UnitedHealthcare®

SignatureValue™ Alliance HMO
Offered by UnitedHealthcare of California

HMO Deductible Schedule of Benefits

25-50/20%/500DED

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

General Features

Calendar Year Deductible On a Family plan, if one individual member meets the Individual deductible amount, his/her deductible is met, and the Family deductible must be met by one or more of the family members. Certain Covered Health Care Services will not be covered until you meet the Calendar Year Deductible. Only amounts incurred for Covered Health Care Services that are subject to the Deductible will count toward the Deductible. The Deductible applies to the Annual Out-of-Pocket Limit. The amounts applied to the Deductible are based upon UnitedHealthcare's contracted rates. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.	Individual: $500 Family: $1,000
Maximum Benefits	Unlimited
Annual Out-of-Pocket Limit On a Family plan, if one individual member meets the Individual out of pocket amount, his/her out of pocket is met and the Family out of pocket must be met by one or more of the family members**.** 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 drugs and acupuncture 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 Individual Out-of-Pocket Limit. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	Individual: $3,000 Family: $6,000
PCP Office Visits	$25 Office Visit Co-payment

General Features (Continued)

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.	$50 Office Visit Co-payment
Hospital Benefits	20% Co-payment after Deductible
Emergency Health Care Services	$250 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.	 $25 Co-payment $50 Co-payment

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	20% Co-payment after Deductible
Clinical Trials Clinical Trial Services require prior authorization by UnitedHealthcare. If you participate in a clinical trial provided by an Out-of-Network Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Network Providers, you will be responsible for payment of the difference between the Out-of-Network Provider's billed charges and the rate negotiated by UnitedHealthcare with Network Providers, in addition to any applicable Co-payments, Co-insurance or Deductibles.	Paid at negotiated rate after Deductible. Balance (if any) is the responsibility of the Member.
Hospice Services (Prognosis of life expectancy of one year or less)	20% Co-payment after Deductible
Hospital Benefits	20% Co-payment after Deductible
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	20% Co-payment after Deductible
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 UnitedHealthcare at the number on your ID card	20% Co-payment after Deductible
Mental Health Care 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.**	20% Co-payment after Deductible

Benefits Available While Hospitalized as an Inpatient (Continued)

Newborn Care (The newborn care Deductible and/or Co-payment 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.)	20% Co-payment after Deductible
Physician Care	No charge
Reconstructive Surgery	20% Co-payment after Deductible
Rehabilitation and Habilitative Services (Including physical, occupational and speech therapy)	20% Co-payment after Deductible
Skilled Nursing Facility Care (Up to 100 days per benefit period)	20% Co-payment after Deductible
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.**	20% Co-payment after Deductible
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 Co-payments for Audiologist and Podiatrist visits will be the same as for the PCP	 $25 Office Visit Co-payment $50 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)	$150 Co-payment
Clinical Trials Clinical Trial Services require prior authorization by UnitedHealthcare. If you participate in a clinical trial provided by an Out-of-Network Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Network Providers, you will be responsible for payment of the difference between the Out-of-Network Provider's billed charges and the rate negotiated by UnitedHealthcare with Network Providers, in addition to any applicable Co-payments, Co-insurance 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.	$50 Co-payment per item
Dental Treatment Anesthesia (Additional Co-payment for outpatient surgery or inpatient hospital benefits may apply.)	$50 Co-payment
Depo-Provera Medication – (other than contraception) (Limited to one Depo-Provera injection every 90 days.) (Additional Co-payment for office visits may apply.)	$75 Co-payment
Dialysis (Additional Co-payment for office visits may apply.)	$50 Co-payment per treatment

Benefits Available on an Outpatient Basis (Continued)

Durable Medical Equipment In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	$70 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
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. (Repairs and/or replacements are not covered, except for malfunctions. Deluxe model and upgrades that are not Medically Necessary are not covered)	$70 Co-payment
Hearing Aid – Bone-Anchored Repairs and/or replacements 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 UnitedHealthcare at the telephone number on your ID card.	 $25 Office Visit Co-payment $50 Office Visit Co-payment
Home Health Care Visits (Up to 100 visits per calendar year)	$25 Co-payment per visit
Home Test Kits for Sexually Transmitted Diseases	Depending upon where the covered health service is provided, benefits will be the same as those stated under each covered health service category in this Schedule of Benefits
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 a home health care or an office visit Co-payment. In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	$150 Co-payment per medication

Benefits Available on an Outpatient Basis (Continued)

Injectable Drugs (Co-payment/Co-insurance not applicable to injectable immunizations, birth control, infertility and insulin.) Outpatient Injectable Medication Self-Injectable Medication Applies to dollar co-payments only: In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate. 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 Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.	$150 Co-payment per medication
Laboratory Services (When available through and authorized by your Network Medical Group) (Additional Co-payment for office visits may apply)	$25 Co-payment
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 UnitedHealthcare at the telephone number on your ID card.	 No charge No charge
Mental Health Care Services 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 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 Autism Spectrum Disorders, laboratory charges, or other medical Partial Hospitalization/Day Treatment and Intensive Outpatient Treatment, and psychiatric observation **(Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage)**	 $50 Office Visit Co-payment No charge
Oral Surgery Services	20% Co-payment after Deductible
Outpatient Habilitative Services and Outpatient Therapy	$25 Office Visit Co-payment
Outpatient Medical Rehabilitation Therapy at a Network Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	$25 Office Visit Co-payment
Outpatient Surgery at a Network Free-Standing or Outpatient Surgery Facility	20% Co-payment after Deductible

Benefits Available on an Outpatient Basis (Continued)

Physician Care PCP Office Visit Specialist Office Visit Co-payments for Audiologist and Podiatrist visits will be the same as for the PCP.	 $25 Office Visit Co-payment $50 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 Network 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 us at the telephone number on your ID card. 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 Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.	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.	$70 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

Benefits Available on an Outpatient Basis (Continued)

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.	 $25 Co-payment $150 Co-payment
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.**	 $50 Office Visit Co-payment No charge
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 Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.	No charge
Vasectomy	No charge
Virtual Care Services 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 the telephone number on your ID card.	No charge
Vision Refractions	$25 Co-payment

Note: Benefits with Percentage Co-payment amounts are based upon the Allowed Amount, or the Recognized Amount as applicable, which is defined in the Evidence of Coverage.

Allowed Amounts

Allowed Amounts are the amount we determine that we will pay for Benefits.

- For Network Benefits for Covered Health Care Services provided by a Network Provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.
- For Covered Health Care Services that are **Ancillary Services received at Network facilities on a non-Emergency basis at which, or as a result of which, services are received from out-of-Network Providers**, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance or deductible. You shall pay no more than the same cost sharing than you would pay for the same Covered Health Care Services received from a Network Provider.
- For Covered Health Care Services that are ***non-Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below,*** you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the Combined Evidence of Coverage and Disclosure Form.

- For Covered Health Care Services that are ***Emergency Health Care Services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the Combined Evidence of Coverage and Disclosure Form.
- For Covered Health Care Services that are ***Air Ambulance services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the Combined Evidence of Coverage and Disclosure Form.

Allowed Amounts are determined in accordance with our reimbursement policy guidelines or as required by law, as described in the Combined Evidence of Coverage and Disclosure Form.

For Network Benefits, Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as arranged by us, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Care Services, Allowed Amounts are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

When Covered Health Care Services are received from an out-of-Network provider as described below, Allowed Amounts are determined as follows:

For non-Emergency Covered Health Care Services received at certain Network facilities from out-of-Network Physicians when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Ac*t with respect to a visit as defined by the Secretary, the Allowed Amount is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement.*
- The reimbursement rate as determined by state law.
- The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and an out-of-Network Physician may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible.

For Emergency Health Care Services provided by an out-of-Network provider, the Allowed Amount is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement.*
- The reimbursement rate as determined by state law.
- The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible.

For Air Ambulance transportation provided by an out-of-Network provider, the Allowed Amount is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement*.
- The reimbursement rate as determined by state law.
- The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance or deductible which is based on the rates that would apply if the service was provided by a Network provider.

For Emergency ground ambulance transportation provided by an out-of-Network provider, the Allowed Amount, which includes mileage, is a rate agreed upon by the out-of-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here.

EACH OF THE ABOVE-NOTED BENEFITS IS COVERED WHEN AUTHORIZED BY YOUR NETWORK MEDICAL GROUP OR UNITEDHEALTHCARE, EXCEPT IN THE CASE OF A MEDICALLY NECESSARY EMERGENCY HEALTH CARE SERVICES OR URGENTLY NEEDED SERVICE OR OTHER SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS AS DESCRIBED ABOVE. 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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