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 – within physician service area – outside physician service area	 $20 $50	 $20 $50	 No charge $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 – within physician service area – outside physician service area	 $30 $75	 $30 $75	 $30 $75	 No charge $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).