Premium rates and/or product forms included herein are subject to approval by regulators. If the rates or product forms offered herein are subsequently modified by regulators we will immediately advise you of the change in plan design and retroactively adjust premium in subsequent billings, in accordance with applicable law.

UnitedHealthcare SignatureValue™ Focus Offered by UnitedHealthcare of California

HMO Deductible Schedule of Benefits

SILVER FOCUS 2000 - 1

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

General Features

Calendar Year Deductible[1]	Individual $2,000 Family $4,000
Maximum Benefits	Unlimited
Annual Out-of-Pocket Maximum[2]	Individual $6,750 Family $13,500
PCP/ Other Practitioner Office Visits	$45 Office Visit Copayment
Specialist (Member required to obtain referrals to Specialists, except for OB/GYN Physician Services and Emergency/Urgently Needed Services)	$65 Office Visit Copayment
Hospital Benefits	40% Copayment after Deductible
Emergency Services (Copayment waived if admitted)	$400 Copayment
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 geographic area served by your medical group.	 $45 Office Visit Copayment $100 Copayment

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	40% Copayment after Deductible
Clinical Trials[3]	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)	40% Copayment after Deductible
Hospital Benefits	40% Copayment after Deductible
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	40% Copayment after Deductible
Maternity Care[6]	40% Copayment after Deductible

Benefits Available While Hospitalized as an Inpatient (Continued)

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.**)	40% Copayment after Deductible
Newborn Care	40% Copayment after Deductible
Physician Care	40% Copayment
Reconstructive Surgery	40% Copayment after Deductible
Rehabilitation and Habilitation Care (Including physical, occupational and speech therapy)	40% Copayment after Deductible
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**.	40% Copayment after Deductible
Skilled Nursing Facility Care (Up to 100 days per benefit period)	40% Copayment after Deductible
Substance Related and Addictive Disorder including, but not limited to, Inpatient Medical Detoxification and Residential Treatment Centers **Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a description of this coverage.**	40% Copayment after Deductible
Termination of Pregnancy (Medical/medication and surgical)	40% Copayment after Deductible

Benefits Available on an Outpatient Basis

Acupuncture **Please refer to your Acupuncture Supplement to the Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	$10 Copayment
Allergy Testing/Treatment (Serum is covered) PCP Office Visit Specialist	 $45 Office Visit Copayment $65 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[3]	Paid at negotiated rate Balance (if any) is the responsibility of the Member

Benefits Available on an Outpatient Basis (Continued)

Cochlear Implant Devices[4] (Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation/habilitation therapy may apply.)	$50 Copayment
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	$45 Office Visit Copayment
Specialist	$65 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)	40% Copayment after Deductible
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 replacements 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	$45 Office Visit Copayment
Specialist	$65 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	$45 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)

Injectable Drugs [4,7] (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.)	
Outpatient Injectable Medication	$150 Copayment per medication
Self-Injectable Medication	$150 Copayment per medication
Laboratory Services (When available through and authorized by your Participating Medical Group. Additional Copayment for office visits may apply.)	$25 Copayment
Maternity Care, Tests and Procedures[6]	
PCP Office Visit	No charge
Specialist	No charge
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 evaluations and treatment, individual/group counseling, referral services, and medication management	$65 Office Visit Copayment
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 **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**)	No charge
Outpatient Habilitative Services – Outpatient Therapy	$45 Office Visit Copayment
Oral Surgery Services[4]	40% Copayment after Deductible
Outpatient Prescription Drug Benefit[8] (Copayment applies per Prescription Unit or up to 30 days)	
Tier 1	$20 Copayment
Tier 2	$50 Copayment after Deductible
Tier 3	$100 Copayment after Deductible
Tier 4	25% Copayment after Deductible up to $250 per script
Prescription Drug Deductible (Per Member per Calendar Year) 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.	$200/individual; $400/family

Benefits Available on an Outpatient Basis (Continued)

Outpatient Rehabilitation Services – Outpatient Therapy	$45 Office Visit Copayment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	40% Copayment after Deductible
Outpatient Surgery Physician Care	40% Copayment
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 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	$45 Office Visit Copayment
Specialist	$65 Office Visit Copayment
Preventive Care Services[7,8] (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: • Colorectal Screening • Hearing Screening • Human Immunodeficiency Virus (HIV) Screening • Immunizations • Newborn Testing • Prostate Screening • Vision Screening • Well-Baby/Child/Adolescent • 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 Therapy[5]	
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
Radiology Services[4]	
Standard: (Additional Copayment for office visits may apply)	$25 Copayment

Benefits Available on an Outpatient Basis (Continued)

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 Copayment will be charged for each part of the body scanned as part of an imaging procedure.	$200 Copayment
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**.	
Specialized Footwear for Foot Disfigurement[4]	$50 Copayment per item
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	$65 Office Visit Copayment No charge
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.**	
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.	$25 Copayment
Vision Refractions (For pediatric vision, please refer to your Vision Services Supplement to the Combined Evidence of Coverage and Disclosure Form for a description of this coverage.)	$45 Office Visit Copayment

Note: Benefits with Percentage Copayment amounts are based upon the UnitedHealthcare negotiated rate.

[1]Certain Covered Services will not be covered until you meet the Calendar Year Deductible. Only amounts incurred for Covered Services that are subject to the Deductible will count toward the Deductible. The Deductible applies to the Annual Out-of-Pocket Maximum. The amounts applied to the Deductible are based upon UnitedHealthcare's contracted rates. The Family Deductible is an embedded deductible. When an individual member of a family unit satisfies the Individual Deductible for the Calendar Year, no further Deductible will be required for that individual member for the remainder of the Calendar Year. The remaining family members will continue to pay full member charges for services that are subject to the deductible until the member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible.

[2]Annual Out-of-Pocket 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.

[3]Clinical Trial Services require preauthorization by UnitedHealthcare. If you participate in a 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 Provider's billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable copayments, coinsurance or deductibles.

[4]Copayment 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.)

[5]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. Replacement of external hearing aid components is covered under the Durable Medical Equipment benefit. Deluxe model and upgrades that are not medically necessary are not covered.

[6]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 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.

[7] FDA-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.

[8]Refer 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 ARE COVERED WHEN RENDERED OR AUTHORIZED BY YOUR PARTICIPATING MEDICAL GROUP OR UNITEDHEALTHCARE, EXCEPT IN THE CASE OF A MEDICALLY NECESSARY EMERGENCY OR AN 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.

P.O. Box 30968
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800-624-8822
711 (TTY)
www.myuhc.com

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