# UnitedHealthcare detailed benefit grids.

California Small Business (1–100)
Effective January 1, 2021.

United Healthcare®

# Contents



**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, Core and Doctors[1] (Network Only) Plans

| Metallic Level | Platinum | | Platinum | | Platinum | |
|---|---|---|---|---|---|---|
| **PPO/EPO Plan** | **15/10%** | | **15/250/20%** | | **250/20%** | |
| **Network[1]** | **Network** | **Non-Network[1]** | **Network** | **Non-Network[1]** | **Network** | **Non-Network[1]** |
| Annual Deductible[2] (individual/family) | None | $1,000/$2,000 | $250/$500 | $1,000/$2,000 | $250/$500 | $1,000/$2,000 |
| Annual Out-of-Pocket Maximum[3] (individual/family) | $3,600/$7,200 | $7,200/$14,400 | $3,600/$7,200 | $7,200/$14,400 | $3,600/$7,200 | $7,200/$14,400 |
| **Professional Services** | | | | | | |
| Office Visits - PCP | $15 | 50% after deductible | $15 | 50% after deductible | No copayment | 50% after deductible |
| Office Visits - Specialist | $40 | 50% after deductible | $40 | 50% after deductible | $75 | 50% after deductible |
| Laboratory[4] (standard) | 10% | No benefit | 20% after deductible | No benefit | 20% after deductible | No benefit |
| Radiology[4] (standard) | 10% | 50% after deductible | 20% after deductible | 50% after deductible | 20% after deductible | 50% after deductible |
| Maternity Care[5] | $15 | 50% after deductible | $15 | 50% after deductible | No copayment | 50% after deductible |
| Preventive Care Services | No copayment | No benefit | No copayment | No benefit | No copayment | No benefit |
| **Hospitalization Services** | | | | | | |
| Inpatient Hospital Benefits | 10% | 50% after deductible | 20% after deductible | 50% after deductible | 20% after deductible | 50% after deductible |
| Inpatient Physician Care | 10% | 50% after deductible | 20% after deductible | 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 | 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 | 20% after deductible, plus $150 per occurrence deductible | Same as Network benefit |
| Urgent Care Services | $50 | 50% after deductible | $50 | 50% after deductible | $50 | 50% after deductible |
| Ambulance Services | 10% | Same as Network benefit | 20% after deductible | 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 | 20% after deductible | 50% after deductible |
| Durable Medical Equipment | 10% | 50% after deductible | 20% after deductible | 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 | 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 | 20% after deductible | 50% after deductible |
| Injections Received in a Physician's Office | $15 | 50% after deductible | $15 | 50% after deductible | No copayment | 50% after deductible |
| **Mental Health & Substance Use Disorder Services** | | | | | | |
| Inpatient | 10% | 50% after deductible | 20% after deductible | 50% after deductible | 20% after deductible | 50% after deductible |
| Outpatient | $15 | 50% after deductible | $15 | 50% after deductible | No copayment | 50% after deductible |
| **Outpatient Prescription Drug Coverage** | | | | | | |
| Calendar Year Deductible (individual/family) | None | No benefit | None | No benefit | None | No benefit |
| Tier 1 | $5 | | $5 | | $5 | |
| Tier 2 | $35 | | $35 | | $35 | |
| Tier 3 | $80 | | $80 | | $80 | |
| Tier 4 | 25% up to $250 | | 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 | No copayment | 50% after deductible |
| Vision Exam (routine) | No copayment | 50% | No copayment | 50% | No copayment | 50% |
| Glasses (frames & lens) | 10% | 50% | 20% | 50% | 20% | 50% |

[1] For Doctors plans, no benefits for Non-Network services, except for emergency health and urgent care services. For Select Plus and Core plans, 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 Maximum.

[4] The outpatient per occurrence deductible may be waived for outpatient services received at an in-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.

# Select Plus, Core and Doctors [1] (Network Only) Plans, continued

| Metallic Level | Gold | | Gold | |
|---|---|---|---|---|
| **PPO/EPO Plan** | **30/30%** | | **30/500/20%** | |
| **Network[1]** | **Network** | **Non-Network[1]** | **Network** | **Non-Network[1]** |
| Annual Deductible[2] (individual/family) | None | $1,000/$2,000 | $500/$1,000 | $1,000/$2,000 |
| Annual Out-of-Pocket Maximum[3] (individual/family) | $7,800/$15,600 | $15,600/$31,200 | $7,800/$15,600 | $15,600/$31,200 |
| **Professional Services** | | | | |
| Office Visits - PCP | $30 | 50% after deductible | $30 | 50% after deductible |
| Office Visits - Specialist | $60 | 50% after deductible | $60 | 50% after deductible |
| Laboratory[4] (standard) | 30% for independent, non-hospital affiliated provider; 50% for hospital affiliated provider | No benefit | 20% after deductible for independent, non-hospital affiliated provider; 40% after deductible for hospital affiliated provider | No benefit |
| Radiology[4] (standard) | 30% for independent, non-hospital affiliated provider; 50% 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] | $30 | 50% after deductible | $30 | 50% after deductible |
| Preventive Care Services | No copayment | No benefit | No copayment | No benefit |
| **Hospitalization Services** | | | | |
| Inpatient Hospital Benefits | 30% | 50% after deductible | 20% after deductible, plus $250 per occurrence deductible | 50% after deductible, plus $250 per occurrence deductible |
| Inpatient Physician Care | 30% | 50% after deductible | 20% after deductible | 50% after deductible |
| Skilled Nursing Facility Care (100 days per benefit period) | 30% | 50% after deductible | 20% after deductible | 50% after deductible |
| **Emergency Health Coverage** | | | | |
| Emergency Services | 30% after $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 | 30% | Same as Network benefit | 20% after deductible | Same as Network benefit |
| **Outpatient Services** | | | | |
| Outpatient Surgery[4] | 30% after $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 | 30% | 50% after deductible | 20% after deductible | 50% after deductible |
| Home Health Services (Up to 100 visits per calendar year) | 30% | 50% after deductible | 20% after deductible | 50% after deductible |
| Infertility Services (Benefits limited to $2,000 per lifetime) | 30% | 50% after deductible | 20% after deductible | 50% after deductible |
| Injections Received in a Physician's Office | $30 | 50% after deductible | $25 | 50% after deductible |
| **Mental Health & Substance Use Disorder Services** | | | | |
| Inpatient | 30% | 50% after deductible | 20% after deductible | 50% after deductible |
| Outpatient | $30 | 50% after deductible | $30 | 50% after deductible |
| **Outpatient Prescription Drug Coverage** | | | | |
| Calendar Year Deductible (individual/family) | None | No benefit | $300/$600 does not apply to Tier 1 | No benefit |
| Tier 1 | $10 | | $10 | |
| Tier 2 | $40 | | $40 | |
| Tier 3 | $85 | | $85 | |
| 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 & lens) | 30% | 50% | 20% | 50% |

[1] For Doctors plans, no benefits for Non-Network services, except for emergency health and urgent care services. For Select Plus and Core plans, 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 Maximum.

[4] The outpatient per occurrence deductible may be waived for outpatient services received at an in-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.

# Select Plus, Core and Doctors [1] (Network Only) Plans, continued

| Metallic Level | Gold | | Gold | |
|---|---|---|---|---|
| **PPO/EPO Plan** | **35/1000/20%** | | **1500/30%** | |
| **Network[1]** | **Network** | **Non-Network[1]** | **Network** | **Non-Network[1]** |
| Annual Deductible[2] (individual/family) | $1,000/$2,000 | $2,000/$4,000 | $1,500/$3,000 | $3,000/$6,000 |
| Annual Out-of-Pocket Maximum[3] (individual/family) | $7,800/$15,600 | $15,600/$31,200 | $8,000/$16,000 | $16,000/$32,000 |
| **Professional Services** | | | | |
| Office Visits - PCP | $35 | 50% after deductible | No copayment | 50% after deductible |
| Office Visits - Specialist | $70 | 50% after deductible | $90 | 50% after deductible |
| Laboratory[4] (standard) | 20% after deductible for independent, non-hospital affiliated provider; 40% after deductible for hospital affiliated provider | No benefit | 30% after deductible for independent, non-hospital affiliated provider; 50% after deductible for hospital affiliated provider | No benefit |
| Radiology[4] (standard) | 20% after deductible for independent, non-hospital affiliated provider; 40% after deductible for hospital affiliated provider | 50% after deductible | 30% after deductible for independent, non-hospital affiliated provider; 50% after deductible for hospital affiliated provider | 50% after deductible |
| Maternity Care[5] | $35 | 50% after deductible | No copayment | 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 | 30% after deductible, plus $250 per occurrence deductible | 50% after deductible, plus $250 per occurrence deductible |
| Inpatient Physician Care | 20% after deductible | 50% after deductible | 30% after deductible | 50% after deductible |
| Skilled Nursing Facility Care (100 days per benefit period) | 20% after deductible | 50% after deductible | 30% after deductible | 50% after deductible |
| **Emergency Health Coverage** | | | | |
| Emergency Services | 20% after deductible, plus $250 per occurrence deductible | Same as Network benefit | 30% after deductible, plus $250 per occurrence deductible | Same as Network benefit |
| Urgent Care Services | $75 | 50% after deductible | $50 | 50% after deductible |
| Ambulance Services | 20% after deductible | Same as Network benefit | 30% 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 | 30% after deductible, plus $250 per occurrence deductible | 50% after deductible, plus $250 per occurrence deductible |
| Durable Medical Equipment | 20% after deductible | 50% after deductible | 30% after deductible | 50% after deductible |
| Home Health Services (Up to 100 visits per calendar year) | 20% after deductible | 50% after deductible | 30% after deductible | 50% after deductible |
| Infertility Services (Benefits limited to $2,000 per lifetime) | 20% after deductible | 50% after deductible | 30% after deductible | 50% after deductible |
| Injections Received in a Physician's Office | $35 | 50% after deductible | No copayment | 50% after deductible |
| **Mental Health & Substance Use Disorder Services** | | | | |
| Inpatient | 20% after deductible | 50% after deductible | 30% after deductible | 50% after deductible |
| Outpatient | $35 | 50% after deductible | No copayment | 50% after deductible |
| **Outpatient Prescription Drug Coverage** | | | | |
| Calendar Year Deductible (individual/family) | $300/$600 does not apply to Tier 1 | No benefit | $300/$600 does not apply to Tier 1 | No benefit |
| Tier 1 | $10 | | $5 | |
| Tier 2 | $40 | | $50 | |
| Tier 3 | $85 | | $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 & lens) | 20% | 50% | 30% | 50% |

[1] For Doctors plans, no benefits for Non-Network services, except for emergency health and urgent care services. For Select Plus and Core plans, 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 Maximum.

[4] The outpatient per occurrence deductible may be waived for outpatient services received at an in-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.

# Select Plus, Core and Doctors [1] (Network Only) Plans, continued

| Metallic Level | Silver | | Silver | |
|---|---|---|---|---|
| **PPO/EPO Plan** | **55/1750/40%** | | **55/2250/40%** | |
| **Network[1]** | **Network** | **Non-Network[1]** | **Network** | **Non-Network[1]** |
| Annual Deductible[2] (individual/family) | $1,750/$3,500 | $3,500/$7,000 | $2,250/$4,500 | $4,500/$9,000 |
| Annual Out-of-Pocket Maximum[3] (individual/family) | $8,500/$17,000 | $17,000/$34,000 | $8,500/$17,000 | $17,000/$34,000 |
| **Professional Services** | | | | |
| Office Visits - PCP | $55 | 50% after deductible | $55 | 50% after deductible |
| Office Visits - Specialist | $95 | 50% after deductible | $95 | 50% after deductible |
| Laboratory[4] (standard) | 40% after deductible for independent, non-hospital affiliated provider; 50% after deductible for hospital affiliated provider | No benefit | 40% after deductible for independent, non-hospital affiliated provider; 50% after deductible for hospital affiliated provider | No benefit |
| 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 for independent, non-hospital affiliated provider; 50% after deductible for hospital affiliated provider | 50% after deductible |
| Maternity Care[5] | $55 | 50% after deductible | $55 | 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, plus $250 per occurrence deductible | 50% after deductible, plus $250 per occurrence 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, plus $300 per occurrence deductible | Same as Network benefit |
| Urgent Care Services | $80 | 50% after deductible | $80 | 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, plus $250 per occurrence deductible | 50% after deductible, plus $250 per occurrence 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 | $55 | 50% after deductible | $55 | 50% after deductible |
| **Mental Health & Substance Use Disorder Services** | | | | |
| Inpatient | 40% after deductible | 50% after deductible | 40% after deductible | 50% after deductible |
| Outpatient | $55 | 50% after deductible | $55 | 50% after deductible |
| **Outpatient Prescription Drug Coverage** | | | | |
| Calendar Year Deductible (individual/family) | $300/$600 does not apply to Tier 1 | No benefit | $300/$600 does not apply to Tier 1 | No benefit |
| Tier 1 | $15 | | $15 | |
| Tier 2 | $70 | | $70 | |
| Tier 3 | $115 | | $115 | |
| 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 & lens) | 40% | 50% | 40% | 50% |

[1] For Doctors plans, no benefits for Non-Network services, except for emergency health and urgent care services. For Select Plus and Core plans, 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 Maximum.

[4] The outpatient per occurrence deductible may be waived for outpatient services received at an in-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.

# Select Plus, Core and Doctors [1] (Network Only) Plans, continued

| Metallic Level | Bronze | |
|---|---|---|
| **PPO/EPO Plan** | **7200/40%** | |
| **Network[1]** | **Network** | **Non-Network[1]** |
| Annual Deductible[2] (individual/family) | $7,200/$14,400 | $14,400/$28,800 |
| Annual Out-of-Pocket Maximum[3] (individual/family) | $8,500/$17,000 | $17,000/$34,000 |
| **Professional Services** | | |
| Office Visits - PCP | 40% after deductible | 50% after deductible |
| Office Visits - Specialist | 40% after deductible | 50% after deductible |
| Laboratory[4] (standard) | 40% after deductible | No benefit |
| Radiology[4] (standard) | 40% after deductible | 50% after deductible |
| Maternity Care[5] | 40% after deductible | 50% after deductible |
| Preventive Care Services | No copayment | No benefit |
| **Hospitalization Services** | | |
| Inpatient Hospital Benefits | 40% after deductible | 50% after deductible |
| Inpatient Physician Care | 40% after deductible | 50% after deductible |
| Skilled Nursing Facility Care (100 days per benefit period) | 40% after deductible | 50% after deductible |
| **Emergency Health Coverage** | | |
| Emergency Services | 40% after deductible | Same as Network benefit |
| Urgent Care Services | 40% after deductible | 50% after deductible |
| Ambulance Services | 40% after deductible | Same as Network benefit |
| **Outpatient Services** | | |
| Outpatient Surgery[4] | 40% after deductible | 50% after deductible |
| Durable Medical Equipment | 40% after deductible | 50% after deductible |
| Home Health Services (Up to 100 visits per calendar year) | 40% after deductible | 50% after deductible |
| Infertility Services (Benefits limited to $2,000 per lifetime) | 40% after deductible | 50% after deductible |
| Injections Received in a Physician's Office | 40% after deductible | 50% after deductible |
| **Mental Health & Substance Use Disorder Services** | | |
| Inpatient | 40% after deductible | 50% after deductible |
| Outpatient | 40% after deductible | 50% after deductible |
| **Outpatient Prescription Drug Coverage** | | |
| Calendar Year Deductible (individual/family) | $350/$700 does not apply to Tier 1 | No benefit |
| Tier 1 | $15 | |
| Tier 2 | $70 | |
| Tier 3 | $115 | |
| Tier 4 | 25% up to $500 | |
| **Pediatric Dental & Vision Coverage[6]** | | |
| Dental Exam (preventive/diagnostic) | No copayment | 50% after deductible |
| Vision Exam (routine) | No copayment | 50% |
| Glasses (frames & lens) | 40% | 50% |

[1] For Doctors plans, no benefits for Non-Network services, except for emergency health and urgent care services. For Select Plus and Core plans, 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 Maximum.

[4] The outpatient per occurrence deductible may be waived for outpatient services received at an in-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.

# Select Plus, Core and Doctors[1] (Network Only) HDHP Plans

| Metallic Level | Silver | | Bronze | |
|---|---|---|---|---|
| **PPO/EPO HDHP Plan** | **HDHP w/Motion 2550/40%** | | **HDHP w/Motion 7000/0%** | |
| **Network** | **Network** | **Non-Network[1]** | **Network** | **Non-Network[1]** |
| Annual Deductible[2] (individual/family) | $2,550/$2,800[5] | $5,100/$5,700[5] | $7,000/$14,000[6] | $14,000/$28,000[6] |
| Annual Out-of-Pocket Maximum[3] (individual/family) | $6,850/$13,700 | $13,700/$27,400 | $7,000/$14,000 | $14,000/$28,000 |
| **Professional Services** | | | | |
| Office Visits - PCP | 40% after deductible | 50% after deductible | No copay after deductible | No copay after deductible |
| Office Visits - Specialist | 40% after deductible | 50% after deductible | No copay after deductible | No copay after deductible |
| Laboratory (standard) | 40% after deductible | No benefit | No copay after deductible | No benefit |
| Radiology (standard) | 40% after deductible | 50% after deductible | No copay after deductible | No copay after deductible |
| Maternity Care | 40% 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 | 40% after deductible | 50% after deductible | No copay after deductible | No copay after deductible |
| Inpatient Physician Care | 40% after deductible | 50% after deductible | No copay after deductible | No copay after deductible |
| Skilled Nursing Facility Care (100 days per benefit period) | 40% after deductible | 50% after deductible | No copay after deductible | No copay after deductible |
| **Emergency Health Coverage** | | | | |
| Emergency Services | 40% after deductible | Same as Network benefit | No copay after deductible | No copay after deductible |
| Urgent Care Services | 40% after deductible | 50% after deductible | No copay after deductible | No copay after deductible |
| Ambulance Services | 40% after deductible | Same as Network benefit | No copay after deductible | No copay after deductible |
| **Outpatient Services** | | | | |
| Outpatient Surgery | 40% after deductible | 50% after deductible | No copay after deductible | No copay after deductible |
| Durable Medical Equipment | 40% after deductible | 50% after deductible | No copay after deductible | No copay after deductible |
| Home Health Services (Up to 100 visits per calendar year) | 40% after deductible | 50% after deductible | No copay after deductible | No copay after deductible |
| Infertility Services (Benefits limited to $2,000 per lifetime) | 40% after deductible | 50% after deductible | No copay after deductible | No copay after deductible |
| Injections Received in a Physician's Office | 40% after deductible | 50% after deductible | No copay after deductible | No copay after deductible |
| **Mental Health & Substance Use Disorder Services** | | | | |
| Inpatient | 40% after deductible | 50% after deductible | No copay after deductible | No copay after deductible |
| Outpatient | 40% 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 | No benefit | Annual Deductible applies | No benefit |
| Tier 1 | $15 | | No copayment | |
| Tier 2 | $70 | | No copayment | |
| Tier 3 | $115 | | 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 & lens) | 40% after deductible | 50% after deductible | No copay after deductible | No copay after deductible |

[1] Non-Network benefits are not available with Doctors Plans. For Select Plus and Core plans, 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 Maximum. When a member of a family unit satisfies the individual Out-of-Pocket Maximum 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.

# Core State Plans

| Metallic Level | Platinum | | Gold | |
|---|---|---|---|---|
| **PPO Plan** | **15/10%** | | **25/350/20%** | |
| **Network** | **Network** | **Non-Network[1]** | **Network** | **Non-Network[1]** |
| Annual Deductible[2] (individual/family) | None | $1,000/$2,000 | $350/$700 | $1,400/$2,800 |
| Annual Out-of-Pocket Maximum[3] (individual/family) | $4,500/$9,000 | $9,000/$18,000 | $7,800/$15,600 | $12,800/$25,600 |
| **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 | No benefit | $25 | No benefit |
| Radiology (standard) | $30 | 50% after deductible | $65 | 50% after deductible |
| Maternity Care[4] | $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 | $200 | Same as Network benefit | 20% after deductible | Same as Network benefit |
| Urgent Care Services | $15 | 50% after deductible | $25 | 50% after deductible |
| Ambulance Services | $150 | Same as Network benefit | 20% 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 | Not covered | Not covered | Not covered | Not covered |
| 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 | No benefit | None | No benefit |
| Tier 1 | $10 | | $15 | |
| Tier 2 | $25 | | $50 | |
| Tier 3 | $40 | | $80 | |
| Tier 4 | 10% up to $250 | | 20% up to $250 | |
| **Pediatric Dental & Vision Coverage[5]** | | | | |
| 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 & lens) | No copayment | 50% | No copayment | 50% |
| **Optional Group Coverage - Infertility Services** | | | | |
| (Benefits limited to $2,000 medical and $1,500 drug coverage per lifetime) | 10% | 50% after deductible | 20% after deductible | 50% 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] 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 Maximum.
[4] No copayment applies to physician office visits for prenatal care.
[5] One routine vision exam and one pair of glasses per calendar year for children under age 19.

# Core State Plans, continued

| Metallic Level | Silver | | Bronze | |
|---|---|---|---|---|
| **PPO Plan** | **50/2250/30%** | | **65/6300/40%** | |
| **Network** | **Network** | **Non-Network[1]** | **Network** | **Non-Network[1]** |
| 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 Maximum[3] (individual/family) | $8,200/$16,400 | $15,900/$31,800 | $8,200/$16,400 | $15,900/$31,800 |
| **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) | $50 | No benefit | $40 | No benefit |
| Radiology (standard) | $85 | 50% after deductible | 40% after deductible | 50% after deductible |
| Maternity Care[4] | $50 | 50% after deductible | $65 | 50% after deductible |
| Preventive Care Services | No copayment | No benefit | No copayment | No benefit |
| **Hospitalization Services** | | | | |
| Inpatient Hospital Benefits | 30% after deductible | 50% after deductible | 40% after deductible | 50% after 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 | 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 | 30% after deductible | Same as Network benefit | 40% after deductible | Same as Network benefit |
| **Outpatient Services** | | | | |
| Outpatient Surgery | 30% after deductible | 50% after deductible | 40% after deductible | 50% after deductible |
| Durable Medical Equipment | 30% | 50% after deductible | 40% after deductible | 50% after deductible |
| Home Health Services (Up to 100 visits per calendar year) | 30% | 50% after deductible | 40% after deductible | 50% after deductible |
| Infertility Services | Not covered | Not covered | Not covered | Not covered |
| Injections Received in a Physician's Office | $50 | 50% after deductible | $65 | 50% after deductible |
| **Mental Health & Substance Use Disorder Services** | | | | |
| Inpatient | 30% 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 does not apply to Tier 1 | No benefit | $500/$1,000 | No benefit |
| Tier 1 | $17 | | $18 | |
| Tier 2 | $70 | | 40% up to $500 | |
| Tier 3 | $100 | | 40% up to $500 | |
| Tier 4 | 30% up to $250 | | 40% up to $500 | |
| **Pediatric Dental & Vision Coverage[5]** | | | | |
| 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 & lens) | No copayment | 50% | 40% | 50% |
| **Optional Group Coverage - Infertility Services** | | | | |
| (Benefits limited to $2,000 medical and $1,500 drug coverage per lifetime) | 30% after deductible | 50% after deductible | 40% after deductible | 50% 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] 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 Maximum.

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

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

# Navigate State Plans

| Metallic Level | Platinum | Gold | Silver | Bronze |
|---|---|---|---|---|
| **EPO Plan** | **15/10%** | **25/350/20%** | **50/2250/30%** | **65/6300/40%** |
| **Network** | **Network[1]** | **Network[1]** | **Network[1]** | **Network[1]** |
| Annual Deductible[2] (individual/ family) | None | $350/$700 | $2,250/$4,500 | $6,300/$12,600 |
| Annual Out-of-Pocket Maximum[3] (individual/family) | $4,500/$9,000 | $7,800/$15,600 | $8,200/$16,400 | $8,200/$16,400 |
| **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 | $50 | $40 |
| Radiology (standard) | $30 | $65 | $85 | 40% after deductible |
| Maternity Care[4] | $15 | $25 | $50 | $65 |
| Preventive Care Services | No copayment | No copayment | No copayment | No copayment |
| **Hospitalization Services** | | | | |
| Inpatient Hospital Benefits | 10% | 20% after deductible | 30% after deductible | 40% after deductible |
| Inpatient Physician Care | 10% | 20% after deductible | 30% after deductible | 40% after deductible |
| Skilled Nursing Facility Care (100 days per benefit period) | 10% | 20% after deductible | 30% after deductible | 40% after deductible |
| **Emergency Health Coverage** | | | | |
| Emergency Services | $200 | 20% after deductible | 30% after deductible | 40% after deductible |
| Urgent Care Services | $15 | $25 | $50 | $65 for first 3 visits, then deductible applies |
| Ambulance Services | $150 | 20% after deductible | 30% after deductible | 40% after deductible |
| **Outpatient Services** | | | | |
| Outpatient Surgery | 10% | 20% | 30% after deductible | 40% after deductible |
| Durable Medical Equipment | 10% | 20% | 30% | 40% after deductible |
| Home Health Services (Up to 100 visits per calendar year) | 10% | 20% | 30% | 40% after deductible |
| Infertility Services (Benefits limited to $2000 per lifetime) | 10% | 20% | 30% | 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 | 30% after deductible | 40% after deductible |
| Outpatient | $15 | $25 | $50 | No copayment |
| **Outpatient Prescription Drug Coverage** | | | | |
| Calendar Year Deductible (individual/family) | None | None | $300/$600 does not apply to Tier 1 | $500/$1000 |
| Tier 1 | $10 | $15 | $17 | $18 |
| Tier 2 | $25 | $50 | $70 | 40% up to $500 |
| Tier 3 | $40 | $80 | $100 | 40% up to $500 |
| Tier 4 | 10% up to $250 | 20% up to $250 | 30% up to $250 | 40% up to $500 |
| **Pediatric Dental & Vision Coverage[5]** | | | | |
| 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 & lens) | 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 calendaryear.
[3] Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Maximum.
[4] No copayment applies to physician office visits for prenatal care.
[5] One routine vision exam and one pair of glasses per calendar year for children under age 19.

# 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** |
|---|---|
| **PPO Plan[1]** | **2250/30%** |
| **Network** | **Network & Non-Network** |
| Annual Deductible[2] (individual/family) | $2,250/$4,500 |
| Annual Out-of-Pocket Maximum[3] (individual/family) | $8,500/$17,000 |
| **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 $2000 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[4]** | |
| Calendar Year Deductible (individual/family) | $300/$600 does not apply to Tier 1 |
| Tier 1 | $15 |
| Tier 2 | $70 |
| Tier 3 | $115 |
| Tier 4 | 25% up to $250 |
| **Pediatric Dental & Vision Coverage[5]** | |
| Dental Exam (preventive/diagnostic) | No copayment |
| Vision Exam (routine) | No copayment |
| Glasses (frames & lens) | 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 Maximum.
[4] Non-Network outpatient prescription drug coverage is not available.
[5] One routine vision exam and one pair of glasses per calendar year for children under age 19.

# Signature, Advantage, Alliance and Harmony Plans

| Metallic Level | Platinum | Platinum | Platinum (Signature & Advantage Only) |
|---|---|---|---|
| **HMO Plan** | **20-40/400d** | **20-40/20%** | **0-80/20%** |
| Annual Deductible[1] (individual/family) | None | $350/$700 | $2,250/$4,500 |
| Annual Out-of-Pocket Maximum[2] (individual/family) | $4,500/$9,000 | $7,800/$15,600 | $8,200/$16,400 |
| **Professional Services** | | | |
| Office Visits - PCP | $15 | $25 | $50 |
| Office Visits - Specialist | $30 | $50 | $85 |
| Laboratory (standard) | $15 | $25 | $50 |
| Radiology (standard) | $30 | $65 | $85 |
| Maternity Care | $15 | $25 | $50 |
| Preventive Care Services | No copayment | No copayment | No copayment |
| **Hospitalization Services** | | | |
| Inpatient Hospital Benefits | 10% | 20% after deductible | 30% after deductible |
| Inpatient Physician Care | 10% | 20% after deductible | 30% after deductible |
| Skilled Nursing Facility Care (100 days per benefit period) | 10% | 20% after deductible | 30% after deductible |
| **Emergency Health Coverage** | | | |
| Emergency Services | $400 | 20% | 20% |
| Urgent Care Services<br>– within physician service area<br>– outside physician service area | <br>$20<br>$50 | <br>$20<br>$50 | <br>No charge<br>$50 |
| Ambulance Services | $100 | $100 | $100 |
| **Outpatient Services** | | | |
| Outpatient Surgery | $250 | 20% | 20% |
| Durable Medical Equipment | $50 | $50 | $50 |
| Home Health Services (Up to 100 visits per calendar year) | $20 | $20 | No charge |
| Infertility Services | Not Covered | Not Covered | Not Covered |
| Injectable Drugs | $150 | $150 | $150 |
| **Mental Health & Substance Use Disorder Services** | | | |
| Inpatient | $400/day, max 5 days per stay | 20% | 20% |
| Outpatient | $20 | $20 | No charge |
| **Outpatient Prescription Drug Coverage** | | | |
| Calendar Year Deductible (individual/family) | None | None | None |
| Tier 1 | $10 | $10 | $5 |
| Tier 2 | $35 | $35 | $40 |
| Tier 3 | $70 | $70 | $80 |
| Tier 4 | 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 |
| Vision Exam (routine) | No charge | No charge | No charge |
| Glasses (frames & lens) | 10% | 20% | 20% |
| **Optional Group Coverage – Infertility Services** | 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 Maximum.
[3] One routine vision exam and one pair of glasses per calendar year for children under age 19.

# Signature, Advantage, Alliance and Harmony Plans, continued

| Metallic Level | Gold | Gold | Gold | Gold (Signature & Advantage Only) |
|---|---|---|---|---|
| **HMO Plan** | **30-70/800d** | **30-70/20%/500ded** | **30-70/30%/1250ded** | **0-90/30%/1750ded** |
| Annual Deductible[1] (individual/family) | None | $500/$1,000 | $1,250/$2,500 | $1,750/$3,500 |
| Annual Out-of-Pocket Maximum[2] (individual/family) | $7,000/$14,000 | $7,500/$15,000 | $7,800/$15,600 | $8,000/$16,000 |
| **Professional Services** | | | | |
| Office Visits - PCP | $30 | $30 | $30 | No charge |
| Office Visits - Specialist | $70 | $70 | $70 | $90 |
| Laboratory (standard) | $30 | $30 | $30 | $30 |
| Radiology (standard) | $30 | $30 | $30 | $30 |
| Maternity Care | No charge | No charge | No charge | No charge |
| Preventive Care Services | No charge | No charge | No charge | No charge |
| **Hospitalization Services** | | | | |
| Inpatient Hospital Benefits | $800/day, max 5 days per stay | 20% after deductible | 30% after deductible | 30% after deductible |
| Inpatient Physician Care | No charge | 20% | 30% | 30% |
| Skilled Nursing Facility Care (100 days per benefit period) | $300/day, max 5 days per stay | 20% after deductible | 30% after deductible | 30% after deductible |
| **Emergency Health Coverage** | | | | |
| Emergency Services | $500 | $500 after deductible | 30% after deductible | 30% after deductible |
| Urgent Care Services<br>– within physician service area<br>– outside physician service area | <br>$30<br>$75 | <br>$30<br>$75 | <br>$30<br>$75 | <br>No charge<br>$75 |
| Ambulance Services | $100 | $100 | $100 | $100 |
| **Outpatient Services** | | | | |
| Outpatient Surgery | $500 | 20% after deductible | 30% after deductible | 30% after deductible |
| Durable Medical Equipment | $50 | $50 | $50 | $50 |
| Home Health Services (Up to 100 visits per calendar year) | $30 | $30 | $30 | No charge |
| Infertility Services | Not covered | Not covered | Not covered | Not covered |
| Injectable Drugs | $150 | $150 | $150 | $150 |
| **Mental Health & Substance Use Disorder Services** | | | | |
| Inpatient | $600/day, max 5 days per stay | 20% after deductible | 30% after deductible | 30% after deductible |
| Outpatient | $30 | $30 | $30 | No charge |
| **Outpatient Prescription Drug Coverage** | | | | |
| Calendar Year Deductible (individual/family) | $100/$200 (does not apply to Tier 1) | $250/$500 (does not apply to Tier 1) | $250/$500 (does not apply to Tier 1) | None |
| Tier 1 | $10 | $10 | $10 | $5 |
| Tier 2 | $40 | $40 | $40 | $40 |
| Tier 3 | $85 | $85 | $85 | $80 |
| Tier 4 | 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 |
| Vision Exam (routine) | No charge | No charge | No charge | No charge |
| Glasses (frames & lens) | 10% | 20% | 30% | 30% |
| **Optional Group Coverage – Infertility Services** | 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 Maximum.
[3] One routine vision exam and one pair of glasses per calendar year for children under age 19.

# Signature, Advantage, Alliance and Harmony Plans, continued

| Metallic Level | Silver | Silver (Harmony Only) |
|---|---|---|
| **HMO Plan** | **50-90/40%/2250ded** | **30%/2250ded** |
| Annual Deductible[1] (individual/family) | $2,250/$4,500 | $2,250/$4,500 |
| Annual Out-of-Pocket Maximum[2] (individual/family) | $8,550/$17,100 | $8,550/$17,100 |
| **Professional Services** | | |
| Office Visits - PCP | $50 | 30% after deductible |
| Office Visits - Specialist | $90 | 30% after deductible |
| Laboratory (standard) | $45 | 30% after deductible |
| Radiology (standard) | $45 | 30% after deductible |
| Maternity Care | No charge | 30% after deductible |
| Preventive Care Services | No charge | No charge |
| **Hospitalization Services** | | |
| Inpatient Hospital Benefits | 40% after deductible | 30% after deductible |
| Inpatient Physician Care | 40% | 30% after deductible |
| Skilled Nursing Facility Care (100 days per benefit period) | 40% after deductible | 30% after deductible |
| **Emergency Health Coverage** | | |
| Emergency Services | 40% after deductible | 30% after deductible |
| Urgent Care Services | | |
| – within physician service area | $50 | 30% after deductible |
| – outside physician service area | $100 | 30% after deductible |
| Ambulance Services | $100 | 30% after deductible |
| **Outpatient Services** | | |
| Outpatient Surgery | 40% after deductible | 30% after deductible |
| Durable Medical Equipment | $50 | 30% after deductible |
| Home Health Services (Up to 100 visits per calendar year) | $50 | 30% after deductible |
| Infertility Services | Not covered | Not covered |
| Injectable Drugs | $150 | 30% after deductible |
| **Mental Health & Substance Use Disorder Services** | | |
| Inpatient | 40% after deductible | 30% after deductible |
| Outpatient | $50 | 30% after deductible |
| **Outpatient Prescription Drug Coverage** | | |
| Calendar Year Deductible (individual/family) | $300/$600 (does not apply to Tier 1) | $300/$600 (does not apply to Tier 1) |
| Tier 1 | $15 | $15 |
| Tier 2 | $50 | $50 |
| Tier 3 | $100 | $100 |
| Tier 4 | 25% up to $250 | 25% up to $250 |
| **Pediatric Dental & Vision Coverage[3]** | | |
| Dental Exam (preventive/diagnostic) | No charge | No charge |
| Vision Exam (routine) | No charge | No charge |
| Glasses (frames & lens) | 40% | 30% |
| **Optional Group Coverage – Infertility Services** | 50% | 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 Maximum.
[3] One routine vision exam and one pair of glasses per calendar year for children under age 19.

# Alliance State Plans

| Metallic Level | Platinum | Gold | Silver |
|---|---|---|---|
| **HMO Plan** | **Platinum 90 HMO 0/15** | **Gold 80 HMO 350/25** | **Silver 70 HMO 2250/50** |
| Annual Deductible[1] (individual/family) | None | $350/$700 | $2,250/$4,500 |
| Annual Out-of-Pocket Maximum[2] (individual/family) | $4,500/$9,000 | $7,800/$15,600 | $8,200/$16,400 |
| **Professional Services** | | | |
| Office Visits - PCP | $15 | $25 | $50 |
| Office Visits - Specialist | $30 | $50 | $85 |
| Laboratory (standard) | $15 | $25 | $50 |
| Radiology (standard) | $30 | $65 | $85 |
| Maternity Care | No charge | No charge | No charge |
| Preventive Care Services | No charge | No charge | No charge |
| **Hospitalization Services** | | | |
| Inpatient Hospital Benefits | 10% | 20% after deductible | 30% after deductible |
| Inpatient Physician Care | 10% | 20% after deductible | 30% after deductible |
| Skilled Nursing Facility Care (100 days per benefit period) | 10% | 20% after deductible | 30% after deductible |
| **Emergency Health Coverage** | | | |
| Emergency Services | $200 | 20% after deductible | 30% after deductible |
| Urgent Care Services | | | |
| – within physician service area | $15 | $25 | $50 |
| – outside physician service area | $15 | $25 | $50 |
| Ambulance Services | $150 | 20% after deductible | 30% after deductible |
| **Outpatient Services** | | | |
| Outpatient Surgery | 10% | 20% | 30% after deductible |
| Durable Medical Equipment | 10% | 20% | 30% |
| Home Health Services (Up to 100 visits per calendar year) | 10% | 20% | 30% |
| Infertility Services | Not covered | Not covered | Not covered |
| Injectable Drugs | 10% | 20% | 30% |
| **Mental Health & Substance Use Disorder Services** | | | |
| Inpatient | 10% | 20% after deductible | 30% after deductible |
| Outpatient | $15 | $25 | $50 |
| **Outpatient Prescription Drug Coverage** | | | |
| Calendar Year Deductible (individual/family) | None | None | $300/$600 (does not apply to Tier 1) |
| Tier 1 | $10 | $15 | $17 |
| Tier 2 | $25 | $50 | $70 |
| Tier 3 | $40 | $80 | $100 |
| Tier 4 | 10% up to $250 | 20% up to $250 | 30% up to $250 |
| **Pediatric Dental & Vision Coverage[3]** | | | |
| Dental Exam (preventive/diagnostic) | No charge | No charge | No charge |
| Vision Exam (routine) | No charge | No charge | No charge |
| Glasses (frames & lens) | No charge | No charge | No charge |
| **Optional Group Coverage – Infertility Services** | 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 Maximum.
[3] One routine vision exam and one pair of glasses per calendar year for children under age 19.

United Healthcare®

[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.

Health plan coverage provided by or through UnitedHealthcare Insurance Company, UHC of California and UnitedHealthcare Benefits Plan of California.. Administrative services provided by United HealthCare Services, Inc., OptumRx or OptumHealth Care Solutions, Inc. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC).