Physician in your Network Participating Medical Group.

General Features

Calendar Year Deductible	None
Maximum Benefits	Unlimited
Annual Out-of-Pocket Limit Annual Out-of-Pocket Limit includes Co-payments for UnitedHealthcare benefits including behavioral health and prescription drug. It does not include standalone, separate and independent Dental, Vision and Chiropractic benefit plans offered to groups. Co-payments for certain types of Covered Health Care Services do not apply toward the Out-of-Pocket Limit and will require a Co-payment even after the Out-of-Pocket Limit has been met. The Annual Out-of-Pocket Limit includes Co-payments for UnitedHealthcare benefits including behavioral health and prescription drug benefits. It does not include standalone, separate and independent Dental, Vision and Chiropractic benefit plans offered to groups. When an individual member of a family unit has paid an amount of Deductible and Co-payments for the Calendar Year equal to the Individual Out-of-Pocket Limit, no further Co-payments will be due for Covered Health Care Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Co-payment until a member satisfies the Individual Out-of-Pocket Limit or until a family satisfies the Family Out-of-Pocket Limit.	Individual: $2,000 Family: $4,000
PCP Office Visits	$30 Office Visit Co-payment
Specialist Office Visits (Member required to obtain referral to Specialists except for OB/GYN Physician Services and Emergency/Urgently Needed Services) Co-payments for audiologist and podiatrist visits will be the same as for the PCP.	$30 Office Visit Co-payment
Hospital Benefits (Only one hospital Co-payment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Co-payment for that admit)	$500 Co-payment per admit
Emergency Services	$100 Co-payment Co-payment waived if admitted
Urgently Needed Services	
Urgent care services – services provided **within** the geographic area served by your medical group	$30 Co-payment
Urgent care services – services provided **outside** of the geographic area served by your medical group	$100 Co-payment
Please consult your EOC for additional details. Consult your physician website or office for available urgent care facilities within the area served by your medical group.	

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	$500 Co-payment per admit
Clinical Trials Clinical Trial services require prior authorization by UnitedHealthcare. If you participate in a Cancer Clinical Trial provided by an Out-of-Network Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Participating Providers, you will be responsible for payment of the difference between the Out-of-Network Providers billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Co-payments, coinsurance or deductibles.	Paid at negotiated rate. Balance (if any) is the responsibility of the Member.
Hospice Services (Prognosis of life expectancy of one year or less)	$500 Co-payment per admit
Hospital Benefits (Only one hospital Co-payment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Co-payment for that admit)	$500 Co-payment per admit
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	$500 Co-payment per admit
Maternity Care Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card.	$500 Co-payment per admit
Mental Health Services including, but not limited to, Residential Treatment Centers **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.)** (Only one hospital Co-payment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Co-payment for that admit)	$250 Co-payment per admit
Newborn Care The inpatient hospital benefits Co-payment does not apply to newborns when the newborn is discharged with the mother within 48 hours of the normal vaginal delivery or 96 hours of the cesarean delivery. Please see the Combined Evidence of Coverage and Disclosure Form for more details.	$500 Co-payment per admit
Physician Care	No charge
Reconstructive Surgery	$500 Co-payment per admit
Rehabilitation Care (Including physical, occupational and speech therapy)	$500 Co-payment per admit
Severe Mental Illness Benefit and Serious Emotional Disturbances of a Child Inpatient and Residential Treatment Unlimited days **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage**.	$250 Co-payment per admit
Skilled Nursing Facility Care (Up to 100 days per benefit period)	$500 Co-payment per admit
Substance Related and Addictive Disorder including, but not limited to, Inpatient Medical Detoxification and Residential Treatment Centers **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	No charge
Termination of Pregnancy (Medical/medication and surgical)	$125 Co-payment

Benefits Available on an Outpatient Basis

Allergy Testing/Treatment (Serum is covered) PCP Office Visit Specialist Office Visit	 $30 Office Visit Co-payment $30 Office Visit Co-payment
Ambulance (Only one ambulance Co-payment per trip may be applicable. If a subsequent ambulance transfer to another facility is necessary, you are not responsible for the additional ambulance Co-payment)	$50 Co-Payment
Clinical Trials Clinical Trial services require prior authorization by UnitedHealthcare. If you participate in a Cancer Clinical Trial provided by an Out-of-Network Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Participating Providers, you will be responsible for payment of the difference between the Out-of-Network Providers billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Co-payments, coinsurance or deductibles.	Paid at negotiated rate. Balance (if any) is the responsibility of the Member.
Cochlear Implant Devices (Additional Co-payment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply) In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	$30 Co-payment per item
Dental Treatment Anesthesia (Additional Co-payment for outpatient surgery or inpatient hospital benefits may apply)	$30 Co-payment
Dialysis (Physician office visit Co-payment may apply)	$30 Co-payment per treatment
Durable Medical Equipment In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	$50 Co-payment per item
Durable Medical Equipment for the Treatment of Pediatric Asthma (Includes nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthma of Dependent children who are covered until at least the end of the month in which Member turns 19 years of age.)	No charge
Family Planning (Non-Preventive Care) Vasectomy Depo-Provera Injection – (other than contraception) PCP Office Visit Specialist Office Visit Depo-Provera Medication – (other than contraception) (Limited to one Depo-Provera injection every 90 days.) Termination of Pregnancy (Medical/medication and surgical) FDA-approved contraceptive methods and procedures recommended by the Health Resources and Services Administration as preventive care services will be 100% covered. Co-payment applies to contraceptive methods and procedures that are **NOT** defined as Covered Health Care Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.	 $50 Co-payment $30 Office Visit Co-payment $30 Office Visit Co-payment $35 Co-payment $125 Co-payment
Hearing Aid - Standard $5,000 annual benefit maximum per calendar year. Limited to one hearing aid (including repair and replacement) per hearing impaired ear every three years. (Repairs and/or replacements are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.)	$50 Co-payment
Hearing Aid - Bone Anchored Bone anchored hearing aid will be subject to applicable medical/surgical categories (e.g. inpatient hospital, physician fees) only for members who meet the medical criteria specified in the Combined Evidence of Coverage and Disclosure Form. Repairs and/or replacement for a bone anchored hearing aid are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.	Depending upon where the covered health service is provided, benefits for bone anchored hearing aid will be the same as those stated under each covered health service category in this Schedule of Benefits.

Benefits Available on an Outpatient Basis (Continued)

Hearing Exam	
PCP Office Visit	$30 Office Visit Co-payment
Specialist Office Visit	$30 Office Visit Co-payment
Co-payments for audiologist and podiatrist visits will be the same as for the PCP. Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card.	
Home Health Care Visits (Up to 100 visits per calendar year) For Infusion Therapy, a separate Infusion Therapy Copayment applies per 30 days	$10 Co-payment per visit
Hospice Services (Prognosis of life expectancy of one year or less)	No charge
Infertility Services	Not covered
Infusion Therapy (Infusion Therapy is a separate Co-payment in addition to an office visit Co-payment.) In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	$50 Co-payment per medication
Injectable Drugs Outpatient Injectable Medication Self-Injectable Medication (Co-payment/Coinsurance not applicable to injectable immunizations, birth control, Infertility and insulin. If injectable drugs are administered in a physician's office, office visit Co-payment/Coinsurance may also apply) FDA-approved contraceptive methods and procedures recommended by the Health Resources and Services Administration as preventive care services will be 100% covered. Co-payment applies to contraceptive methods and procedures that are **NOT** defined as Covered Health Care Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.	$50 Co-payment per medication
Laboratory Services (When available through or authorized by your Participating Medical Group. Additional Co-payment for office visits may apply)	No charge
Maternity Care, Tests and Procedures	
PCP Office Visit	No charge
Specialist Office Visit	No charge
Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card.	
Mental Health Services (including Severe Mental Illness and Serious Emotional Disturbances of Child)	
Outpatient Office Visits include: Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, individual/ group counseling, individual/ group evaluations and treatment, referral services, and medication management	$30 Office Visit Co-payment
All Other Outpatient Treatment include: Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, crisis intervention, electro-convulsive therapy, psychological testing, facility charges for day treatment centers, Behavioral Health Treatment for pervasive developmental Disorder or Autism Spectrum Disorders, laboratory charges, or other medical Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment, and psychiatric observation **(Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**)	No charge

Benefits Available on an Outpatient Basis (Continued)

Oral Surgery Services In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	$50 Co-payment
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	$30 Office Visit Co-payment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	$250 Co-payment
Physician Care PCP Office Visit Specialist Office Visit	 $30 Office Visit Co-payment $30 Office Visit Co-payment
Preventive Care Services (Services as recommended by the American Academy of Pediatrics (AAP) including the Bright Futures Recommendations for pediatric preventive health care, the U.S. Preventive Services Task Force with an "A" or "B" recommended rating, the Advisory Committee on Immunization Practices and the Health Resources and Services Administration (HRSA), and HRSA-supported preventive care guidelines for women, and as authorized by your Primary Care Physician in your Participating Medical Group.) Covered Health Care Services will include, but are not limited to, the following: • Colorectal Screening • Hearing Screening • Human Immunodeficiency Virus (HIV) Screening • Immunizations • Newborn Testing • Prostate Screening • Vision Screening • Well-Baby/Child/Adolescent care • Well-Woman, including routine prenatal obstetrical office visits Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form. Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card.	No charge
Prosthetics and Corrective Appliances In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	$50 Co-payment per item
Radiation Therapy Standard: (Photon beam radiation therapy) Complex: (Examples include, but are not limited to, brachytherapy, radioactive implants and conformal photon beam; Co-payment applies per 30 days or treatment plan, whichever is shorter; Gamma Knife and Stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Co-payment amount if any) In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	 No charge $50 Co-payment
Radiology Services Standard: (Additional Co-payment for office visits may apply) Specialized Scanning and Imaging Procedures: (Examples include but are not limited to, CT, SPECT, PET, MRA and MRI – with or without contrast media) A separate Co-payment will be charged for each part of the body scanned as part of an imaging procedure. In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	 No charge $50 Co-payment
Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED) **Please see outpatient "Mental Health Services" section for cost sharing and services that apply to SMI and SED. Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage**.	

Benefits Available on an Outpatient Basis (Continued)

Substance Related and Addictive Disorder	
Outpatient Office Visits include, but are not limited to: Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, individual/group evaluations and treatment, individual/group counseling and detoxifications, referral services, and medication management	No charge
All Other Outpatient Treatment includes, but are not limited to: Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, crisis intervention, facility charges for day treatment centers, laboratory charges. and methadone maintenance treatment **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	No charge
Virtual Visits Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling Customer Service at the telephone number on your ID card.	$25 Co-payment
Vision Refractions	$30 Co-payment

Note: Benefits with Percentage Co-payment amounts are based upon the UnitedHealthcare negotiated rate.

EACH OF THE ABOVE-NOTED BENEFITS IS COVERED WHEN AUTHORIZED BY YOUR PARTICIPATING MEDICAL GROUP OR UNITEDHEALTHCARE, EXCEPT IN THE CASE OF A MEDICALLY NECESSARY EMERGENCY OR URGENTLY NEEDED SERVICE. A UTILIZATION REVIEW COMMITTEE MAY REVIEW THE REQUEST FOR SERVICES.

Note: This is not a contract. This is a Schedule of Benefits and its enclosures constitute only a summary of the Health Plan.

THE MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT AND THE UNITEDHEALTHCARE OF CALIFORNIA COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM AND ADDITIONAL BENEFIT MATERIALS MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. A SPECIMEN COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST AND IS AVAILABLE AT THE UNITEDHEALTHCARE OFFICE AND YOUR EMPLOYER'S PERSONNEL OFFICE. UNITEDHEALTHCARE'S MOST RECENT AUDITED FINANCIAL INFORMATION IS ALSO AVAILABLE UPON REQUEST.

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