

Signature Value [™] 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

General Features	
Calendar Year Deductible	Individual \$2,000
On a Family plan, if one individual member meets the Individual deductible amount,	his/ Family \$4,000
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 Calend	lar
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.	
Maximum Benefits	Unlimited
Annual Out-of-Pocket Limit	Individual \$3,500
On a Family plan, if one individual member meets the Individual out of pocket amou	
his/ her out of pocket is met and the Family out of pocket must be met by one or more	
the family members.	
Co-payments for certain types of Covered Health Care Services do not apply toward	I 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	t
UnitedHealthcare benefits including behavioral health and prescription drug benefits	I t
does not include standalone, separate and independent Dental, Vision and Chiropra	
benefit plans offered to groups. When an individual member of a family unit has paid	
amount of Deductible and Co-payments for the Calendar Year equal to the Individual	ll
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 wi	
continue to pay the applicable Co-payment until a member satisfies the Individual O	ut-
of-Pocket Limit or until a family satisfies the Family Out-of-Pocket Limit.	
PCP Office Visits	\$25 Co-payment
Specialist Office Visits	\$40 Co-payment
(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.	
Hospital Benefits	20% Co-payment after Deductible
Emergency Services	20% Co-payment after Deductible
,	
Urgently Needed Services	
Urgent care services – services provided within the geographic	\$25 Co-payment
area served by your medical group	
Urgent care services – services provided outside of the	\$50 Co-payment
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.	

Benefits Available While Hospitalized as an Inpatient

Benefits Available While Hospitalized as an Inpatient Bone Marrow Transplants	20% Co-payment after Deductible
Bone Mariow Transplants	20 / 00-payment after beductible
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	Paid at negotiated rate after Deductible Balance (if any) is the responsibility of the Member
any applicable Co-payments, coinsurance or deductibles. Hospice Services	20% Co-payment after Deductible
(Prognosis of life expectancy of one year or less)	2070 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
Maternity Care 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	20% Co-payment after Deductible
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 complete description of this coverage.	20% Co-payment after Deductible
Newborn Care (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.)	20% Co-payment after Deductible
Physician Care	20% Co-payment after Deductible
Reconstructive Surgery	20% Co-payment after Deductible
Rehabilitation Care (Including physical, occupational and speech therapy)	20% Co-payment 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 complete description of this coverage.	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 Evidence of Coverage and Disclosure Form for a complete description of this coverage.	No charge
Termination of Pregnancy (Medical/medication and surgical)	20% Co-payment after Deductible

Benefits Available on an Outpatient Basis

Benefits Available on an Outpatient Basis Allergy Testing/Treatment (Serum is covered)	
PCP Office Visit	\$25 Co-payment
Specialist Office Visit	\$40 Co-payment
Ambulance	20% Co-payment after Deductible
Clinical Trials F	Paid at negotiated rate after Deductible
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.	Balance (if any) is the responsibility of the Member
Cochlear Implant Devices (Additional Co-payment for outpatient surgery or inpatient hospital benefits and	20% Co-payment after Deductible
outpatient rehabilitation therapy may apply.)	
Dental Treatment Anesthesia (Additional Co-payment for outpatient surgery or inpatient hospital benefits may apply)	20% Co-payment after Deductible
Dialysis (Physician office visit Co-payment may apply)	20% Co-payment after Deductible
Durable Medical Equipment	20% Co-payment after Deductible
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.)	20% Co-payment after Deductible
Family Planning (Non-Preventive Care)	000/ 0
Vasectomy	20% Co-payment after Deductible
Depo-Provera Injection – (other than contraception) PCP Office Visit	¢25 Ca naymant
Specialist Office Visit	\$25 Co-payment \$40 Co-payment
Depo-Provera Medication – (other than contraception)	20% Co-payment after Deductible
Termination of Pregnancy (Medical/medication and surgical)	20% Co-payment after Deductible
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.	20% de payment anoi Beddensie
Hearing Aid - Standard	20% Co-payment after Deductible
\$5,000 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.)	
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.	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

Benefits Available on an Outpatient Basis (Continued)	
Hearing Exam	* 05.0
PCP Office Visit	\$25 Co-payment
Specialist Office Visit Co-payments for Audiologist and Podiatrist visits will be the	\$40 Co-payment
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.	
Home Health Care Visits	\$25 Co-payment per visit
For Infusion Therapy, a separate Infusion Therapy Copayment	, , , , ,
applies per 30 days	
Hospice Services	20% Co-payment after Deductible
(Prognosis of life expectancy of one year or less)	
Infertility Services	Not covered
Infusion Therapy	\$250 Co-payment per medication
(Infusion Therapy is a separate Co-payment in addition to an office visit Co-	, , , , , , , , , , , , , , , , , , ,
payment.) In instances where the negotiated rate is less than your Co-payment,	
you will pay only the negotiated rate.	
Injectable Drugs	30% up to \$250 Co-payment
Outpatient Injectable Medication	per medication
Self-Injectable Medication	
(Co-payment/coinsurance not applicable to injectable immunizations, birth	
control, infertility and insulin. If injectable drugs are administered in a	
physician's office, office visit Co-payment/Coinsurance may also apply) 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.	
Laboratory Services	No oborgo
(When available through and authorized by your Participating Medical Group.	No charge
Additional Co-payment for office visits may apply)	
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	φ20 00 payment
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	
Mental Health Services (including Severe Mental Illness and Serious Emotional	,
Disturbances of Child)	
Outpatient Office Visits include:	\$25 Co-payment
Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures,	
individual/ group counseling, individual/ group evaluations and treatment, referral	
services, and medication management	
All Other Outpatient Treatment include:	No charge after Deductible
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 of	
Autism Spectrum Disorders, laboratory charges, or other medical Partial Hospitalization/	
Day Treatment and Intensive Outpatient Treatment, and psychiatric observation	
(Please refer to your UnitedHealthcare of California Combined Evidence of	
Coverage and Disclosure Form for a complete description of this coverage)	
LG -NG-SOB CA HMO Ded (Eff 7-1-2018)	

Benefits Available on an Outpatient Basis (Continued)

Oral Surgery Services	20% Co-payment after Deductible
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	\$25 Co-payment
Outpatient Surgery at a Participating Free-Standing or Outpatient	20% Co-payment after Deductible
Surgery Facility	
Physician Care	
PCP Office Visit	\$25 Co-payment
Specialist Office Visit	\$40 Co-payment
Co-payments for Audiologist and Podiatrist visits will be the same as for the PCP.	
Preventive Care Services	No charge

(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:

- 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 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.

Disclosure i offit.	
Prosthetics and Corrective Appliances	20% Co-payment after Deductible
Radiation Therapy	
Standard:	20% Co-payment after Deductible
(Photon beam radiation therapy)	
Complex:	20% Co-payment after Deductible
(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.)	
Radiology Services	
Standard:	No charge
(Additional Co-payment for office visits may apply)	
Specialized Scanning and Imaging Procedures:	\$100 Co-payment
(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.

Benefits Available on an Outpatient Basis (Continued)

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.

Substance Related and Addictive Disorder

Outpatient Office Visits include, but are not limited to:

No charge

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:

No charge

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 complete a description of this coverage.

Virtual Visits \$25 Co-payment

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.

Vision Refractions \$25 Co-payment

Note: Benefits with Percentage Co-payment amounts are based upon the UnitedHealthcare negotiated rate.

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.

Customer Service: 800-624-8822 711 (TTY) www.myuhc.com