

PENDING REGULATORY APPROVAL

SignatureValue™ Harmony HMO Offered by UnitedHealthcare of California

HMO Deductible Schedule of Benefits

SignatureValue Harmony HMO Silver 55-80/40%/2250 Ded

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

General Features

| | |
|---|--|
| <p>Calendar Year Deductible</p> <p>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 Limit. 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.</p> | <p>\$2,250/Individual \$4,500/Family</p> |
| <p>Maximum Benefits</p> | <p>Unlimited</p> |
| <p>Annual Out-of-Pocket Limit</p> <p>Annual Out-of-Pocket Limit includes Co-payments 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 limit for the calendar year, no further co-payments will be required for that individual member for the remainder of the calendar year. The remaining family members will continue to pay co-payments until a member satisfies the individual out-of-pocket or the family as a whole meets the family out of pocket limit.</p> | <p>\$8,150/Individual \$16,300/Family</p> |
| <p>PCP/Other Practitioner Office Visits</p> | <p>\$55 Office Visit Co-payment</p> |
| <p>Specialist (Member required to obtain referral to Specialists, except for OB/GYN Physician Services and Emergency/Urgently Needed Services)</p> | <p>\$80 Office Visit Co-payment</p> |
| <p>Hospital Benefits</p> | <p>40% Co-payment after Deductible</p> |
| <p>Emergency Services</p> | <p>40% Co-payment after Deductible</p> |
| <p>Urgently Needed Services</p> <p>Urgent care services – services provided within the geographic area served by your medical group</p> <p>Urgent care services – services provided outside of the geographic area served by your medical group</p> <p>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.</p> | <p>\$55 Office Visit Co-payment \$100 Co-payment</p> |

Benefits Available While Hospitalized as an Inpatient

| | |
|--|---|
| Bone Marrow Transplants | 40% Co-payment after Deductible |
| Clinical Trials Clinical Trial services require prior authorization by UnitedHealthcare. If you participate in a Cancer Clinical Trial provided by an Out-of-Network Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Network Providers, you will be responsible for payment of the difference between the Out-of-Network Providers billed charges and the rate negotiated by UnitedHealthcare with Network Providers, in addition to any applicable Co-payments or deductibles. | Paid at negotiated rate. Balance (if any) is the responsibility of the Member. |
| Hospice Services (Prognosis of life expectancy of one year or less) | 40% Co-payment after Deductible |
| Hospital Benefits | 40% Co-payment after Deductible |
| Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy) | 40% 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 No charge. There may be a separate Co-payment for the office visit and other additional charges for services rendered. Please call the number on your Health Plan ID card. | 40% 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.) | 40% Co-payment after Deductible |
| Newborn Care The inpatient hospital benefits Co-payment 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. | 40% Co-payment after Deductible |
| Physician Care | 40% Co-payment |
| Reconstructive Surgery | 40% Co-payment after Deductible |
| Rehabilitation and Habilitation Care (Including physical, occupational and speech therapy) | 40% 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. | 40% Co-payment after Deductible |
| Skilled Nursing Facility Care (Up to 100 days per benefit period) | 40% 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. | 40% Co-payment after Deductible |
| Termination of Pregnancy (Medical/medication and surgical) | 40% Co-payment after Deductible |

Benefits Available on an Outpatient Basis

| | |
|--|--|
| Acupuncture Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage. | \$10 Co-payment |
| Allergy Testing/Treatment (Serum is covered) PCP Office Visit Specialist | \$55 Office Visit Co-payment \$80 Office Visit Co-payment |

Benefits Available on an Outpatient Basis (Continued)

| | |
|--|---|
| 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) | \$100 Co-payment |
| Chiropractic Care (20-visit maximum per calendar year) Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage. | \$15 Co-payment |
| Clinical Trials Clinical Trial services require prior authorization by UnitedHealthcare. If you participate in a Cancer Clinical Trial provided by an Out-of-Network Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Network Providers, you will be responsible for payment of the difference between the Out-of-Network Providers billed charges and the rate negotiated by UnitedHealthcare with Network Providers, in addition to any applicable Co-payments or deductibles. | Paid at negotiated rate. Balance (if any) is the responsibility of the member. |
| Cochlear Implant Devices (Additional Co-payment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation/habilitation therapy may apply) Co-payment shall never exceed the plan's actual cost of the service. | \$50 Co-payment per item |
| Dental Treatment Anesthesia (Additional Co-payment 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 Co-payment |
| Dialysis (Physician office visit Co-payment may apply) | \$50 Co-payment per treatment |
| Durable Medical Equipment Co-payment shall never exceed the plan's actual cost of the service. | \$50 Co-payment 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 who are covered until at least the end of the month in which Member turns 19 years of age.) | No charge |
| Family Planning (Non-Preventive Care) 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. | |
| Vasectomy | \$55 Co-payment |
| Depo-Provera Injection – (other than contraception) | |
| PCP/Practitioner Office Visit | \$55 Office Visit Co-payment |
| Specialist Office Visit | \$80 Office Visit Co-payment |
| Depo-Provera Medication – (other than contraception) (Limited to one Depo-Provera injection every 90 days.) | \$35 Co-payment |
| Termination of Pregnancy (Medical/medication and surgical) | 40% Co-payment after Deductible |
| Hearing Aid - Standard (\$2,000 annual benefit maximum per calendar year. Limited to one hearing aid (including repair and replacement) per hearing impaired ear every three years.) | \$50 Co-payment |
| Hearing Aid – Bone-Anchored Repairs and/or replacement 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. |
| Hearing Exam PCP Office Visit/Nonphysician Health Care Practitioner Office Visit Specialist | \$55 Office Visit Co-payment \$80 Office Visit Co-payment |

Benefits Available on an Outpatient Basis (Continued)

| | |
|---|--|
| <p>Outpatient Prescription Drug Benefit</p> <p>Refer to your Supplement to the Combined Evidence of Coverage and Disclosure Form and Pharmacy Schedule of Benefits for Outpatient Prescription Drug Coverage details. (Co-payment applies per Prescription Unit or up to 30 days)</p> <p>Tier 1 \$20 Co-payment Tier 2 \$50 Co-payment Tier 3 \$100 Co-payment Tier 4 25% Co-payment Up to \$250 per script</p> <p>Prescription Drug Deductible \$300/individual; \$600/family (Per member per Calendar Year) Applies to Tiers 2, 3, and 4 (applies to retail and mail services)</p> <p>Co-payment Maximum of \$250 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 and Outpatient Therapy | \$55 Office Visit Co-payment |
| Outpatient Surgery at a Network Free-Standing Outpatient Surgery Facility | 40% Co-payment after Deductible |
| Outpatient Surgery Physician Care | 40% Co-payment |
| <p>Pediatric Dental Services</p> <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> | See your Supplement to the UnitedHealthcare of California for pediatric dental benefits. |
| <p>Pediatric Vision Services</p> <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> | See your Supplement to the UnitedHealthcare of California for pediatric vision benefits. |
| <p>Physician Care</p> <p>PCP Office Visit/Nonphysician Health Care Practitioner Office Visit \$55 Office Visit Co-payment Specialist \$80 Office Visit Co-payment</p> | |
| <p>Preventive Care Services</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 No charge. There may be a separate co-payment for the office visit and other additional charges for services rendered. Please call the number on your Health Plan 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. (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 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 • Well-Woman, including routine prenatal obstetrical office visits <p>Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form.</p> | No charge |

