

# SignatureValue™ HMO

## Offered by UnitedHealthcare of California

PERFORMANCE HMO SCHEDULE OF BENEFITS (NETWORK 1)

10/0%

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

### General Features

Calendar Year Deductible	None
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-

## 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	

## Benefits Available on an Outpatient Basis

<p>Allergy Testing/Treatment (Serum is covered) PCP Office Visit Specialist Office Visit</p>	<p>\$10 Office Visit Co-payment \$10 Office Visit Co-payment</p>
<p>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)</p>	<p>No charge</p>
<p>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.</p>	<p>Paid at negotiated rate. Balance (if any) is the responsibility of the Member.</p>
<p>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.</p>	<p>No charge</p>
<p>Dental Treatment Anesthesia (Additional Co-payment for outpatient surgery or inpatient hospital benefits may apply)</p>	<p>\$10 Co-payment</p>
<p>Depo-Provera Medication – (other than contraception) (limited to one Depo-Provera injection every 90 days. Additional Co-payment for office visits may apply.)</p>	<p>\$35 Co-payment</p>
<p>Dialysis (Additional Co-payment for office visits may apply)</p>	<p>\$</p>

## **Benefits Available on an Outpatient Basis (Continued)**

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.

**Benefits Available on an Outpatient Basis (Continued)**

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	\$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 Habilitative Services and Outpatient Therapy	\$10 Office Visit Co-payment
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	\$10 Office Visit Co-payment
Free-Standing or Outpatient Surgery	No charge
Physician Care	
PCP Office Visit	\$10 Office Visit
Specialist Office Visit	\$10 Office Visit

## Benefits Available on an Outpatient Basis (Continued)

### Prosthetics and Corrective Appliances

In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.

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-

## 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 n

**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 ID 20 BDC 0 gPni.001 Tw 0.3350.001toFc .uE

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**\$5/\$25/50% HMO \$3000**

Drug conversion programs.