UnitedHealthcare
Detailed Benefit Grids

California Small Business (1–100)
Effective January 1, 2020

UnitedHealthcare®

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Insurance Products

HMO Plans

Formal Insurance product names:
Navigate = UnitedHealthcare Navigate®
Core = UnitedHealthcare Core
Choice Plus = UnitedHealthcare Choice Plus
Select Plus = UnitedHealthcare Select Plus

Formal HMO product names:
Signature = UnitedHealthcare SignatureValue®
Advantage = UnitedHealthcare SignatureValue® Advantage
Alliance = UnitedHealthcare SignatureValue® Alliance
Focus = UnitedHealthcare SignatureValue® Focus
SignatureValue Harmony = UnitedHealthcare SignatureValue® Harmony

Formal PPO product name:
Non-Differential PPO = Non-Differential PPO

Select Plus and Core Plans

Metallic Level	Platinum		Platinum	
Select Plus/Core Plan	**10/10%**		**15/250/20%**	
Network[1]	**Network**	**Non-Network**	**Network**	**Non-Network**
Annual Deductible[2] (individual/family)	None	$1,000/$2,000	$250/$500	$1,000/$2,000
Annual Out-of-Pocket Limit[3] (individual/family)	$3,500/$7,000	$7,000/$14,000	$3,500/$7,000	$7,000/$14,000
Professional Services				
Office Visits - PCP	$10	50% after deductible	$15	50% after deductible
Office Visits - Specialist	$25	50% after deductible	$30	50% after deductible
Laboratory[4] (standard)	10%	50% after deductible	20% after deductible	50% after deductible
Radiology[4] (standard)	10%	50% after deductible	20% after deductible	50% after deductible
Maternity Care[5]	$10	50% after deductible	$15	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	10%	50% after deductible	20% after deductible	50% after deductible
Inpatient Physician Care	10%	50% after deductible	20% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	10%	50% after deductible	20% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	10% plus $150 per occurrence deductible	Same as Network benefit	20% after deductible, plus $150 per occurrence deductible	Same as Network benefit
Urgent Care Services	$50	50% after deductible	$50	50% after deductible
Ambulance Services	10%	Same as Network benefit	20% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery[4]	10%	50% after deductible	20% after deductible	50% after deductible
Durable Medical Equipment	10%	50% after deductible	20% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	10%	50% after deductible	20% after deductible	50% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	10%	50% after deductible	20% after deductible	50% after deductible
Injections Received in a Physician's Office	$10	50% after deductible	$15	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	10%	50% after deductible	20% after deductible	50% after deductible
Outpatient	$10	50% after deductible	$15	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	None		None	
Tier 1	$10		$10	
Tier 2	$35		$35	
Tier 3	$70		$70	
Tier 4	10% up to $250		10% up to $250	
Pediatric Dental & Vision Coverage[6]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	10%	50%	20%	50%

[1] Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.
[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per occurrence deductible does not apply to the Annual Deductible.
[3] Member cost share, including office visits, annual deductible, per occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.
[4] The outpatient per occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.
[5] No copayment applies to physician office visits for prenatal care.
[6] One routine vision exam and one pair of glasses per calendar year for children under age 19.
For additional details on exclusions/limitations on benefits, refer to Benefit Summary and Schedule of Benefits.

Select Plus and Core Plans, continued

Metallic Level	Platinum		Gold	
Select Plus/Core Plan	**250/20%**		**25/30%**	
Network[1]	**Network**	**Non-Network**	**Network**	**Non-Network**
Annual Deductible[2] (individual/family)	$250/$500	$1,000/$2,000	None	$1,000/$2,000
Annual Out-of-Pocket Limit[3] (individual/family)	$3,500/$7,000	$7,000/$14,000	$6,500/$13,000	$13,000/$26,000
Professional Services				
Office Visits - PCP	No copayment	50% after deductible	$25	50% after deductible
Office Visits - Specialist	$75	50% after deductible	$50	50% after deductible
Laboratory[4] (standard)	20% after deductible	50% after deductible	30% for independent, non-hospital-affiliated provider; 50% for hospital-affiliated provider	50% after deductible
Radiology[4] (standard)	20% after deductible	50% after deductible	30% for independent, non-hospital-affiliated provider; 50% for hospital-affiliated provider	50% after deductible
Maternity Care[5]	No copayment	50% after deductible	$25	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	20% after deductible	50% after deductible	30%	50% after deductible
Inpatient Physician Care	20% after deductible	50% after deductible	30%	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	50% after deductible	30%	50% after deductible
Emergency Health Coverage				
Emergency Services	20% after deductible, plus $150 per-occurrence deductible	Same as Network benefit	30% after $250 per-occurrence deductible	Same as Network benefit
Urgent Care Services	$50	50% after deductible	$75	50% after deductible
Ambulance Services	20% after deductible	Same as Network benefit	30%	Same as Network benefit
Outpatient Services				
Outpatient Surgery[4]	20% after deductible	50% after deductible	30% after $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Durable Medical Equipment	20% after deductible	50% after deductible	30%	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	20% after deductible	50% after deductible	30%	50% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	20% after deductible	50% after deductible	30%	50% after deductible
Injections Received in a Physician's Office	No copayment	50% after deductible	$25	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	20% after deductible	50% after deductible	30%	50% after deductible
Outpatient	No copayment	50% after deductible	$25	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	None		None	
Tier 1	$5		$15	
Tier 2	$35		$40	
Tier 3	$70		$80	
Tier 4	10% up to $250		25% up to $250	
Pediatric Dental & Vision Coverage[6]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	20%	50%	30%	50%

[1] Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per occurrence deductible does not apply to the Annual Deductible.

[3] Member cost share, including office visits, annual deductible, per occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

[4] The outpatient per occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.

[5] No copayment applies to physician office visits for prenatal care.

[6] One routine vision exam and one pair of glasses per calendar year for children under age 19.

For additional details on exclusions/limitations on benefits, refer to Benefit Summary and Schedule of Benefits.

Select Plus and Core Plans, continued

Metallic Level	Gold		Gold	
Select Plus/Core Plan	**25/500/20%**		**25/1000/20%**	
Network[1]	**Network**	**Non-Network**	**Network**	**Non-Network**
Annual Deductible[2] (individual/family)	$500/$1,000	$1,000/$2,000	$1,000/$2,000	$2,000/$4,000
Annual Out-of-Pocket Limit[3] (individual/family)	$6,500/$13,000	$13,000/$26,000	$6,500/$13,000	$13,000/$26,000
Professional Services				
Office Visits - PCP	$25	50% after deductible	$25	50% after deductible
Office Visits - Specialist	$50	50% after deductible	$50	50% after deductible
Laboratory[4] (standard)	20% after deductible for independent, non-hospital-affiliated provider; 40% after deductible for hospital-affiliated provider	50% after deductible	20% after deductible for independent, non-hospital-affiliated provider; 40% after deductible for hospital-affiliated provider	50% after deductible
Radiology[4] (standard)	20% after deductible for independent, non-hospital-affiliated provider; 40% after deductible for hospital-affiliated provider	50% after deductible	20% after deductible for independent, non-hospital-affiliated provider; 40% after deductible for hospital-affiliated provider	50% after deductible
Maternity Care[5]	$25	50% after deductible	$25	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Inpatient Physician Care	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	20% after deductible, plus $250 per occurrence deductible	Same as Network benefit	20% after deductible, plus $250 per occurrence deductible	Same as Network benefit
Urgent Care Services	$75	50% after deductible	$75	50% after deductible
Ambulance Services	20% after deductible	Same as Network benefit	20% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery[4]	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Durable Medical Equipment	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Injections Received in a Physician's Office	$25	50% after deductible	$25	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	$25	50% after deductible	$25	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	$250/$500 does not apply to Tier 1		$250/$500 does not apply to Tier 1	
Tier 1	$15		$15	
Tier 2	$40		$40	
Tier 3	$80		$80	
Tier 4	25% up to $250		25% up to $250	
Pediatric Dental & Vision Coverage[6]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	20%	50%	20%	50%

[1] Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.
[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per occurrence deductible does not apply to the Annual Deductible.
[3] Member cost share, including office visits, annual deductible, per occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.
[4] The outpatient per occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.
[5] No copayment applies to physician office visits for prenatal care.
[6] One routine vision exam and one pair of glasses per calendar year for children under age 19.
For additional details on exclusions/limitations on benefits, refer to Benefit Summary and Schedule of Benefits.

Select Plus and Core Plans, continued

Metallic Level	Gold		Silver	
Select Plus/Core Plan	**1500/30%**		**50/1500/40%**	
Network[1]	**Network**	**Non-Network**	**Network**	**Non-Network**
Annual Deductible[2] (individual/family)	$1,500/$3,000	$3,000/$6,000	$1,500/$3,000	$3,000/$6,000
Annual Out-of-Pocket Limit[3] (individual/family)	$6,500/$13,000	$13,000/$26,000	$8,150/$16,300	$16,300/$32,600
Professional Services				
Office Visits - PCP	No copayment	50% after deductible	$50	50% after deductible
Office Visits - Specialist	$75	50% after deductible	$80	50% after deductible
Laboratory[4] (standard)	30% after deductible for independent, non-hospital-affiliated provider; 50% after deductible for hospital-affiliated provider	50% after deductible	40% after deductible for independent, non-hospital-affiliated provider; 50% after deductible for hospital-affiliated provider	50% after deductible
Radiology[4] (standard)	30% after deductible for independent, non-hospital-affiliated provider; 50% after deductible for hospital-affiliated provider	50% after deductible	40% after deductible for independent, non-hospital-affiliated provider; 50% after deductible for hospital-affiliated provider	50% after deductible
Maternity Care[5]	No copayment	50% after deductible	$50	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	30% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	40% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Inpatient Physician Care	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	30% after deductible, plus $250 per occurrence deductible	Same as Network benefit	40% after deductible, plus $300 per occurrence deductible	Same as Network benefit
Urgent Care Services	$50	50% after deductible	$80	50% after deductible
Ambulance Services	30% after deductible	Same as Network benefit	40% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery[4]	30% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	40% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Durable Medical Equipment	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Injections Received in a Physician's Office	No copayment	50% after deductible	$50	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient	No copayment	50% after deductible	$50	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	$250/$500 does not apply to Tier 1		$300/$600 does not apply to Tier 1	
Tier 1	$5		$20	
Tier 2	$50		$50	
Tier 3	$100		$100	
Tier 4	25% up to $250		25% up to $250	
Pediatric Dental & Vision Coverage[6]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	30%	50%	40%	50%

[1] Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.
[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per occurrence deductible does not apply to the Annual Deductible.
[3] Member cost share, including office visits, annual deductible, per occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.
[4] The outpatient per occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.
[5] No copayment applies to physician office visits for prenatal care.
[6] One routine vision exam and one pair of glasses per calendar year for children under age 19.
For additional details on exclusions/limitations on benefits, refer to Benefit Summary and Schedule of Benefits.

Select Plus and Core Plans, continued

Metallic Level	Silver		Bronze	
Select Plus/Core Plan	**50/2250/40%**		**7200/40%**	
Network[1]	**Network**	**Non-Network**	**Network**	**Non-Network**
Annual Deductible[2] (individual/family)	$2,250/$4,500	$4,500/$9,000	$7,200/$14,400	$14,400/$28,800
Annual Out-of-Pocket Limit[3] (individual/family)	$8,150/$16,300	$16,300/$32,600	$8,150/$16,300	$16,300/$32,600
Professional Services				
Office Visits - PCP	$50	50% after deductible	40% after deductible	50% after deductible
Office Visits - Specialist	$80	50% after deductible	40% after deductible	50% after deductible
Laboratory[4] (standard)	40% after deductible for independent, non-hospital-affiliated provider; 50% after deductible for hospital-affiliated provider	50% after deductible	40% after deductible	50% after deductible
Radiology[4] (standard)	40% after deductible for independent, non-hospital-affiliated provider; 50% after deductible for hospital-affiliated provider	50% after deductible	40% after deductible	50% after deductible
Maternity Care[5]	$50	50% after deductible	40% after deductible	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	40% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	40% after deductible	50% after deductible
Inpatient Physician Care	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	40% after deductible, plus $300 per occurrence deductible	Same as Network benefit	40% after deductible	Same as Network benefit
Urgent Care Services	$80	50% after deductible	40% after deductible	50% after deductible
Ambulance Services	40% after deductible	Same as Network benefit	40% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery[4]	40% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	40% after deductible	50% after deductible
Durable Medical Equipment	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Injections Received in a Physician's Office	$50	50% after deductible	40% after deductible	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient	$50	50% after deductible	40% after deductible	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	$300/$600 does not apply to Tier 1		$350/$700 does not apply to Tier 1	
Tier 1	$20		$20	
Tier 2	$50		$50	
Tier 3	$100		$100	
Tier 4	25% up to $250		25% up to $500	
Pediatric Dental & Vision Coverage[6]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	40%	50%	40%	50%

[1] Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.
[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per occurrence deductible does not apply to the Annual Deductible.
[3] Member cost share, including office visits, annual deductible, per occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.
[4] The outpatient per occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.
[5] No copayment applies to physician office visits for prenatal care.
[6] One routine vision exam and one pair of glasses per calendar year for children under age 19.
For additional details on exclusions/limitations on benefits, refer to Benefit Summary and Schedule of Benefits.

Select Plus and Core HDHP Plans

Metallic Level	Silver		Bronze	
Select Plus/Core HDHP Plan	**HDHP w/UnitedHealthcare Motion® 2300/30%**		**HDHP 6900/0%**	
Network[1]	**Network**	**Non-Network**	**Network**	**Non-Network**
Annual Deductible[2] (individual/family)	$2,300/$2,800[5]	$4,600/$5,600[5]	$6,900/$13,800[6]	$13,800/$27,600[6]
Annual Out-of-Pocket Limit[3] (individual/family)	$6,650/$13,300	$13,300/$26,600	$6,900/$13,800	$13,800/$27,600
Professional Services				
Office Visits - PCP	30% after deductible	50% after deductible	No copay after deductible	No copay after deductible
Office Visits - Specialist	30% after deductible	50% after deductible	No copay after deductible	No copay after deductible
Laboratory (standard)	30% after deductible	50% after deductible	No copay after deductible	No copay after deductible
Radiology (standard)	30% after deductible	50% after deductible	No copay after deductible	No copay after deductible
Maternity Care	30% after deductible	50% after deductible	No copay after deductible	No copay after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	30% after deductible	50% after deductible	No copay after deductible	No copay after deductible
Inpatient Physician Care	30% after deductible	50% after deductible	No copay after deductible	No copay after deductible
Skilled Nursing Facility Care (100 days per benefit period)	30% after deductible	50% after deductible	No copay after deductible	No copay after deductible
Emergency Health Coverage				
Emergency Services	30% after deductible	Same as Network benefit	No copay after deductible	No copay after deductible
Urgent Care Services	30% after deductible	50% after deductible	No copay after deductible	No copay after deductible
Ambulance Services	30% after deductible	Same as Network benefit	No copay after deductible	No copay after deductible
Outpatient Services				
Outpatient Surgery	30% after deductible	50% after deductible	No copay after deductible	No copay after deductible
Durable Medical Equipment	30% after deductible	50% after deductible	No copay after deductible	No copay after deductible
Home Health Services (Up to 100 visits per calendar year)	30% after deductible	50% after deductible	No copay after deductible	No copay after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	30% after deductible	50% after deductible	No copay after deductible	No copay after deductible
Injections Received in a Physician's Office	30% after deductible	50% after deductible	No copay after deductible	No copay after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	30% after deductible	50% after deductible	No copay after deductible	No copay after deductible
Outpatient	30% after deductible	50% after deductible	No copay after deductible	No copay after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	Annual Deductible applies		Annual Deductible applies	
Tier 1	$20		No copayment	
Tier 2	$50		No copayment	
Tier 3	$100		No copayment	
Tier 4	25% up to $250		No copayment	
Pediatric Dental & Vision Coverage[4]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	No copay after deductible
Vision Exam (routine)	No copayment	50% after deductible	No copayment	No copay after deductible
Glasses (frames & lenses)	30% after deductible	50% after deductible	No copay after deductible	No copay after deductible

[1] Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

[2] The Annual Deductible is combined for medical and pharmacy benefits.

[3] Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit. When a member of a family unit satisfies the individual Out-of-Pocket Limit amount for the calendar year, no further copayments will be required for him or her for that calendar year.

[4] One routine vision exam and one pair of glasses per calendar year for children under age 19.

[5] The entire Family Deductible must be met before benefits can be paid for each eligible member of a family. One or more eligible members of a family unit may satisfy the Family Deductible.

[6] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

For additional details on exclusions/limitations on benefits, refer to Benefit Summary and Schedule of Benefits.

Core State Plans

Metallic Level	Platinum		Gold	
Select Plus/Core State Plan	**15/10%**		**25/250/20%**	
Network[1]	**Network**	**Non-Network**	**Network**	**Non-Network**
Annual Deductible[2] (individual/family)	None	$1,000/$2,000	$250/$500	$1,000/$2,000
Annual Out-of-Pocket Limit[3] (individual/family)	$4,500/$9,000	$9,000/$18,000	$7,800/$15,600	$15,600/$31,200
Professional Services				
Office Visits - PCP	$15	50% after deductible	$25	50% after deductible
Office Visits - Specialist	$30	50% after deductible	$50	50% after deductible
Laboratory (standard)	$15	50% after deductible	$25	50% after deductible
Radiology (standard)	$30	50% after deductible	$65	50% after deductible
Maternity Care[5]	$15	50% after deductible	$25	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	10%	50% after deductible	20% after deductible	50% after deductible
Inpatient Physician Care	10%	50% after deductible	20% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	10%	50% after deductible	20% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	$150	Same as Network benefit	$250 after deductible	Same as Network benefit
Urgent Care Services	$15	50% after deductible	$25	50% after deductible
Ambulance Services	$150	Same as Network benefit	$250 after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery	10%	50% after deductible	20%	50% after deductible
Durable Medical Equipment	10%	50% after deductible	20%	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	10%	50% after deductible	20%	50% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	10%	50% after deductible	20%	50% after deductible
Injections Received in a Physician's Office	$15	50% after deductible	$25	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	10%	50% after deductible	20% after deductible	50% after deductible
Outpatient	$15	50% after deductible	$25	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	None		None	
Tier 1	$5		$15	
Tier 2	$15		$50	
Tier 3	$25		$80	
Tier 4	10% up to $250		20% up to $250	
Pediatric Dental & Vision Coverage[6]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	No copayment	50%	No copayment	50%

[1] Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

[3] The Annual Deductible is combined for medical and pharmacy benefits.

[4] Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

[5] No copayment applies to physician office visits for prenatal care.

[6] One routine vision exam and one pair of glasses per calendar year for children under age 19.

For additional details on exclusions/limitations on benefits, refer to Benefit Summary and Schedule of Benefits.

Core State Plans, continued

Metallic Level	Silver		Bronze	
Select Plus/Core State Plan	**50/2250/20%**		**65/6300/40%**	
Network[1]	**Network**	**Non-Network**	**Network**	**Non-Network**
Annual Deductible[2] (individual/family)	$2,250/$4,500	$4,500/$9,000	$6,300/$12,600	$12,600/$25,200
Annual Out-of-Pocket Limit[4] (individual/family)	$7,800/$15,600	$15,600/$31,200	$7,800/$15,600	$15,600/$31,200
Professional Services				
Office Visits - PCP	$50	50% after deductible	$65 for first 3 visits, then deductible applies	50% after deductible
Office Visits - Specialist	$85	50% after deductible	$95 for first 3 visits, then deductible applies	50% after deductible
Laboratory (standard)	$40	50% after deductible	$40	50% after deductible
Radiology (standard)	$85	50% after deductible	40% after deductible	50% after deductible
Maternity Care[5]	$50	50% after deductible	$65	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	20% after deductible	50% after deductible	40% after deductible	50% after deductible
Inpatient Physician Care	20% after deductible	50% after deductible	40% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	50% after deductible	40% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	$400 after deductible	Same as Network benefit	40% after deductible	Same as Network benefit
Urgent Care Services	$50	50% after deductible	$65 for first 3 visits, then deductible applies	50% after deductible
Ambulance Services	$250 after deductible	Same as Network benefit	40% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery	20%	50% after deductible	40% after deductible	50% after deductible
Durable Medical Equipment	20%	50% after deductible	40% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	20%	50% after deductible	40% after deductible	50% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	20%	50% after deductible	40% after deductible	50% after deductible
Injections Received in a Physician's Office	$50	50% after deductible	$65	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	20% after deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient	$50	50% after deductible	No copayment	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	$300/$600		$500/$1,000	
Tier 1	$17		$18	
Tier 2	$65		40% up to $500	
Tier 3	$90		40% up to $500	
Tier 4	20% up to $250		40% up to $500	
Pediatric Dental & Vision Coverage[6]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	No copayment	50%	40%	50%

[1] Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

[3] The Annual Deductible is combined for medical and pharmacy benefits.

[4] Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

[5] No copayment applies to physician office visits for prenatal care.

[6] One routine vision exam and one pair of glasses per calendar year for children under age 19.

For additional details on exclusions/limitations on benefits, refer to Benefit Summary and Schedule of Benefits.

Navigate State Plans

Metallic Level	Platinum	Gold	Silver	Bronze
Navigate Plan	**15/10%**	**25/250/20%**	**50/2250/20%**	**65/6300/40%**
Network[1]	**Network**	**Network**	**Network**	**Network**
Annual Deductible[2] (individual/family)	None	$250/$500	$2,250/$4,500	$6,300/$12,600
Annual Out-of-Pocket Limit[4] (individual/family)	$4,500/$9,000	$7,800/$15,600	$7,800/$15,600	$7,800/$15,600
Professional Services				
Office Visits - PCP	$15	$25	$50	$65 for first 3 visits, then deductible applies
Office Visits - Specialist	$30	$50	$85	$95 for first 3 visits, then deductible applies
Laboratory (standard)	$15	$25	$40	$40
Radiology (standard)	$30	$65	$85	40% after deductible
Maternity Care[5]	$15	$25	$50	$65
Preventive Care Services	No copayment	No copayment	No copayment	No copayment
Hospitalization Services				
Inpatient Hospital Benefits	10%	20% after deductible	20% after deductible	40% after deductible
Inpatient Physician Care	10%	20% after deductible	20% after deductible	40% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	10%	20% after deductible	20% after deductible	40% after deductible
Emergency Health Coverage				
Emergency Services	$150	$250 after deductible	$400 after deductible	40% after deductible
Urgent Care Services	$15	$25	$50	$65 for first 3 visits, then deductible applies
Ambulance Services	$150	$250 after deductible	$250 after deductible	40% after deductible
Outpatient Services				
Outpatient Surgery	10%	20%	20%	40% after deductible
Durable Medical Equipment	10%	20%	20%	40% after deductible
Home Health Services (Up to 100 visits per calendar year)	10%	20%	20%	40% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	10%	20%	20%	40% after deductible
Injections Received in a Physician's Office	$15	$25	$50	$65
Mental Health & Substance Use Disorder Services				
Inpatient	10%	20% after deductible	20% after deductible	40% after deductible
Outpatient	$15	$25	$50	No copayment
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	None	None	$300/$600	$500/$1,000
Tier 1	$5	$15	$17	$18
Tier 2	$15	$50	$65	40% up to $500
Tier 3	$25	$80	$90	40% up to $500
Tier 4	10% up to $250	20% up to $250	20% up to $250	40% up to $500
Pediatric Dental & Vision Coverage[6]				
Dental Exam (preventive/diagnostic)	No copayment	No copayment	No copayment	No copayment
Vision Exam (routine)	No copayment	No copayment	No copayment	No copayment
Glasses (frames & lenses)	No copayment	No copayment	No copayment	40%

[1] No benefits for Non-Network services, except for emergency health and urgent care services. Members must obtain an electronic referral from their primary care physician before seeing another network physician.

[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

[3] The Annual Deductible is combined for medical and pharmacy benefits.

[4] Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

[5] No copayment applies to physician office visits for prenatal care.

[6] One routine vision exam and one pair of glasses per calendar year for children under age 19.

For additional details on exclusions/limitations on benefits, refer to Benefit Summary and Schedule of Benefits.

Non-Differential PPO

The UnitedHealthcare Non-Differential PPO product helps provide freedom for dealing with health care situations. This flexible product provides broader-based coverage to include more doctors and specialists to visit without referrals. With this version of health coverage, benefits are provided for covered health services received from any physician or other licensed health care professional.

Metallic Level	**Silver**
Non-Differential PPO Plan[1]	**2250/30%**
Network	**Network & Non-Network**
Annual Deductible[2] (individual/family)	$2,250/$4,500
Annual Out-of-Pocket Limit[3] (individual/family)	$7,350/$14,700
Professional Services	
Office Visits - PCP	30% after deductible
Office Visits - Specialist	30% after deductible
Laboratory (standard)	30% after deductible
Radiology (standard)	30% after deductible
Maternity Care	30% after deductible
Preventive Care Services	No copayment
Hospitalization Services	
Inpatient Hospital Benefits	30% after deductible
Inpatient Physician Care	30% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	30% after deductible
Emergency Health Coverage	
Emergency Services	30% after deductible
Urgent Care Services	30% after deductible
Ambulance Services	30% after deductible
Outpatient Services	
Outpatient Surgery	30% after deductible
Durable Medical Equipment	30% after deductible
Home Health Services (Up to 100 visits per calendar year)	30% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	30% after deductible
Injections Received in a Physician's Office	30% after deductible
Mental Health & Substance Use Disorder Services	
Inpatient	30% after deductible
Outpatient	30% after deductible
Outpatient Prescription Drug Coverage	
Calendar Year Deductible (individual/family)	$200/$400 does not apply to Tier 1
Tier 1	$20
Tier 2	$50
Tier 3	$100
Tier 4	25% up to $250
Pediatric Dental & Vision Coverage[4]	
Dental Exam (preventive/diagnostic)	No copayment
Vision Exam (routine)	No copayment
Glasses (frames & lenses)	30%

[1] Out-of-area plan available outside of our contracted network service areas. Subject to underwriting guidelines.

[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

[3] Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

[4] One routine vision exam and one pair of glasses per calendar year for children under age 19.

For additional details on exclusions/limitations on benefits, refer to Benefit Summary and Schedule of Benefits.

Advantage, Alliance, Focus and UnitedHealthcare SignatureValue® Harmony Plans

Metallic Level	Platinum	Platinum	Platinum	Gold	Gold	Gold
HMO Plan	**20-40/500d**	**20-40/20%**	**0-80/20%**	**30-60/1000d**	**30-60/20%/ 500ded**	**30-60/30%/ 1250ded**
Annual Deductible[1] (individual/family)	None	None	None	None	$500/$1,000	$1,250/$2,500
Annual Out-of-Pocket Limit[2] (individual/ family)	$3,000/$6,000	$3,500/$7,000	$4,000/$8,000	$6,000/$12,000	$6,500/$13,000	$6,500/$13,000
Professional Services						
Office Visits - PCP	$20	$20	No charge	$30	$30	$30
Office Visits - Specialist	$40	$40	$80	$60	$60	$60
Laboratory (standard)	$15	$25	$25	$30	$30	$30
Radiology (standard)	$15	$25	$25	$30	$30	$30
Maternity Care	No charge	No charge	No charge	No charge	No charge	No charge
Preventive Care Services	No charge	No charge	No charge	No charge	No charge	No charge
Hospitalization Services						
Inpatient Hospital Benefits	$500/day, max 4 days per stay	20%	20%	$1,000/day, max 4 days per stay	20% after deductible	30% after deductible
Inpatient Physician Care	No charge	No charge	No charge	No charge	20%	30%
Skilled Nursing Facility Care (100 days per benefit period)	$300/day, max 4 days per stay	20%	20%	$300/day, max 4 days per stay	20% after deductible	30% after deductible
Emergency Health Coverage						
Emergency Services	$400	20%	20%	$500	$500 after deductible	30% after deductible
Urgently Needed Services • within physician service area	$20	$20	No charge	$30	$30	$30
• outside physician service area	$50	$50	$50	$75	$75	$75
Ambulance Services	$100	$100	$100	$100	$100	$100
Outpatient Services						
Outpatient Surgery	$250	20%	20%	$500	20% after deductible	30% after deductible
Durable Medical Equipment	$50	$50	$50	$50	$50	$50
Home Health Services (Up to 100 visits per calendar year)	$20	$20	No charge	$30	$30	$30
Infertility Services	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Injectable Drugs	$150	$150	$150	$150	$150	$150
Mental Health & Substance Use Disorder Services						
Inpatient	$500/day, max 4 days per stay	20%	20%	$600/day, max 4 days per stay	20% after deductible	30% after deductible
Outpatient	$20	$20	No charge	$30	$30	$30
Outpatient Prescription Drug Coverage						
Calendar Year Deductible (individual/family)	None	None	None	$100/$200 (does not apply to Tier 1)	$250/$500 (does not apply to Tier 1)	$250/$500 (does not apply to Tier 1)
Tier 1	$15	$15	$5	$15	$15	$15
Tier 2	$35	$35	$35	$40	$40	$40
Tier 3	$70	$70	$70	$80	$80	$80
Tier 4	25% up to $250	25% up to $250	25% up to $250	25% up to $250	25% up to $250	25% up to $250
Pediatric Dental & Vision Coverage[3]						
Dental Exam (preventive/diagnostic)	No charge	No charge	No charge	No charge	No charge	No charge
Vision Exam (routine)	No charge	No charge	No charge	No charge	No charge	No charge
Glasses (frames & lenses)	10%	20%	20%	10%	20%	30%
Optional Group Coverage						
Infertility Services	50%	50%	50%	50%	50%	50%

[1] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

[2] Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

[3] One routine vision exam and one pair of glasses per calendar year for children under age 19.

For additional details on exclusions/limitations on benefits, refer to Benefit Summary and Schedule of Benefits.

Advantage, Alliance, Focus and UnitedHealthcare SignatureValue® Harmony Plans, continued

Metallic Level	Gold	Silver	Silver	Bronze
HMO Plan	**0-80/30%/ 1500ded**	**55-80/40%/ 2250ded**	**30%/2250ded (Alliance & SignatureValue Harmony only)**	**40%/7200ded (Alliance & SignatureValue Harmony only)**
Annual Deductible[1] (individual/family)	$1,500/$3,000	$2,250/$4,500	$2,250/$4,500	$7,200/$14,400
Annual Out-of-Pocket Limit[2] (individual/family)	$7,500/$15,000	$8,150/$16,300	$8,150/$16,300	$8,150/$16,300
Professional Services				
Office Visits - PCP	No charge	$55	30% after deductible	40% after deductible
Office Visits - Specialist	$80	$80	30% after deductible	40% after deductible
Laboratory (standard)	$30	$45	30% after deductible	40% after deductible
Radiology (standard)	$30	$45	30% after deductible	40% after deductible
Maternity Care	No charge	No charge	30% after deductible	40% after deductible
Preventive Care Services	No charge	No charge	No charge	No charge
Hospitalization Services				
Inpatient Hospital Benefits	30% after deductible	40% after deductible	30% after deductible	40% after deductible
Inpatient Physician Care	30%	40%	30% after deductible	40% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	30% after deductible	40% after deductible	30% after deductible	40% after deductible
Emergency Health Coverage				
Emergency Services	30% after deductible	40% after deductible	30% after deductible	40% after deductible
Urgently Needed Services • within physician service area	No charge	$55	30% after deductible	40% after deductible
• outside physician service area	$75	$100	30% after deductible	40% after deductible
Ambulance Services	$100	$100	30% after deductible	40% after deductible
Outpatient Services				
Outpatient Surgery	30% after deductible	40% after deductible	30% after deductible	40% after deductible
Durable Medical Equipment	$50	$50	30% after deductible	40% after deductible
Home Health Services (Up to 100 visits per calendar year)	No charge	$55	30% after deductible	40% after deductible
Infertility Services	Not covered	Not covered	Not covered	Not covered
Injectable Drugs	$150	$150	30% after deductible	40% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	30% after deductible	40% after deductible	30% after deductible	40% after deductible
Outpatient	No charge	$55	30% after deductible	40% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	$250/$500 (does not apply to Tier 1)	$300/$600 (does not apply to Tier 1)	$300/$600 (does not apply to Tier 1)	$350/$700
Tier 1	$5	$20	$20	40% up to $500
Tier 2	$50	$50	$50	40% up to $500
Tier 3	$100	$100	$100	40% up to $500
Tier 4	25% up to $250	25% up to $250	25% up to $250	40% up to $500
Pediatric Dental & Vision Coverage[3]				
Dental Exam (preventive/diagnostic)	No charge	No charge	No charge	No charge
Vision Exam (routine)	No charge	No charge	No charge	No charge
Glasses (frames & lenses)	30%	40%	30%	40%
Optional Group Coverage				
Infertility Services	50%	50%	50% after deductible	50% after deductible

[1] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

[2] Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

[3] One routine vision exam and one pair of glasses per calendar year for children under age 19.

For additional details on exclusions/limitations on benefits, refer to Benefit Summary and Schedule of Benefits.

Alliance and UnitedHealthcare SignatureValue® Harmony HDHP Plans

Metallic Level	Bronze (Alliance Only)	Bronze (SignatureValue Harmony Only)
HMO Plan	**HDHP 0%/6900ded**	**HDHP w/Motion 0%/6900ded**
Annual Deductible[1] (individual/family)	$6,900/$13,800	$6,900/$13,800
Annual Out-of-Pocket Limit[2] (individual/family)	$6,900/$13,800	$6,900/$13,800
Professional Services		
Office Visits - PCP	No charge after deductible	No charge after deductible
Office Visits - Specialist	No charge after deductible	No charge after deductible
Laboratory - Standard	No charge after deductible	No charge after deductible
Radiology - Standard	No charge after deductible	No charge after deductible
Maternity Care	No charge after deductible	No charge after deductible
Preventive Care Services	No charge	No charge
Hospitalization Services		
Inpatient Hospital Benefits	No charge after deductible	No charge after deductible
Inpatient Physician Care	No charge after deductible	No charge after deductible
Skilled Nursing Facility Care (100 days per benefit period)	No charge after deductible	No charge after deductible
Emergency Health Coverage		
Emergency Services	No charge after deductible	No charge after deductible
Urgently Needed Services • within physician service area	No charge after deductible	No charge after deductible
• outside physician service area	No charge after deductible	No charge after deductible
Ambulance Services	No charge after deductible	No charge after deductible
Outpatient Services		
Outpatient Surgery	No charge after deductible	No charge after deductible
Outpatient Surgery Physician Care	No charge after deductible	No charge after deductible
Durable Medical Equipment	No charge after deductible	No charge after deductible
Home Health Services (Up to 100 visits per calendar year)	No charge after deductible	No charge after deductible
Infertility Services	Not covered	Not covered
Injectable Drugs	No charge after deductible	No charge after deductible
Mental Health & Substance Use Disorder Services		
Inpatient	No charge after deductible	No charge after deductible
Outpatient	No charge after deductible	No charge after deductible
Outpatient Prescription Drug Coverage		
Calendar Year Deductible (individual/family)	Annual Deductible applies	Annual Deductible applies
Tier 1	No charge	No charge
Tier 2	No charge	No charge
Tier 3	No charge	No charge
Tier 4	No charge	No charge
Pediatric Dental & Vision Coverage[3]		
Dental Exam (preventive/diagnostic)	No charge	No charge
Vision Exam (routine)	No charge	No charge
Glasses (frames & lenses)	No charge after deductible	No charge after deductible
Optional Group Coverage		
Infertility Services	No charge after deductible	No charge after deductible

[1] The Annual Deductible is combined for medical and pharmacy benefits. When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

[2] Annual deductible applies to the Out-of-Pocket Limit.

[3] One routine vision exam and one pair of glasses per calendar year for children under age 19.

For additional details on exclusions/limitations on benefits, refer to Benefit Summary and Schedule of Benefits.

Alliance State Plans

Metallic Level	Platinum	Gold	Silver	Bronze
HMO Plan	**Platinum 90 HMO 0/15**	**Gold 80 HMO 250/25**	**Silver 70 HMO 2250/50**	**Bronze 60 HMO HDHP 6900/0%**
Annual Deductible[1] (individual/family)	None	$250/$500	$2,250/$4,500	$6,900/$13,800[2]
Annual Out-of-Pocket Limit[3] (individual/family)	$4,500/$9,000	$7,800/$15,600	$7,800/$15,600	$6,900/$13,800
Professional Services				
Office Visits - PCP	$15	$25	$50	No charge after deductible
Office Visits - Specialist	$30	$50	$85	No charge after deductible
Laboratory - Standard	$15	$25	$40	No charge after deductible
Radiology - Standard	$30	$65	$85	No charge after deductible
Maternity Care	No charge	No charge	No charge	No charge after deductible
Preventive Care Services	No charge	No charge	No charge	No charge
Hospitalization Services				
Inpatient Hospital Benefits	10%	20% after deductible	20% after deductible	No charge after deductible
Inpatient Physician Care	10%	20% after deductible	20% after deductible	No charge after deductible
Skilled Nursing Facility Care (100 days per benefit period)	10%	20% after deductible	20% after deductible	No charge after deductible
Emergency Health Coverage				
Emergency Services	$150	$250 after deductible	$400 after deductible	No charge after deductible
Urgently Needed Services • within physician service area	$15	$25	$50	No charge after deductible
• outside physician service area	$15	$25	$50	No charge after deductible
Ambulance Services	$150	$250 after deductible	$250 after deductible	No charge after deductible
Outpatient Services				
Outpatient Surgery	10%	20%	20%	No charge after deductible
Durable Medical Equipment	10%	20%	20%	No charge after deductible
Home Health Services (Up to 100 visits per calendar year)	10%	$30	20%	No charge after deductible
Infertility Services	Not covered	Not covered	Not covered	Not covered
Injectable Drugs	10%	20%	20%	No charge after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	10%	20% after deductible	20% after deductible	No charge after deductible
Outpatient	$15	$25	$50	No charge after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	None	None	$300/$600	Annual Deductible applies
Tier 1	$5	$15	$17	No charge
Tier 2	$15	$50	$65	No charge
Tier 3	$25	$80	$90	No charge
Tier 4	10% up to $250	20% up to $250	20% up to $250	No charge
Pediatric Dental & Vision Coverage[4]				
Dental Exam (preventive/diagnostic)	No charge	No charge	No charge	No charge
Vision Exam (routine)	No charge	No charge	No charge	No charge
Glasses (frames & lens)	No charge	No charge	No charge	No charge
Optional Group Coverage				
Infertility Services	50%	50%	50%	50% after deductible

This offer is being issued under UHCBPCA. Select, Choice and Core products are Pending Regulatory Approval.

[1] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

[2] The Annual Deductible is combined for medical and pharmacy benefits.

[3] Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

[4] One routine vision exam and one pair of glasses per calendar year for children under age 19.

For additional details on exclusions/limitations on benefits, refer to Benefit Summary and Schedule of Benefits.

UnitedHealthcare Motion is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. Receiving an activity tracker and/or certain credits and/or purchasing an activity tracker with earnings may have tax implications. You should consult an appropriate tax professional to determine if you have any tax obligations from receiving an activity tracker and/or certain credits under this program, as applicable. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-855-256-8669 or at the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Subject to HSA eligibility, as applicable.

These benefit grids are intended only to highlight plan benefits and should not be relied upon to fully determine coverage. Every effort has been made to ensure accuracy in information printed in this book; however, UnitedHealthcare and its affiliates cannot guarantee that there are no errors. In the event of a conflict between this document and the terms of an individual member's Certificate of Coverage/Evidence of Coverage, the Certificate of Coverage/Evidence of Coverage prevails.

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