

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

General Features	
Calendar Year Deductible	Individual: \$2,000
On a Family plan, if one individual member meets the Individual deductible amount,	Family: \$4,000
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.	
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 amoun	
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 Service	
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 prescript	tion
drug benefits. It does not include standalone, separate and independent Dental, Visio	
and Chiropractic benefit plans offered to groups. When an individual member of a fan	
unit has paid an amount of Deductible and Co-payments for the Calendar Year equal	
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	
PCP Office Visits	\$25 Office Visit Co-payment
Specialist Office Visits	\$40 Office Visit Co-payment
	\$40 Onice visit 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 area served by your	\$25 Co-payment
medical group	<i>q_0 00 paymon</i>
Urgent care services – services provided outside of the geographic area served by	\$25 Co-payment
your medical group	φ <u></u> ₂ ο σο payment
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	
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Benefits Available While Hospitalized as an Inpatient Bone Marrow Transplants

20% Co-payment after Deductible

Clinical Trials	Paid at negotiated rate after
Clinical Trial Services require prior authorization by UnitedHealthcare. If you	Deductible. Balance (if any) is
participate in a clinical trial provided by an Out-of-Network Provider that does not	the responsibility of
agree to perform these services at the rate UnitedHealthcare negotiates with	the Member.
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.	
Hospice Services	20% Co-payment after Deductible
(Prognosis of life expectancy of one year or less)	
Hospital Benefits	20% Co-payment after Deductible
Mastectomy/Breast Reconstruction	20% Co-payment after Deductible
(After mastectomy and complications from mastectomy)	
	200/ Concerns often Doductible
Maternity Care	20% Co-payment after Deductible
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	
Mental Health Services including, but not limited to, Residential Treatment Centers	20% Co-payment after Deductible
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
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Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage. 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	20% Co-payment after Deductible 20% Co-payment after Deductible
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Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage. 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.) Physician Care Reconstructive Surgery Rehabilitation Care (Including physical, occupational and speech therapy) 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. Skilled Nursing Facility Care (Up to 100 days per benefit period) Substance Related and Addictive Disorder including, but not limited to, Inpatient Medical Detoxification and Residential Treatment Centers	20% Co-payment after Deductible 20% Co-payment after Deductible 20% Co-payment after Deductible 20% Co-payment after Deductible 20% Co-payment after Deductible
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Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage. 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.) Physician Care Reconstructive Surgery Rehabilitation Care (Including physical, occupational and speech therapy) 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. Skilled Nursing Facility Care (Up to 100 days per benefit period) 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	20% Co-payment after Deductible 20% Co-payment after Deductible 20% Co-payment after Deductible 20% Co-payment after Deductible

Allergy Testing/Treatment	
(Serum is covered)	
PCP Office Visit	\$25 Office Visit Co-payment
Specialist Office Visit	\$40 Office Visit Co-payment
Ambulance	20% Co-payment after Deductible
(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)	
Clinical Trials	Paid at negotiated rate.
Clinical Trial Services require prior authorization by UnitedHealthcare. If you	Balance (if any) is
participate in a clinical trial provided by an Out-of-Network Provider that does	the responsibility
not agree to perform these services at the rate UnitedHealthcare negotiates	of the Member.
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.	
Cochlear Implant Devices	20% Co-payment after Deductible
(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	
Dental Treatment Anesthesia	20% Co-payment after Deductible
(Additional Co-payment for outpatient surgery or inpatient hospital benefits and	
outpatient rehabilitation therapy may apply.)	
Depo-Provera Medication – (other than contraception)	20% Co-payment after Deductible
Limited to one Dep-Provera injection every 90 days. (Additional Co-payment for	
office visits may apply.)	
Dialysis	20% Co-payment after Deductible
(Additional Co-payment for office visits may apply)	
Durable Medical Equipment	20% Co-payment after Deductible
In instances where the negotiated rate is less than your Co-payment, you will pay	
only the negotiated rate.	
Durable Medical Equipment for the Treatment of Pediatric Asthma	20% Co-payment after Deductible
(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.)	
Hearing Aid - Standard	20% Co-payment after Deductible
\$5000 annual benefit maximum per calendar year. Limited to one hearing aid	20% Co-payment after Deddclible
(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)	
	Den en die er om en ook ene die
Hearing Aid – Bone-Anchored	Depending upon where the
Repairs and/or replacements are not covered, except for malfunctions. Deluxe model	covered health service is
and upgrades that are not medically necessary are not covered. Bone-anchored	provided, benefits for bone
hearing aid will be subject to applicable medical/surgical categories (e.g. inpatient	anchored hearing aid will be
hospital, physician fees) only for members who meet the medical criteria specified in	
the Combined Evidence of Coverage and Disclosure Form. Repairs and/or	under each covered health
replacement for a bone-anchored hearing aid are not covered, except for malfunction	
Deluxe model and upgrades that are not medically necessary are not covered.	Schedule of Benefits
Hearing Exam	
PCP Office Visit	\$25 Office Visit Co-paymen
Specialist Office Visit	\$40 Office Visit Co-payment
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.	

Benefits Available on an Outpatient Basis (Continued)

Home Health Care Visits	\$25 Co-payment per visit
For Infusion Therapy, a separate Infusion Therapy Co-payment applies per 30 d	ays
servic for Sexu a	Depending upon where the covered health te is provided, benefits for Home Test Kits ally Transmitted Disease will be the same s those stated under each covered health vice category in this Schedule of Benefits.
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 a home health care or an office visit Co-payment.)	
Applies to dollar co-payments only: In instances where the negotiated rate is les than your Co-payment, you will pay only the negotiated rate.	S
Injectable Drugs	30% up to \$250 Co-payment per
(Co-payment/coinsurance not applicable to injectable immunizations, birth contro infertility and insulin.) Outpatient Injectable Medication	
Self-Injectable Medication <i>Applies to dollar co-payments only:</i> In instances where the negotiated rate is les your Co-payment, you will pay only the negotiated rate.	s than
FDA-approved contraceptive methods and procedures recommended by the Hea Resources and Services Administration as preventive care services will be 100% covered. Co-payment applies to contraceptive methods and procedures that are	, 0
defined as Covered Services under the Preventive Care Services and Family Pla benefit as specified in the Combined Evidence of Coverage and Disclosure Form	anning 1.
Laboratory Services (When available through and authorized by your Participating Medical Group. Additional Co-payment for office visits may apply.)	No charge
Maternity Care, Tests and Procedures PCP Office Visit Specialist Office Visit	\$25 Co-payment \$25 Co-payment
Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preve health care) and the Health Resources and Services Administration as preventive	ntive
services will be covered as Paid in Full. There may be a separate Co-payment for office visit and other additional charges for services rendered. Please call the Cu Service number on your ID card	or the
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	\$25 Office Visit Co-payment
procedures, individual/ group counseling, individual/ group evaluations and treatment, referral services, and medication management	
All Other Outpatient Treatment include: Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, crisis	No charge after deductible
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, and psychiatric observation (Please refer to your UnitedHealthcare of California Combined Evidence	
of Coverage and Disclosure Form for a complete description of this coverage)	

Benefits Available on an Outpatient Basis (Continued)

Oral Surgery Services	20% Co-payment after Deductible
Applies to dollar co-payments only: In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	2070 OG-payment and Deductible
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	\$25 Office Visit Co-payment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	20% Co-payment after Deductible
Physician Care PCP Office Visit Specialist Office Visit Co-payments for Audiologist and Podiatrist visits will be the same as for the PCP.	\$25 Office Visit Co-payment \$40 Office Visit Co-payment
 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: Colorectal Screening Hearing Screening Human Immunodeficiency Virus (HIV) Screening Immunizations Newborn Testing Prostate Screening Well-Baby/Child/Adolescent care Well-Baby/Child/Adolescent care Well-Baby/Child/Adolescent care Well-Baby/Child preventive Services Task Force, AAP (Bright Futures Recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric 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 and Services Administration as preventive and procedures recommended by the Health Resources and Services Administration as preventive the services will be 100% covered. Co-payment for the Office visit eare services will be 100% covered services and 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 and Services and Services Administration as preventive care services will be 100% covered. Co-payment applies to contraceptive methods and procedures that are NOT de	No charge
Prosthetics and Corrective Appliances In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	20% Co-payment after Deductible
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.	20% Co-payment after Deductible 20% Co-payment after Deductible

Benefits Available on an Outpatient Basis (Continued)

Benefits Available on an Outpatient Basis (Continued)	
Radiology Services	
Standard: (Additional Co-payment for office visits may apply)	No charge
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. In instances where the negotiated rate is less than your	
Co-payment, you will pay only the negotiated rate.	
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.	
Termination of Pregnancy (Medical/medication and surgical)	No charge 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	3
benefit as specified in the Combined Evidence of Coverage and Disclosure Form.	
Vasectomy	20% Co-payment after Deductible
Virtual Care Services	No charge
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.

P.O. Box 30968 Salt Lake City, UT 84130-0968 Customer Service: 800-624-8822 711 (TTY) www.myuhc.com

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\$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.



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** 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** 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 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**, 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)

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