SignatureValue ™ HMO
Offered by UnitedHealthcare of California

CS VEBA Alliance HMO Deductible Schedule of Benefits

HRA-QUALIFIED DEDUCTIBLE HEALTH PLAN

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General Features (Continued)

Hospital Benefits	20% Co-payment after Deductible
Emergency Health Care Services	

Benefits Available While Hospitalized as an Inpatient (Continued)

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	

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.	30% up to $250 Co-payment per medication
Laboratory Services (When available through and authorized by your Network Medical Group) (Additional Co-payment for office visits may apply)	No charge
Maternity Care, Tests and Procedures	
PCP Office Visit	$25 Co-payment
Specialist Office Visit	$25 Co-payment
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.	

Benefits Available on an Outpatient Basis (Continued)

Physician Care	
PCP Office Visit	$25 Office Visit Co-payment
Specialist Office Visit	$40 Office Visit Co-payment
Co-payments for Audiologist and Podiatrist visits will be the same as for the PCP.	

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 appl1.5 (i)2 >>BDC 0 g 05.78 3182.78 310.02 0(c)-2 (om)1.7 (m)ovipp(es)-2 (

Benefits Available on an Outpatient Basis (Continued)

Radiology Services	
Standard: (Additional Co-payment for office visits may apply)	No charge
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.	$100 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 Disclo sure Form for a complete description of this coverage.	

- 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 tohmount sm(s)36e.ount s.
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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 s

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