CALIFORNIA SCHOOLS VEBA

UnitedHealthcare®

UnitedHealthcare SignatureValue™ Offered by UnitedHealthcare of California

40/20%

Performance HMO Schedule of Benefits (Benefit Package B, Network 3)

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

General Features

Calendar Year Deductible	None
Maximum Benefits	Unlimited
Annual Copayment Maximum[1] (maximum per family[2])	$5,000/individual $10,000/family
Office Visits	$40 Copayment
Hospital Benefits	20% Copayment[3]
Emergency Services (Copayment waived if admitted)	$300 Copayment
Urgently Needed Services (Medically Necessary services served by your Participating Medical Group. Please consult your brochure for additional details. Copayment waived if admitted)	$100 Copayment
Urgent Care as provided by your selected PMG/IPA	$40 Copayment
Pre-Existing Conditions	All conditions covered, provided they are covered benefits

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	20% Copayment[3]
Clinical Trials[4]	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Hospice Services (Prognosis of life expectancy of one year or less)	20% Copayment[3]
Hospital Benefits[5]	20% Copayment[3]
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	20% Copayment[3]
Maternity Care[8]	20% Copayment[3]
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 UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a description of this coverage.)** (Only one hospital Copayment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment.)	20% Copayment[3]
Newborn Care[5]	20% Copayment[3]
Physician Care	Paid in full
Reconstructive Surgery	20% Copayment[3]
Rehabilitation Care (Including physical, occupational and speech therapy)	20% Copayment[3]

Benefits Available While Hospitalized as an Inpatient (Continued)

Skilled Nursing Facility Care (Up to 100 days per benefit period)	Paid in full
Voluntary Termination of Pregnancy (Medical/medication and surgical) 1st trimester 2nd trimester (12-20 weeks) – After 20 weeks, not covered unless Medically Necessary, such as the mother's life is in jeopardy or fetus is not viable.	 $50 Copayment $100 Copayment

Benefits Available on an Outpatient Basis

Allergy Testing/Treatment (Serum is covered)	$40 Office Visit Copayment
Ambulance	Paid in full
Clinical Trials[4]	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Cochlear Implant Devices (Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply)	Paid in full
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)	$40 Copayment
Dialysis (Physician office visit may apply)	$40 Copayment per treatment
Durable Medical Equipment	Paid in full
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 under the age of 19.)	Paid in full
Family Planning (Non-Preventive Care)[9] Vasectomy Depo-Provera Injection – (other than contraception)[9] Depo-Provera Medication – (other than contraception)[9] (Limited to one Depo-Provera injection every 90 days.) Voluntary Termination of Pregnancy (Medical/medication and surgical) 1st trimester 2nd trimester (12-20 weeks) – After 20 weeks, not covered unless Medically Necessary, such as the mother's life is in jeopardy or fetus is not viable.	 Copayment will be the applicable Physician office visit, Outpatient Surgery or Inpatient Surgery Copayment $40 Office Visit Copayment $35 Copayment $50 Copayment $100 Copayment
Hearing Aid – Standard $5,000 annual benefit maximum per calendar year. Limited to one hearing aid (including repair/replacement) per hearing-impaired ear every three years.	Paid in full
Hearing Aid – Bone Anchored[7] Repairs and/or replacements 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
Hearing Exam[8]	Paid in full
Home Health Care Visits	Paid in full
Hospice Services (Prognosis of life expectancy of one year or less)	Paid in full
Infertility Services	Not covered

Benefits Available on an Outpatient Basis (Continued)

Infusion Therapy (Infusion Therapy is a separate Copayment in addition to a home health care or an office visit Copayment. Copayment applies per 30 days or treatment plan, whichever is shorter)	Paid in full
Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications)[9] (Copayment not applicable to allergy serum, immunizations, birth control, Infertility and insulin. The Self-Injectable medications Copayment applies per 30 days or treatment plan, whichever is shorter. Please see the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for more information on these benefits, if any. Office visit Copayment may also apply)	Paid in full
Laboratory Services (When available through or authorized by your UnitedHealthcare Performance HMO Participating Medical Group)	Paid in full
Maternity Care, Tests and Procedures[8]	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 UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a description of this coverage.)**	$40 Office Visit Copayment
Oral Surgery Services	$40 Copayment[6]
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	$40 Office Visit Copayment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	$500 Copayment per admit
Physician Care (For children under two years of age, refer to Well-Baby Care)	$40 Office Visit Copayment
Preventive Care Services[8, 9] 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 a "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 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.	Paid in full
Prosthetics and Corrective Appliances	Paid in full

Benefits Available on an Outpatient Basis (Continued)

Radiation Therapy	
Standard:	Paid in full
(Photon beam radiation therapy)	
Complex:	Paid in full
(Examples include, but are not limited to, brachytherapy, radioactive implants and conformal photon beam; Copayment applies per 30 days or treatment plan, whichever is shorter; GammaKnife and stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Copayment amount if any)	
Radiology Services	
Standard:	Paid in full
Specialized scanning and imaging procedures:	$200 Copayment
(Examples include but are not limited to, CT, SPECT, PET, MRA and MRI – with or without contrast media) A separate Copayment will be charged for each part of the body scanned as part of an imaging procedure.	
Vision Refractions	Paid in full

[1] The Annual Out-of-Pocket Maximum includes Copayments for UnitedHealthcare supplemental benefits, except for standalone Dental, Vision, and Rx.

[2] When individual or a family meets annual copayment maximum, no further copayments are required for the year for that individual or family.

[3] Each hospital admission requires a 20% Copayment.

[4] Clinical Trial services require preauthorization by UnitedHealthcare. If you participate in a Cancer 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 Providers billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Copayments, coinsurance or deductibles.

[5] The inpatient hospital benefits Copayment 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.

[6] In instances where the negotiated rate is less than your Copayment, you will pay only the negotiated rate.

[7] 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.

[8] 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 copayment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card.

[9] FDA-approved contraceptive methods and procedures recommended by the Health Resources and Services Administration as preventive care services will be 100% covered. Copayment applies to contraceptive methods and procedures that are **NOT** defined as Covered Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form

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 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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