HMO Schedule of Benefits

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

General Features

General Feature	Signature Value Advantage Plan	Signature Value Plan
Calendar Year Deductible	-0-	-0-
Maximum Benefits	Unlimited	Unlimited
Annual Copayment Maximum[1] *(3 individual maximum per family)*	$1,000 / individual $3,000 / family	$1,000 / individual $3,000 / family
Office Visits	$10 copayment	$20 copayment
Hospitalization	Paid In Full	Paid In Full
Emergency Services *(Copayment waived if admitted)*	$50 Copayment	$50 Copayment
Urgently Needed Services *(Medically necessary services required outside geographic area served by your Participating Medical Group.)*	$50 Copayment	$50 Copayment
Pre-Existing Conditions	All conditions covered, provided they are covered benefits.	

Benefits Available While Hospitalized as an Inpatient	Signature Value Advantage Plan	Signature Value Plan
Bone Marrow Transplants – *(donor searches limited to $15,000 per procedure)*	Paid In Full	Paid In Full
Cancer Clinical Trials[2,3]	Paid at contracting rate. Balance, if any, is the responsibility of the Member.	Paid at contracting rate. Balance, if any, is the responsibility of the Member
Hospice Care *(prognosis of life expectancy of one year or less)*	Paid In Full	Paid In Full
Hospital Benefits[4] *(autologous (self-donated) blood up to $120.00 per unit)*	Paid In Full	Paid In Full
Mastectomy/Breast Reconstruction *(after mastectomy and complications from mastectomy)*	Paid In Full	Paid In Full
Maternity Care	Paid In Full	Paid In Full
Mental Health Services (As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and the treatment of Serious Emotional Disturbance of Children (SED). **Please refer to your Supplement to the Combined Evidence of Coverage and Disclosure Form for a description of this coverage)**	Paid in Full	Paid in Full
Newborn Care[4]	Paid In Full	Paid In Full
Physician Care	Paid In Full	Paid In Full
Reconstructive Surgery	Paid In Full	Paid In Full
Rehabilitation Care *(including physical, occupational and speech therapy)*	Paid In Full	Paid In Full
Skilled Nursing Care *(up to 100 consecutive calendar days from the first treatment per disability)*	Paid In Full	Paid In Full
Voluntary Interruption of Pregnancy (medical/medication and surgical) - 1st trimester - 2nd trimester - After 20 weeks	$75 Copayment $150 Copayment Not covered unless mother's life is in jeopardy or fetus not viable	$75 Copayment $150 Copayment Not covered unless mother's life is in jeopardy or fetus not viable

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Benefits Available on an Outpatient Basis	Signature Value Advantage Plan	Signature Value Plan
Allergy Testing/Treatment	$10.00 copayment	$20.00 copayment
Ambulance	Paid In Full	Paid In Full
Cancer Clinical Trials[2,3]	Paid at contracting rate. Balance, if any, is the responsibility of the Member.	Paid at contracting rate. Balance, if any, is the responsibility of the Member
Cochlear Implants *(outpatient surgery or inpatient hospitalization and outpatient rehabilitation therapy copayments may apply)*	Paid In Full	Paid In Full
Crisis Intervention *(Up to 20 visits for crisis intervention per calendar year)*	$35 Copayment per visit	$35 Copayment per visit
Dental Treatment Anesthesia *(additional charges for outpatient & inpatient surgery may apply)*	$10 Copayment	$20 Copayment
Durable Medical Equipment, Corrective Appliances & Prosthetics ($5,000 annual benefit maximum per calendar year.)	Paid In Full	Paid In Full
Family Planning /Voluntary Interruption of Pregnancy - Vasectomy - Tubal ligation[5] - Insertion/removal of Intra-Uterine Device (IUD) - Intra-Uterine Device (IUD) - Removal of Norplant - Depo-Provera infection - Depo-Provera medication (limited to one Depo-Provera injection every 90 days) - Voluntary interruption of pregnancy - 1st trimester - 2nd trimester - After 20 weeks	 $50 Copayment $100 Copayment $10 Copayment 50% of cost Copayment[6] $10 Copayment $10 Copayment $35 Copayment $75 Copayment $150 Copayment Not covered unless mother's life is in jeopardy or fetus not viable	 $50 Copayment $100 Copayment $20 Copayment 50% of cost Copayment[6] $20 Copayment $20 Copayment $35 Copayment $75 Copayment $150 Copayment Not covered unless mother's life is in jeopardy or fetus not viable
Health Education Services	Paid In Full	Paid In Full
Hearing Aid – Standard $5,000 Benefit Maximum every three years. Limited to a single hearing aid (including repair/replacement) every three years.	Paid In Full	Paid In Full
Hearing Aid – Bone Anchored[5] Limited to a single hearing aid during the entire period of time the member is enrolled in the Health Plan (per lifetime). Repairs and/or replacements are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.	Paid In Full	Paid In Full
Hearing Screening	$10 Copayment	$20 Copayment
Hemodialysis *(Physician office visit Copayment may apply)*	$10 per treatment	$20 per treatment
Home Health Care	Paid In Full	Paid In Full
Hospice Care	Paid In Full	Paid In Full
Immunizations *(for children under two years of age, refer to Well-Baby Care)*	$10 Copayment	$20 Copayment
Infertility Services	Not Covered.	50% of cost Copayment, includes advanced infertility treatment, see evidence of coverage for details[6]
Infusion Therapy *(Infusion Therapy is a separate Copayment in addition to a home health or a facility Copayment. Copayment applies per 30 days or treatment plan, whichever is shorter.)*	Paid In Full	Paid In Full

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Benefits Available on an Outpatient Basis	Signature Value Advantage Plan	Signature Value Plan
Injectable Drugs (Copayment not applicable to allergy serum, immunizations, birth control, Infertility and insulin. Please see the Combined Evidence of Coverage and Disclosure Form or the Group Subscriber Agreement for more information on these benefits, if any. Copayment applies per 30 days or treatment plan, whichever is shorter.	Paid In Full	Paid In Full
Laboratory & Radiology *(when available through and authorized by the Member's Participating Medical Group)*	Paid In Full	Paid In Full
Maternity Care, Tests and Procedures	Paid In Full	Paid In Full
Mental Health Service *(As required by state law, coverage includes treatment for Severe Mental Illnesses of adults and children and for children the treatment of Serious Emotional Disturbance of Children. Please refer to your Supplement to the Combined Evidence of Coverage and Disclosure Form for a description of this coverage.)*	$10 Copayment per visit.	$20 Copayment per visit.
Oral Surgery Services	Paid In Full	Paid In Full
Outpatient Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility *(including physical, occupational and speech therapy)*	$10 Copayment	$20 Copayment
Outpatient Surgery	Paid In Full	Paid In Full
Periodic Health Evaluations *Physician, laboratory, radiology and related services as recommended by the American Academy of Pediatrics (AAP) and U.S. Preventative Services Task Force and authorized through your Primary Care Physician in your Participating Medical Group to determine your health status; for children under 2 years of age, refer to Well-Baby Care.*	$10 Copayment	$20 Copayment
Physician Care (for children under 2 years of age, refer to Well-Baby Care)	$10 Copayment	$20 Copayment
Prosthetics & Corrective Appliances	Paid In Full	Paid In Full
Radiation Therapy Standard: (photon beam radiation therapy) Complex: (examples include, but are not limited to, brachytherapy, radioactive implants, and conformal photon beam. Gamma Knife and Stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for copayment amount if any.)	Paid In Full	Paid In Full
Radiological Procedures Standard Specialized Scanning and Imaging Procedures - CT, SPECT, PET & MRI (with or without contrast media)	Paid In Full	Paid In Full
Reconstructive Surgery	Paid In Full	Paid In Full
Vision Refractions & Screening	$10 Copayment	$20 Copayment
Well-Baby Care *Preventative health services, including immunizations recommended by the American Academy of Pediatrics (AAP) & U.S. Preventative Services Task Force & authorized through your Primary Care Physician in your Participating Medical Group for children under two years of age. (The Applicable office visit Copayment applies to infants that re ill at time of services.*	Paid In Full	Paid In Full

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Benefits Available on an Outpatient Basis	Signature Value Advantage Plan	Signature Value Plan
Well-Woman Care *Includes Pap smear (by your Primary Care Physician or an OB/GYN in your Participating Medical Group) and referral by the Participating Medical Group for screening mammography as recommended by the U.S. Preventative Services Task Force*.	$10 Copayment	$20 Copayment
Prescription Drugs – Retail (up to a 30-day supply) Generic Formulary Non-Formulary	 $ 5.00 $ 5.00 $20.00	 $10.00 $25.00 $40.00
Prescription Drugs – Mail Order (up to a 90-day supply) Generic Formulary Non-Formulary	 $10.00 $10.00 $40.00	 $20.00 $50.00 $80.00

[1] Annual Copayment Maximum does not include Copayments for pharmacy and supplemental benefits.
[2] Cancer Trial Services require preauthorization by UnitedHealthcare.
[3] If you participate in a clinical trial provided by a Non-Participating 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 Non-Participating Provider's billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Copayments, Coinsurance or Deductibles.
[4] The newborn care Copayment does not apply 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.
[5] Copayment applies regardless of whether this benefit is performed on an inpatient or outpatient bases. If performed on an inpatient basis, additional inpatient Copayment, if any, will apply.
[6] Percentage Copayment amounts are based upon PacfiCare's contracted rate.

Except in the case of a Medically Necessary Emergency or an Urgently Needed Service (outside geographic area served by your Participating Medical Group), each of the above-noted benefits is covered when authorized by your Participating Medical Group or UnitedHealthcare. A utilization review committee may review the request for services.

NOTE: This is not a contract – This Schedule of Benefits constitutes only a summary of the HMO health plans.

The Medical and Hospital Group Subscriber Agreement and the UnitedHealthcare 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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