COUNTY OF LOS ANGELES

UnitedHealthcare SignatureValue™ Offered by UnitedHealthcare of California

2019 HMO Schedule of Benefits Booklet

COUNTY OF LOS ANGELES

UnitedHealthcare®

SignatureValue™ HMO
Offered by UnitedHealthcare of California

HMO Schedule of Benefits
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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 $1,000 Family $2,000
PCP Office Visits (All Pediatric PCP Office Visits to age 5 [0 – 5 years of age] regardless if seen for sickness, injury, or preventative apply a $0 Copayment)	$10 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) (All Pediatric Specialist Office Visits to age 5 [0 – 5 years of age] regardless if seen for sickness, injury, or preventative apply a $0 Copayment) Co-payments for audiologist and podiatrist visits will be the same as for the PCP.	$10 Office Visit Co-payment
Hospital Benefits	No charge
Emergency Services	$50 Co-payment (Co-payment waived if admitted)
Urgently Needed Services Urgent care services – services provided **within** the geographic area served by your medical group Urgent care services – services provided **outside** of the geographic area served by your medical group 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.	 $10 Co-payment $10 Co-payment

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	No charge
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)	No charge
Hospital Benefits	No charge
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	No charge
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.	No charge
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.)**	No charge
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.	No charge
Physician Care	No charge
Reconstructive Surgery	No charge
Rehabilitation Care (Including physical, occupational and speech therapy)	No charge
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**.	No charge
Skilled Nursing Facility Care (Up to 100 days per benefit period)	No charge
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)	No charge

Benefits Available on an Outpatient Basis

Allergy Testing/Treatment (Serum is covered) PCP Office Visit Specialist Office Visit	 $10 Office Visit Co-payment $10 Office Visit Co-payment
Ambulance	No charge
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.	No charge
Dental Treatment Anesthesia (Additional Co-payment for outpatient surgery or inpatient hospital benefits may apply)	$10 Co-payment
Dialysis (Physician office visit Co-payment may apply)	$10 Co-payment per treatment
Durable Medical Equipment	No charge
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.	 $75 Co-payment $10 Office Visit Co-payment $10 Office Visit Co-payment $35 Co-payment $10 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.)	No charge

Benefits Available on an Outpatient Basis (Continued)

Hearing Aid - Bone Anchored Repairs and/or replacement are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered. 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.
Hearing Exam PCP Office Visit Specialist Office Visit 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.	 $10 Office Visit Co-payment $10 Office Visit Co-payment
Home Health Care Visits	$10 Co-payment per visit
Hospice Services (Prognosis of life expectancy of one year or less)	No charge
Infertility Services	50% of Cost Copayment
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.	No charge
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.	No charge
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 Specialist Office Visit 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 No charge

Benefits Available on an Outpatient Basis (Continued)

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	$10 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
Oral Surgery Services	No charge
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	$10 Office Visit Co-payment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	No charge
Physician Care	
PCP Office Visit	$10 Office Visit Co-payment
Specialist Office Visit (All Pediatric PCP and Specialist Office Visits to age 5 [0 – 5 years of age] regardless if seen for sickness, injury, or preventative apply a $0 Copayment)	$10 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 (All Pediatric PCP Office Visits to age 5 [0 – 5 years of age] regardless if seen for sickness, injury or preventative apply a $0 Copayment) • Well-Woman, including routine prenatal obstetrical office visits, pap smear and screening mammography • Tubal Ligation • Insertion/Removal of Intra-Uterine Device (IUD) • PCP/Specialist Office Visit • Intra-Uterine Device (IUD) • Removal of Norplant • PCP/Specialist Office Visit 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

Benefits Available on an Outpatient Basis (Continued)

Prosthetics and Corrective Appliances	No charge
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 No charge
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 No charge
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**.	
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 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 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.	$10 Co-payment
Vision Refractions	$10 Office Visit 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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HMO PHARMACY SCHEDULE OF BENEFITS

Summary of Benefits	Generic Formulary	Brand-name Formulary
Retail Pharmacy Copayment (per Prescription Unit or up to 30 days)	**$5**	**$20**
Mail Service Pharmacy Copayment (three Prescription Units or up to a 90-day supply)	**$10**	**$40**

This Schedule of Benefits provides specific details about your prescription drug 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 coverage.

What do I pay when I fill a prescription?

You will pay only a Copayment when filling a prescription at a UnitedHealthcare Participating Pharmacy. You will pay a Copayment every time a prescription is filled. Your Copayments are as shown in the grid above.

A copy of the Selected Brands List is available upon request from UnitedHealthcare's Customer Service department and may be found on UnitedHealthcare's Web site at **www.myuhc.com**.

Preauthorization

Selected generic Formulary, brand-name Formulary and non-Formulary medications require a Member to go through a Preauthorization process using criteria based upon Food and Drug Administration (FDA)-approved indications or medical findings, and the current availability of the medication. UnitedHealthcare reviews requests for these selected medications to ensure that they are Medically Necessary, being prescribed according to treatment guidelines consistent with standard professional practice and are not otherwise excluded from coverage.

Because UnitedHealthcare offers a comprehensive Formulary, selected non-Formulary medications will not be covered until one or more Formulary alternatives, or non-Formulary preferred drugs have been tried. UnitedHealthcare understands that situations arise when it may be Medically Necessary for you to receive a certain medication without trying an alternative drug first. In these instances, your Participating Physicians will need to provide evidence to UnitedHealthcare in the form of documents, lab results, records or clinical trials that establish the use of the requested medications as Medically Necessary. Participating Physicians may call or fax Preauthorization requests to UnitedHealthcare. Applicable Copayments will be charged for prescriptions that require Preauthorization if approved.

For a list of the selected medications that require UnitedHealthcare's Preauthorization, please contact UnitedHealthcare's Customer Service department.

Medication Covered by Your Benefit

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

- **Disposable all-in-one prefilled insulin pens**, insulin cartridges and needles for nondisposable pen devices are covered when Medically Necessary, in accordance with UnitedHealthcare's Preauthorization 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 unless they are on UnitedHealthcare's Selected Brands List. A copy of the Selected Brands List is available upon request from UnitedHealthcare's Customer Service department or may be found on UnitedHealthcare's Web site at **www.myuhc.com**.
- **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, inhaler extender devices, urine test strips and anaphylaxis prevention kits (including, but not limited to, EpiPen®, Ana-Kits® and Ana-Guard®). See the medical *Combined Evidence of Coverage and Disclosure Form* for coverage of other injectable medications in Section Five under "Your Medical Benefits."

- **Oral Contraceptives:** Federal Legend oral contraceptives, prescription diaphragms and oral medications for emergency contraception.
- **State Restricted Drugs**: Any medicinal substance that may be dispensed by prescription only, according to state law.
- **Sexual Dysfunction Medication:** Medically Necessary outpatient prescription medications prescribed by a Participating Physician to treat sexual dysfunction when Preauthorized by UnitedHealthcare. Prescription medications for the treatment of sexual dysfunction are Non-Formulary drugs and require Preauthorization by UnitedHealthcare. Medically Necessary prescription medications prescribed for the treatment of sexual dysfunction are limited to eight (8) tablets of Viagra per month, for a Copayment at 50 percent of UnitedHealthcare's contracted rate with the Participating Pharmacy.

Exclusions and Limitations

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

- **Administered Drugs**: 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 Preauthorized 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 nonprescription, 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 Participating 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*.
- **Drugs prescribed by a dentist** or drugs when prescribed for dental treatment are not covered.
- **Drugs when prescribed to shorten the duration of a common cold** are not covered.
- **Enhancement medications** when prescribed for the following nonmedical conditions are not covered: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. Examples of drugs that are excluded when prescribed for such conditions include, but are not limited to, Penlac®, Retin-A®, Renova®, Vaniqa®, Propecia®, Lustra®, Xenical® or Meridia®. This exclusion does not exclude coverage for drugs when Preauthorized as Medically Necessary to treat morbid obesity or diagnosed medical conditions affecting memory, including, but not limited to, Alzheimer's dementia.
- **Infertility:** All forms of prescription medication when prescribed for the treatment of infertility are not covered. If your Employer has purchased coverage for infertility treatment, prescription medications 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* titled "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 Preauthorization requirements. For additional information, refer to Section Five of

your medical *Combined Evidence of Coverage and Disclosure Form* under "Your Medical Benefits."

- **Inpatient Medications**: 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* titled "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 Participating 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 Participating Physician at a Participating Pharmacy and pay the applicable Copayment 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.
- **Medications dispensed by a non-Participating Pharmacy** are not covered except for prescriptions required as a result of an Emergency or Urgently Needed Service.
- **Medications prescribed by non-Participating Physicians** are not covered except for prescriptions required as a result of an Emergency or Urgently Needed Service.
- **New medications that have not been reviewed for safety, efficacy and cost-effectiveness and approved** by UnitedHealthcare are not covered unless Preauthorized by UnitedHealthcare as Medically Necessary.
- **Non-Covered Medical Condition**: Prescription medications for the treatment of a non-covered medical condition are not covered. This exclusion does not exclude Medically Necessary medications 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 participating 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*, 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. Nothing in this section shall prohibit UnitedHealthcare from use of a Formulary, Copayment, 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 Medical Review System as defined in the medical *Combined Evidence of Coverage and Disclosure Form*.
- **Over-the-Counter Drugs:** Medications (except insulin) available without a prescription (over-the-counter) or for which there is a nonprescription chemical and dosage equivalent available, even if ordered by a Physician, are not covered. All nonprescription (over-the-counter) contraceptive jellies, ointments, foams or devices are not covered.
- **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 lost, stolen or destroyed medications are not covered.
- **Saline and irrigation solutions** are not covered. Saline and irrigation solutions are covered when 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,** including, but not limited to, nicotine gum, nicotine patches and nicotine nasal spray, are not covered. However, smoking cessation products are covered when the Member is enrolled in a smoking cessation program approved by UnitedHealthcare. 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 titled "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 nonmedical substances, insulin pumps and related supplies (these services are provided as Durable Medical Equipment) and hypodermic needles and syringes not related to diabetic needs or cartridges are not covered. Birth control devices and supplies or preparations that do not require a Participating

  Physician's prescription by law are also not covered, even if prescribed by a Participating Physician. 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, titled "Your Medical Benefits" under "Outpatient Benefits" located, for example, in subsections titled "Diabetic Self Management", "Durable Medical Equipment," or "Home Health Care and Prosthetics and Corrective Appliances."
- **Workers' Compensation**: Medication 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."

UnitedHealthcare reserves the right to expand the Preauthorization requirement for any drug product.

Questions? Call the HMO Customer Service department at 1-800-367-2660 or 711 (TTY).

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12/24/24 Vision Summary of Benefits

Summary of Benefits	Copayment
Exam	**$10**
Eyewear	**$10**
Frame Allowance or Contact Lenses	**$105**

Vision Care Benefits

As a special supplement to your UnitedHealthcare Health Plan, you and your family can now enjoy the advantages of vision care coverage.

Vision Care: $10 Copayment for exams
$10 Copayment for eyewear

Through an arrangement with Vision Service Plan (VSP), you are fully covered when you visit any of the over 4,000 VSP doctors for any of these services:

Vision Examinations: A complete analysis, every 12 months, of the eyes and related structures to determine the presence of vision problems, or other abnormalities.

Lenses: Every 24 months, the VSP Panel Doctor will order the proper lenses. The doctor verifies the accuracy of the finished lenses.

Frames: You are provided with an allowance of $105. This allowance provides coverage for a wide selection of frames. If you choose a frame that exceeds your plan's allowance, you will receive a 20 percent discount on the amount over your allowance. Have your doctor help you choose a frame based on your needs.

Contact Lenses: VSP offers Members preferred pricing and direct delivery on annual supplies of select brands of soft contact lenses. Even if you choose to use your benefit for glasses, you can still take advantage of this program. Visit **www.vsp.com** or ask your doctor for details.

You Select the Doctor of Your Choice

Contact Lenses: Contact lenses are furnished under the VSP Plan when the VSP doctor secures prior approval for the following conditions:

a. Following cataract surgery
b. To correct extreme visual acuity problems that cannot be corrected with spectacle lenses
c. Anisometropia
d. Keratoconus

When VSP doctors receive approval for such cases, they are fully covered by VSP.

When Members choose contact lenses for other reasons, VSP will make an allowance toward their cost in lieu of all other benefits for that year.

Procedure for Using the Benefit

- In order to access vision care benefits, simply contact your VSP Doctor to make an appointment. If you need help locating a VSP Doctor, call 1-800-367-2660*, or visit **www.vsp.com**
- When calling the doctor's office for an appointment for you or your covered Dependents, identify yourself as a VSP patient. Indicate the organization that provides your benefits (Your employer, HMO, trust fund, etc.) and provide your VSP ID number. The VSP doctor will obtain the necessary authorization and information about your eligibility and coverage.
- When the examination has been completed, pay the Copayment(s) to the doctor for the services described herein. VSP will pay the Doctor directly according to its agreement with the doctor.

Complete Vision Examination Every 12 Months

- Selecting a doctor from the VSP list assures direct payment to the doctor and quality and cost control. However, if the Member seeks the services of doctor who is not a VSP Doctor, the Member should pay the doctor his or her full fee. The Member will be reimbursed in accordance with a reimbursement schedule.

There is no assurance that the schedule will be sufficient to pay for the examination or the glasses.

Reimbursement benefits are not assignable.

Note: When the Member obtains the services from a doctor who is not a VSP doctor and/or obtains glasses from a dispensing optician, the Member should be sure to send the itemized statement of charges to VSP along with the benefit form.

Exclusions and Limitations

Extra Cost. This plan is designed to cover your vision needs rather than cosmetic materials. If you select any of the following, there will be an extra charge:

- Blended lenses
- Contact lenses (except as noted)
- Oversize lenses
- Progressive multifocal lenses
- Photochromic lenses or tinted lenses other than Pink #1 or Pink #2
- Coated lenses
- Laminated lenses
- A frame that costs more than the plan allowance

Not Covered

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing;
- Plano lenses;
- Two pair of glasses in lieu of bifocals;
- Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.

Reimbursement for Services From an Out-of-Network Provider

If the Member chooses to receive services provided by an out-of-network doctor, the Member must pay that doctor's charges in full and then seek reimbursement from VSP as provided in the Reimbursement Schedule described below. Reimbursement is subject to VSP's determination of the Member's eligibility.

There is no assurance that the amounts shown on the Reimbursement Schedule will be sufficient to pay for the examination for eyeglasses or contact lenses. Reimbursement benefits are not assignable. The Member needs to mail a copy of the receipt and itemized statement of full payment that includes the eye examination, lens type and frame to VSP. The documents must include:

1. The Member's name and mailing address.
2. The Member's UnitedHealthcare of California identification number.
3. The Member's employer or group name.
4. The Patient's name, relationship to the Member and date of birth.

The data may be submitted on any generic insurance claim form available from your Non-Participating Provider.

All Claims for reimbursement must be submitted within six months of the completion of the services from which the claim is made.

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

Reimbursement Schedule

Professional Fees

Vision Examination $35.00

Materials

Single Vision Lenses, up to $25.00

Bifocal Lenses, up to $40.00

Trifocal Lenses, up to $50.00

Lenticular Lenses, up to $100.00

Frames, up to $30.00

Necessary Contact Lenses $250.00

Cosmetic Contact Lenses $100.00 The Reimbursement Schedule set forth is based upon the provision of two lenses.

If only one lens is necessary, one-half of the reimbursement allowance will be paid.

CALIFORNIA

Infertility Basic Diagnosis and Treatment Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form

This brochure contains important information for our Members about the UnitedHealthcare Infertility Basic Diagnosis and Treatment supplemental benefit. As a Member you shall be entitled to receive basic diagnostic services and treatment for infertility as described in this brochure. You will find important definitions in the back of this document regarding your infertility supplemental benefit.

Benefits

UnitedHealthcare's Basic Infertility Services must be Medically Necessary and consistent with accepted standards of care for the diagnosis and treatment of infertility. Services must be authorized and directed by the Participating Medical Group or the UnitedHealthcare SignatureValue® Advantage Participating Medical Group (for Advantage participants) and benefits are subject to the Exclusions and Limitations stated below:

Diagnosis of Infertility

a. Complete medical history.
b. General medical examinations. Examples include but are not limited to:
   - Pelvic exam;
   - Routine laboratory investigation for hormonal disturbances (e.g., FSH, LH, prolactin);
   - Cultures for infectious agents;
   - Serum progesterone determination;
   - Laparoscopy;
   - Hysterosalpingogram.
   - Semen analysis up to three times following five days of abstinence;
   - Huhner's Test or Post-Coital Examinations;
   - Laboratory studies (e.g., FSH, LH, prolactin, serum testosterone);
   - Testicular biopsy when Member has demonstrated azoospermia;
   - Scrotal ultrasound, when appropriate for azoospermia;
   - Electrical Assistance for Recovery of Sperm (EARS), when medically indicated, as when the Member is a paraplegic or quadriplegic, as approved by UnitedHealthcare's Medical Director or designee;
   - HIV, Hepatitis B surface antibody, Hepatitis C antibody, HTLV-1 and syphilis testing of partner prior to artificial insemination.

Treatment of Infertility

a. Insemination Procedures are limited to six procedures per lifetime, unless the Member conceives, in which case the benefit renews.
b. Clomid used during the covered periods of infertility is covered as part of this Supplemental Benefit and is not a covered pharmaceutical through UnitedHealthcare's supplemental pharmacy coverage.
c. Gamete Intrafallopian Transfer (GIFT). An infertility treatment that involves obtaining eggs (through medical and surgical procedures) and sperm, loading the eggs and sperm into a catheter, then emptying the contents of the catheter into the fallopian tube. The intent of this procedure is to have fertilization occur in the fallopian tubes.
d. Injectable medications and syringes for the treatment of infertility are covered as part of this Supplemental Infertility Benefit and are not a covered pharmaceutical through UnitedHealthcare's supplemental pharmacy coverage. Examples include:
   - Pergonal;
   - Profasi;
   - Metrodin;
   - Urofollitropin;

Coverage for other injectable drugs not listed above will be reviewed based on Medical Necessity for the specific Member, and Food and Drug Administration (FDA) recommendations, including off-label use for the drug requested.

Coverage

All benefits, including physician services, procedures, diagnostic services or medications, are covered at 50 percent of cost Copayment (based upon UnitedHealthcare's contractual rate for the services provided with the infertility provider(s)).

Exclusions

- Services not authorized and directed by the Participating Medical Group or the Advantage Participating Medical Group (for Advantage participants).
- Medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, anorgasmy or hyporgasmy.
- Infertility service after a previous elective vasectomy or tubal ligation, whether or not a reversal has been attempted or completed.
- Reversal of a previous elective vasectomy or tubal ligation.
- All Medical and Hospital infertility services and supplies for a Member whose fertility is impaired due to an elective sterilization. This includes any

supplies, medications, services and/or procedures used for an excluded benefit, e.g., , ZIFT or IVF.

- Further infertility treatment when either or both partners are unable due to an identified exclusion in this Supplemental Benefit or unwilling to participate in the treatment plan prescribed by the infertility physician.
- Treatment of sterility in which a donor ovum would be necessary (e.g., post-menopausal syndrome).
- Insemination with semen from a partner with an infectious disease which, pursuant to guidelines of the Society of Artificial Reproductive Technology, has a high risk of being transmitted to the partner and/or infecting any resulting fetus. This exclusion would not prohibit the Member's purchase of donor sperm or from obtaining a donor with appropriate testing, at the Member's expense, to receive the eligible infertility benefits.
- Microdissection of the zona or sperm microinjection.
- Experimental and/or Investigational diagnostic studies or procedures, as determined by UnitedHealthcare's Medical Director or Designee.
- Advanced infertility procedures, as well as In Vitro Fertilization (IVF), and Zygote Intrafallopian Transfer (ZIFT) and procedures performed in conjunction with advanced infertility procedures, IVF, and ZIFT.
- Infertility services for non-members (e.g., surrogate mothers who are not UnitedHealthcare Members).
- Maternity care and services for non-members.
- Intravenous Gamma Globulin (IVIG).
- Any costs associated with the collection, preparation, storage of or donor fees for the use of donor sperm that may be used during a course of artificial insemination. This includes HIV testing of donor sperm when infertility exists; e.g., use of another relative's sperm.
- Artificial insemination procedures in excess of six, when a viable infant has not been born as a result of infertility treatment(s) or unless the Member conceives. The benefit will renew if the Member conceives.
- Ovum transplants, ovum or ovum bank charges.

Definitions

1. Infertility is defined as either:
   a. The presence of a demonstrated medical condition recognized by a licensed physician or surgeon as a cause of infertility; or
   b. The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception;
2. Basic Infertility Services are the reasonable and necessary services associated with the diagnosis and treatment as disclosed in this document, unless the UnitedHealthcare Medical Director or designee determines that:
   a. Continued treatment has no reasonable chance of producing a viable pregnancy; or
   b. Advanced Reproductive Therapy services are necessary, which are excluded under this supplemental benefit.
   c. The Member has received the lifetime benefit maximum of six artificial insemination procedures, cumulatively, under one or more UnitedHealthcare Health Plans, has occurred.
3. Gamete Intrafallopian Transfer (GIFT). An infertility treatment that involves obtaining eggs (through medical and surgical procedures) and sperm, loading the eggs and sperm into a catheter, then emptying the contents of the catheter into the fallopian tube. The intent of this procedure is to have fertilization occur in the fallopian tubes
4. Advanced Reproductive Therapy, as excluded under this Basic Infertility Services benefit are:
   a. In Vitro Fertilization (IVF). A highly sophisticated infertility treatment that involves obtaining mature eggs (oocytes) by surgical or nonsurgical procedures and combining the eggs and sperm in a laboratory setting. If fertilization and cell division occur, the resulting embryo(s) are transferred to the uterine cavity where implantation and pregnancy may occur.
   b. Zygote Intrafallopian Transfer (ZIFT). An infertility treatment that involves obtaining mature eggs (oocytes) by surgical or nonsurgical procedures and combining the eggs and sperm in a laboratory setting. The fertilized oocytes, or zygotes, are transferred to the fallopian tube before cell division occurs. The intent of this procedure is to have the zygote travel to the uterus via the fallopian tube.
5. Lifetime benefit maximum is individually cumulative for the Member over one or more UnitedHealthcare plans. Any Member that terminates from a UnitedHealthcare Health Plan with a lifetime benefit maximum, and subsequently re-enrolls in another UnitedHealthcare Plan with a lifetime benefit maximum, will carry over any previous benefit utilization calculated by his or her previous UnitedHealthcare benefit coverage into the new UnitedHealthcare Benefit plan. In the event the Member has exhausted the lifetime benefit maximum on the previous UnitedHealthcare Health Plan, the Member is no longer eligible for any further benefits.

UnitedHealthcare

Mental Health and Substance-Related and Addictive Disorder Services, Provided by U.S. Behavioral Health Plan, California

Schedule of Benefits

Pre-Authorization is required for certain Mental Health Services and Substance-Related and Addictive Disorder Services. You do not need to go through your Primary Care Physician, but you must obtain prior authorization through U.S Behavioral Health Plan, California (USBHPC) for Inpatient services, Residential Treatment services, Intensive Outpatient Program Treatment, Outpatient Electro-Convulsive Treatment, Outpatient Treatment extended beyond 45 minutes, Partial Hospitalization/ Day Treatment, Behavioral Health Treatment for PDD/ Autism including Applied Behavior Analysis (ABA) and other evidence-based behavioral intervention programs, Medical Detoxification, Methadone Maintenance Treatment; and Psychological Testing, except in the event of an Emergency. USBHPC is available to you toll-free, 24 hours a day, 7 days a week, at 1-800-999-9585.

Mental Health Services

Inpatient and Residential Treatment Medically Necessary Mental Health services provided at an Inpatient Treatment Center	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information[1]
Outpatient Treatment (includes individual/ group counseling/ monitoring drug therapy) Outpatient Treatment for Mental Health Services (including SMI and SED conditions) includes Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, Outpatient Electro-Convulsive Therapy (ECT), Outpatient Treatment extended beyond 45 minutes, psychological and neuropsychological testing , applied behavior analysis (ABA) and other evidence-based behavioral intervention programs	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Partial Hospitalization/Day Treatment and Intensive Outpatient Treatment.	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Emergency and Urgently Needed Services[2]	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information

Substance-Related and Addictive Disorder Services

Inpatient and Residential Treatment Medically Necessary treatment of Substance-Related and Addictive Disorders, Including Medical Detoxification, provided at a Participating Facility	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information[1]

Substance-Related and Addictive Disorder Services (Continued)

Outpatient Treatment Outpatient Treatment for Substance-Related and Addictive Disorder Services includes outpatient evaluation and treatment for chemical dependency: • individual and group Substance-Related and Addictive Disorder counseling; • medical detoxification • methadone maintenance treatment; and • outpatient treatment extended beyond 45 minutes.	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Partial Hospitalization/Day Treatment and Intensive Outpatient Treatment.	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Emergency and Urgently Needed Services[2]	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information

Severe Mental Illness Benefit and Serious Emotional Disturbances of a Child[3]

Inpatient and Residential Treatment Unlimited days	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information[1]
Outpatient Treatment Outpatient Treatment for Mental Health Services (including SMI and SED conditions) includes Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, Outpatient Electro-Convulsive Therapy (ECT), Outpatient Treatment extended beyond 45 minutes, psychological and neuropsychological testing, applied behavior analysis (ABA) and other evidence-based behavioral intervention programs	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Partial Hospitalization/Day Treatment or Intensive Outpatient Treatment.	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Emergency and Urgently Needed Services[2]	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information

[1] Each Hospital Admission may require an additional Copayment. Please refer to your UnitedHealthcare of California Medical Plan *Schedule of Benefits.*

[2] Emergency and Urgently Needed Services are Medically Necessary behavioral health services required outside the Service Area to prevent serious deterioration of a Member's health resulting from an unforeseen illness or injury manifesting itself by acute symptoms of sufficient servility, including severe pain, and may result in immediate harm to self or others; placing one's health in serious jeopardy; serious impairment of one's functioning; or serious dysfunction of any bodily organ or part, therefore such treatment cannot be delayed until the Member returns to the Service Area. Please refer to the Supplement to the Combined Evidence of Coverage and Disclosure Form for detailed information on this benefit.

[3] Severe Mental Illness (SMI) diagnoses include: Anorexia Nervosa; Bipolar Disorder; Bulimia Nervosa; Major Depressive Disorders; Obsessive-Compulsive Disorder; Panic Disorder; Pervasive Developmental Disorder, including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified, including Atypical Autism; Schizoaffective Disorder; Schizophrenia. Serious Emotional Disturbance (SED) of a Child Under Age 18 includes a condition identified as a Mental Disorder in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), other than a primary substance-related and addictive disorder or developmental disorder that result in behavior inappropriate to the child's age according to expected developmental norms if the child also meets at least one of the following three criteria:

- As a result of the Mental Disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either:
  (i) the child is at risk of removal from home or has already been removed from the home; or
  (ii) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or
- The child displays psychotic features or risk of suicide or violence due to a Mental Disorder; or
- The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code.

PO Box 30968
Salt Lake City, UT 84130-0968

Customer Service:
1-800-367-2660
711 (TTY)
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