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UnitedHealthcare SignatureValue™ Focus Offered by UnitedHealthcare of California

HMO SCHEDULE OF BENEFITS PLATINUM FOCUS 0

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

General Features

Calendar Year Deductible	None
Maximum Benefits	Unlimited
Annual Copayment Maximum ¹	\$3,000/individual \$6,000/family
PCP/ Other Practitioner Office Visits	\$20 Office Visit Copayment
Specialist (Member required to obtain referral to specialist, except for OB/GYN Physician services and Emergency/Urgently Needed Services)	\$40 Office Visit Copayment
Hospital Benefits	30% Copayment
Emergency Services (Copayment waived if admitted)	\$200 Copayment
Urgently Needed Services Urgent care services – services provided within the geographic area served by your medical group	\$20 Office Visit Copayment
Urgent care services – services provided outside of the geographic area served by your medical group	\$50 Copayment
Please consult your EOC for additional details. Consult your physician website or office for available urgent care facilities within the geographic area served by your medical group.	

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	30% Copayment
Clinical Trials ²	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Hospice Services (Prognosis of life expectancy of one year or less)	30% Copayment
Hospital Benefits	30% Copayment
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	30% Copayment

Benefits Available While Hospitalized as an Inpatient (Continued)

Maternity Care ⁶	30% Copayment
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 description of this coverage.	30% Copayment
Newborn Care ³	30% Copayment
Physician Care	No charge
Reconstructive Surgery	30% Copayment
Rehabilitation and Habilitation Care (Including physical, occupational and speech therapy)	30% Copayment
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 description of this coverage.	30% Copayment
Skilled Nursing Facility Care (Up to 100 days per benefit period)	30% Copayment
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 description of this coverage.	30% Copayment
Termination of Pregnancy (Medical/medication and surgical)	30% Copayment

Benefits Available on an Outpatient Basis

Acupuncture Please refer to your Acupuncture Supplement to the Combined Evidence of Coverage and Disclosure Form for acupuncture benefits.	\$10 Copayment
Allergy Testing/Treatment (Serum is covered) PCP Office Visit Specialist	\$20 Office Visit Copayment \$40 Office Visit Copayment
Ambulance (Only one ambulance Copayment per trip may be applicable. If a subsequent ambulance transfer to another facility is necessary, you are not responsible for the additional ambulance Copayment)	\$100 Copayment
Chiropractic Care (20-visit maximum per calendar year) Please refer to your Chiropractic Supplement to the Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.	\$15 Copayment
Clinical Trials ²	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Cochlear Implant Devices ⁴ (Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation/habilitation therapy may apply)	\$50 Copayment per item

Benefits Available on an Outpatient Basis (Continued)

Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply. Please refer to your Dental Supplement to the Combined Evidence of Coverage and Disclosure Form for pediatric dental benefits.)	\$50 Copayment
Dialysis (Physician office visit Copayment may apply)	\$50 Copayment per treatment
Durable Medical Equipment ⁴	\$50 Copayment 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 under the age of 19.)	No charge
Family Planning (Non-Preventive Care) ⁷	
Vasectomy	\$50 Copayment
Depo-Provera Injection – (other than contraception) ⁷ PCP/ Practitioner Office Visit	\$20 Office Visit Copayment
Specialist	\$40 Office Visit Copayment
Depo-Provera Medication – (other than contraception) ⁷ (Limited to one Depo-Provera injection every 90 days.)	\$35 Copayment
Termination of Pregnancy (Medical/medication and surgical)	30% Copayment
Hearing Aid – Standard (\$2,000 annual benefit maximum per calendar year. Limited to one hearing aid (including repair/replacement) per hearing-impaired ear every three years.)	\$50 Copayment
Hearing Aid - Bone Anchored ⁵ (Repairs and/or replacement 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/ Nonphysician Health Care Practitioner Office Visit	\$20 Office Visit Copayment
Specialist	\$40 Office Visit Copayment
Home Health Care Visits Limited to a maximum of 100 visits per year. Visit limit does not apply to home health visits for rehabilitation and habilitation purposes. Rehabilitation visits limited to a max of 100 per year Habilitation visits limited to a max of 100 per year	\$20 Copayment per visit
Hospice Services (Prognosis of life expectancy of one year or less)	No charge
Infertility Services (If purchased by your employer, please refer to your Infertility Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a description of this coverage.)	Not covered
Infusion Therapy ⁴ (Infusion Therapy is a separate Copayment in addition to a home health care or an office visit Copayment.)	\$150 Copayment per medication

Benefits Available on an Outpatient Basis (Continued)

<p>Injectable Drugs ^{4,8} (Copayment/ Coinsurance not applicable to injectable immunizations, birth control, Infertility and insulin. If injectable drugs are administered in a physician's office, office visit Copayment/ Coinsurance may also apply.)</p>	
Outpatient Injectable Medication	\$150 Copayment per medication
Self-Injectable Medication	\$150 Copayment per medication
<p>Laboratory Services \$15 Copayment (When available through or authorized by your Participating Medical Group. Additional Copayment for office visits may apply.)</p>	
<p>Maternity Care, Tests and Procedures⁶</p>	
PCP Office Visit	No charge
Specialist	No charge
<p>Mental Health Services (including Severe Mental Illness and Serious Emotional Disturbances of Child)</p>	
<p>Outpatient Office Visits include:</p>	
Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, individual/group evaluations and treatment, individual/group counseling, referral services, and medication management	\$40 Office Visit Copayment
<p>All Other Outpatient Treatment include:</p>	
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	No charge
<p>Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.</p>	
Outpatient Habilitative Services – Outpatient Therapy	\$20 Office Visit Copayment
<p>Outpatient Prescription Drug Benefit⁸ (Copayment applies per Prescription Unit or up to 30 days)</p>	
Tier 1	\$15 Copayment
Tier 2	\$35 Copayment
Tier 3	\$50 Copayment
Tier 4	25% Copayment up to \$250 per script
Prescription Drug Deductible (Per member per Calendar Year)	None
<p>Coinsurance/ Copayment Maximum of \$200 for up to a 30 day supply of an orally administered anticancer medication regardless of a Prescription Drug Deductible and/or Medical Deductible.</p>	
Outpatient Rehabilitation Services – Outpatient Therapy	\$20 Office Visit Copayment
Oral Surgery Services ⁴	30% Copayment

Benefits Available on an Outpatient Basis (Continued)

Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	30% Copayment
Outpatient Surgery Physician Care	No charge
Pediatric Dental Services Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a description of this coverage.	See your Supplement to the UnitedHealthcare of California for pediatric dental benefits
Pediatric Vision Services Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.	See your Supplement to the UnitedHealthcare of California for pediatric vision benefits
Physician Care PCP Office Visit/ Nonphysician Health Care Practitioner Office Visit Specialist	\$20 Office Visit Copayment \$40 Office Visit Copayment
Preventive Care Services^{6,7} (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 Services will include, but are not limited to, the following: <ul style="list-style-type: none"> • 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.	No charge
Prosthetics and Corrective Appliances ⁴	\$50 Copayment per item
Radiation Therapy⁴ Standard: (Photon beam radiation therapy)	No charge
Complex: (Examples include, but are not limited to, brachytherapy, radioactive implants and conformal photon beam; Copayment applies per 30 days or treatment plan, whichever is shorter; Gamma Knife and stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Copayment amount if any)	\$200 Copayment

¹Annual Copayment Maximum includes Copayments for UnitedHealthcare benefits including pediatric vision, pediatric dental, behavioral health, prescription drug, chiropractic, and acupuncture benefits. It does not include standalone, separate and independent Dental and Vision benefit plans or infertility benefit, if purchased by the employer group. When an individual member of a family unit satisfies the individual out of pocket maximum for the calendar year, no further out of pocket maximum will be required for that individual member for the remainder of the calendar year. The remaining family members will continue to pay charges until a member or the family as a whole meets the family out of pocket maximum.

²Clinical Trial services require preauthorization by UnitedHealthcare. If you participate in a Cancer Clinical Trial provided by a Non-Participating Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Participating Providers, you will be responsible for payment of the difference between the Non-Participating Providers billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Copayments, coinsurance or deductibles.

³The inpatient hospital benefits Copayment does not apply to newborns when the newborn is discharged with the mother within 48 hours of the normal vaginal delivery or 96 hours of the cesarean delivery. Please see the *Combined Evidence of Coverage and Disclosure Form* for more details.

⁴Copayment shall never exceed the plan's actual cost of the service. For example, if laboratory costs less than \$45 copayment, the lesser amount is the applicable cost sharing amount. (This footnote only applies to dollar copayments.)

⁵Bone 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.

⁶Preventive 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 No charge. There may be a separate copayment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your Health Plan ID card.

⁷FDA-approved contraceptive methods and procedures recommended by the Health Resources and Services Administration as preventive care services will be 100% covered. Copayment applies to contraceptive methods and procedures that are **NOT** defined as Covered Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.

⁸Refer to your Supplement to the Combined Evidence of Coverage and Disclosure Form and Pharmacy Schedule of Benefits for Outpatient Prescription Drug Coverage details.

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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