

SignatureValue™ Harmony HMO Offered by UnitedHealthcare of California

HMO Deductible Schedule of Benefits
HRA-QUALIFIED DEDUCTIBLE HEALTH PLAN
25-40/20%/2000 DED

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

General Features

<p>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.</p>	<p>Individual: \$2,000 Family: \$4,000</p>
<p>Maximum Benefits</p>	<p>Unlimited</p>
<p>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 drug 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 Family Out-of-Pocket Limit.</p>	<p>Individual: \$3,500 Family: \$7,000</p>
<p>PCP Office Visits</p>	<p>\$25 Office Visit Co-payment</p>
<p>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.</p>	<p>\$40 Office Visit Co-payment</p>
<p>Hospital Benefits</p>	<p>20% Co-payment after Deductible</p>
<p>Emergency Services</p>	<p>20% Co-payment after Deductible</p>
<p>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.</p>	<p>\$25 Co-payment \$25 Co-payment</p>

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	20% Co-payment after Deductible
<p>Clinical Trials</p> <p>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 Participating 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 Participating Providers, in addition to any applicable Co-payments, coinsurance or deductibles.</p>	<p>Paid at negotiated rate after Deductible. Balance (if any) is the responsibility of the Member.</p>
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
<p>Maternity Care</p> <p>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</p>	20% Co-payment after Deductible
<p>Mental Health Services including, but not limited to, Residential Treatment Centers</p> <p>Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.</p>	20% Co-payment after Deductible
<p>Newborn Care</p> <p>(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.)</p>	20% Co-payment after Deductible
Physician Care	20% Co-payment after Deductible
Reconstructive Surgery	20% Co-payment after Deductible
<p>Rehabilitation Care</p> <p>(Including physical, occupational and speech therapy)</p>	20% Co-payment after Deductible
<p>Severe Mental Illness Benefit and Serious Emotional Disturbances of a Child</p> <p>Inpatient and Residential Treatment</p> <p>Unlimited days</p> <p>Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.</p>	20% Co-payment after Deductible
<p>Skilled Nursing Facility Care</p> <p>(Up to 100 days per benefit period)</p>	20% Co-payment after Deductible
<p>Substance Related and Addictive Disorder including, but not limited to, Inpatient Medical Detoxification and Residential Treatment Centers</p> <p>Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.</p>	No charge
<p>Termination of Pregnancy</p> <p>(Medical/medication and surgical)</p>	No charge after Deductible

Benefits Available on an Outpatient Basis

<p>Allergy Testing/Treatment (Serum is covered) PCP Office Visit Specialist Office Visit</p>	<p>\$25 Office Visit Co-payment \$40 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>20% Co-payment after Deductible</p>
<p>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 Participating 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 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>20% Co-payment after Deductible</p>
<p>Dental Treatment Anesthesia (Additional Co-payment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply.)</p>	<p>20% Co-payment after Deductible</p>
<p>Depo-Provera Medication – (other than contraception) Limited to one Dep-Provera injection every 90 days. (Additional Co-payment for office visits may apply.)</p>	<p>20% Co-payment after Deductible</p>
<p>Dialysis (Additional Co-payment for office visits may apply)</p>	<p>20% Co-payment after Deductible</p>
<p>Durable Medical Equipment In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.</p>	<p>20% Co-payment after Deductible</p>
<p>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.)</p>	<p>20% Co-payment after Deductible</p>
<p>Hearing Aid - Standard \$5000 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)</p>	<p>20% Co-payment after Deductible</p>
<p>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.</p>	<p>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</p>
<p>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.</p>	<p>\$25 Office Visit Co-payment \$40 Office Visit Co-payment</p>

Benefits Available on an Outpatient Basis (Continued)

<p>Oral Surgery Services <i>Applies to dollar co-payments only:</i> In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.</p>	20% Co-payment after Deductible
<p>Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)</p>	\$25 Office Visit Co-payment
<p>Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility</p>	20% Co-payment after Deductible
<p>Physician Care PCP Office Visit Specialist Office Visit Co-payments for Audiologist and Podiatrist visits will be the same as for the PCP.</p>	<p>\$25 Office Visit Co-payment \$40 Office Visit Co-payment</p>
<p>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 Participating Medical Group.) Covered Health Care Services will include, but are not limited to, the following:</p> <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 <p>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 the Customer Service 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.</p>	No charge
<p>Prosthetics and Corrective Appliances In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.</p>	20% Co-payment after Deductible
<p>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.) <i>Applies to dollar co-payments only:</i> In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.</p>	<p>20% Co-payment after Deductible 20% Co-payment after Deductible</p>

\$10/\$30/50% HMO \$3000



Your prescription plan at a glance

Show this summary to your doctor to discuss ways to pay less for your medications. To learn more about your plan, visit express-scripts.com. First-time visitors, please take a moment to register using your member ID number.

	Express Advantage Network® (EAN) pharmacies* (up to a 30-day supply)	Smart90® retail pharmacies (up to a 90-day supply)	Home delivery from Express Scripts® Pharmacy (up to a 90-day supply)
Generic medications	\$10	\$20	\$20
Preferred brand-name medications	\$30	\$60	\$60
Nonpreferred brand-name medications	50% (\$40 min/\$175 max)	50% (\$80 min/\$350 max)	50% (\$80 min/\$350 max)

*If you use a non-EAN pharmacy, you'll pay an extra \$5 per short-term prescription.

<p>Short-Term Medications (up to a 30-day supply) Use Express Scripts Advantage Network (EAN) pharmacy (for lowest cost) or non-EAN pharmacy</p> <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; padding: 5px; width: 45%;"> <p style="text-align: center; background-color: #0070C0; color: white; margin: 0;">EAN Pharmacies</p> </div> <div style="border: 1px solid black; padding: 5px; width: 45%;"> <p style="text-align: center; background-color: #0070C0; color: white; margin: 0;">Non-EAN Pharmacies</p> </div> </div>	<p>Long-Term Medications (up to a 90-day supply) Use Express Scripts Smart90 pharmacy or Home Delivery from Express Scripts® Pharmacy for lowest cost</p> <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; padding: 5px; width: 45%;"> <p style="text-align: center; background-color: #0070C0; color: white; margin: 0;">Smart90 Pharmacies</p> </div> <div style="border: 1px solid black; padding: 5px; width: 45%;"> <p style="text-align: center; background-color: #0070C0; color: white; margin: 0;">Home Delivery</p> <p style="text-align: center; margin: 5px 0;">Express Scripts® Pharmacy</p> </div> </div>
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Out-of-pocket maximum. Once you reach your out-of-pocket maximum of \$3,000 for individuals or \$6,000 for families, your plan pays 100% of prescription medication expenses for the remainder of the plan year.

Note: If your doctor requests a brand-name medication when a generic equivalent is available, you'll pay the generic copayment, plus the difference in cost between the brand and the generic. (This extra cost applies even if your doctor writes "Dispense as Written" ("DAW") on the prescription.)

For short-term prescriptions, such as antibiotics, use an EAN pharmacy (for lower copays) or a non-EAN pharmacy (where you pay \$5 extra for each short-term prescription). Your Express Scripts Advantage Network has more than 34,000 pharmacies consisting of approximately 50% independent pharmacies in addition to grocers and other stores.

To find a participating pharmacy near you, log in anytime at express-scripts.com and select **Find a Pharmacy** from the menu under **Prescriptions**. You can also get pharmacy information by calling Member Services at 800.918.8011. The pharmacy network is designed to provide you with lower prescription costs at nearby participating pharmacies. Please be aware that you'll pay a higher amount if you choose to use non-EAN pharmacy.

For long-term medications, such as those used to treat high blood pressure or high cholesterol, use a Smart90 (Costco, Rite Aid or Sharp Rees-Stealy) pharmacy or home delivery from Express Scripts® Pharmacy.

Important Note: You'll pay a higher cost for a long-term medication if you fill it at a retail pharmacy other than a Smart90 pharmacy after the third purchase. The medications affected by this plan limit may change.

KEEP THIS INFORMATION
For more information about your plan, log in at express-scripts.com or call Member Services toll free at 800.918.8011.

Drug conversion programs. If you're prescribed a medication that isn't on your health plan's preferred list, yet an alternative plan-preferred medication exists, we may contact your doctor to ask whether that medication would be appropriate for you. If your doctor agrees to use a plan-preferred medication, you'll usually pay less.

Use generics and preferred medications. If you're taking a medication that's not on the preferred list, ask your doctor to consider prescribing a lower-cost generic or preferred brand-name medication. To find out whether your medication is preferred, just log in at [express-scripts.com](https://www.express-scripts.com) and choose **Price a Medication** from the menu under **Prescriptions**. Enter your medication name and view cost and coverage information on the results page. You can also get pricing information from Member Services at 800.918.8011.

Prior authorization: When is a coverage review necessary? Some medications aren't covered unless you first receive approval through a coverage review (prior authorization). This review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective.

There are other medications that may be covered, but with limits (for example, only for a certain amount or for certain uses), unless you receive approval through a coverage review. During this review, Express Scripts asks your doctor for more information than what's on the prescription before the medication may be covered under your plan. To find out whether a medication requires a coverage review, log in at [express-scripts.com](https://www.express-scripts.com) and select **Price a Medication** from the menu under **Prescriptions**. Enter your medication name and view coverage information on the results page.

Specialty medications: Get individualized service through Accredo, an Express Scripts specialty pharmacy. Specialty medications are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, and hepatitis C. Accredo is composed of therapy-specific teams that provide an enhanced level of individual service to patients with special therapy needs.

Whether they're administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service. By ordering your specialty medications through Accredo, you can receive:

- Toll-free access to specialty-trained pharmacists and nurses 24 hours a day, 7 days a week
- Delivery of your medications within the United States, on a scheduled day, Monday through Friday, at no additional charge
- Most supplies, such as needles and syringes, provided with your specialty medications
- Safety checks to help prevent potential drug interactions
- Refill reminders

Automatic refills: A convenient service to help you avoid running out of your long-term medications. Most prescriptions you order from Express Scripts® Pharmacy can be enrolled in automatic refills. Then, when it's time to refill or renew your prescription, your order will automatically ship to you. We'll also notify you seven days before we begin processing your next refill. You have the option to change the next processing date or cancel the prescription from the service before processing begins.

There are three easy ways to enroll in automatic refills:

- Log in at [express-scripts.com](https://www.express-scripts.com) and choose **Automatic Refills** from the menu under **Prescriptions**.
- When refilling a prescription, we ask if you want to enroll it in automatic refills. If you answer "yes," we'll begin automatically refilling your prescription on all future refills.
- Call Member Services at 800.918.8011 and tell the patient care advocate you want to enroll.

Extended payment program: Stretch your home delivery payments. Instead of paying in full up front, you can spread your costs over three monthly credit or debit card installments. There's no waiting—your medication will be shipped from Express Scripts® Pharmacy after the very first payment. When you enroll, the program applies to every home delivery prescription for you and your covered family members. To learn more or to enroll, log in at [express-scripts.com](https://www.express-scripts.com), choose **Payment Methods** from the menu under **Account**. Then click **Edit Information** and **Extended Payment Program**.

Express Scripts manages your prescription plan for California Schools VEBA.
Corresponding Medical Plans: Performance HMO Plan A Network 2, Harmony Journey (select districts)