



# Product Catalog

Plans designed with small business in mind

**California**

Small Business

2–50 Employees

Effective 3/1/2012



## You have to see what's in here.

About UnitedHealthcare. . . . .	1
Medical Products Overview. . . . .	2
UnitedHealthcare Multi-Choice <sup>SM</sup> . . . . .	5
UnitedHealthcare Products. . . . .	8
Choice Plus Traditional Plans. . . . .	9
Choice Plus Balanced Plans . . . . .	10
Choice Plus Balanced Value Plans . . . . .	12
Choice Plus Health Savings Account (HSA) Plans. . . . .	14
Choice Plus Health Reimbursement Account (HRA) Plans. . . . .	16
Non-Differential PPO Plan . . . . .	17
UnitedHealthcare SignatureValue <sup>TM</sup> (HMO) Plans and UnitedHealthcare SignatureValue <sup>TM</sup> Advantage (HMO) Plans. . . . .	18
UnitedHealthcare SignatureValue <sup>TM</sup> Flex (HMO) Plans . . . . .	20
UnitedHealthcare SignatureValue <sup>TM</sup> featuring the HealthCare Partners Network (HMO) Plans . . . . .	22

## About UnitedHealthcare

UnitedHealthcare is a division of UnitedHealth Group, a Fortune 50 company and the single largest health coverage carrier in the country, offering a wide range of health care plans to fit small business needs. As a recognized leader in the industry, we work to enhance the health care experience for the 75 million members we serve. This includes working with providers and physicians to improve the quality and efficiency of health care services, providing greater access to health care for our members and the underserved, developing and implementing products and programs that help our members manage health care costs, and using technology to help our members better navigate the health care system.

Our nationwide network includes more than 660,000 physicians and health care professionals, 5,100 hospitals and 64,000 pharmacies.

We are committed to enhancing the health and well-being of individuals and communities and ensuring the continuing improvement of the quality of health care in the United States.

This Product Catalog is intended only to highlight your benefits and should not be relied upon to fully determine your coverage. If this Product Catalog conflicts in any way with the plan documents, i.e., the *Combined Evidence of Coverage and Disclosure Form (EOC/DF)* or *Certificate of Coverage (COC)* including the *Schedule of Benefits* and any amendment(s), the plan document shall prevail. Your plan document provides the terms and conditions of your coverage with UnitedHealthcare of California and UnitedHealthcare and all applicants have a right to review this document prior to enrollment. Upon request, a copy of the plan document will be provided to all potential enrollees prior to enrollment.

# Medical Products Overview

Our product portfolio includes traditional HMOs and PPOs as well as our popular consumer-driven health plans. We offer a range of benefit design options, so small businesses can choose the plans that suit their employees' needs and fit their budget.

## Traditional Plans – Proven plans with deductibles up to \$500

Plan Code	Plan Description	Deductible				Medical Deductible Type	Plan Coinsurance		Out-of-Pocket Maximum				In-Network Copay*						Pharmacy Plan
		In		Out			In	Out	In		Out		PCP	Spec	UC	ER	OP Surg	IP Hosp	
		Single	Family	Single	Family				Single	Family	Single	Family							
J3-A	20/250/90%	\$250	\$750	\$500	\$1,500	Embedded	90%	70%	\$3,000	\$6,000	\$6,000	\$12,000	\$20	\$40	\$125	\$250	10%	10%	IV
J3-D	30/250/80%	\$250	\$750	\$500	\$1,500	Embedded	80%	60%	\$4,000	\$8,000	\$8,000	\$16,000	\$30	\$50	\$125	\$250	20%	20%	IV
J3-F	30/500/80%	\$500	\$1,500	\$1,000	\$3,000	Embedded	80%	60%	\$4,000	\$8,000	\$8,000	\$16,000	\$30	\$50	\$125	\$250	20%	20%	IV
J3-K	40/500/70%	\$500	\$1,500	\$1,000	\$3,000	Embedded	70%	50%	\$4,000	\$8,000	\$8,000	\$16,000	\$40	\$60	\$125	\$250	30%	30%	IV

## Balanced Plans – Tailored plans with deductibles greater than \$1,000

Plan Code	Plan Description	Deductible				Medical Deductible Type	Plan Coinsurance		Out-of-Pocket Maximum				In-Network Copay*						Pharmacy Plan
		In		Out			In	Out	In		Out		PCP	Spec	UC	ER	OP Surg	IP Hosp	
		Single	Family	Single	Family				Single	Family	Single	Family							
J3-C	30/1000/80%	\$1,000	\$3,000	\$2,000	\$6,000	Embedded	80%	60%	\$5,000	\$10,000	\$10,000	\$20,000	\$30	\$50	\$125	\$250	20%	20%	IW
J3-I	40/1000/70%	\$1,000	\$3,000	\$2,000	\$6,000	Embedded	70%	50%	\$5,000	\$10,000	\$10,000	\$20,000	\$40	\$60	\$125	\$250	30%	30%	IW
6Z-A**	40/1000/50%	\$1,000	\$3,000	\$2,000	\$6,000	Embedded	50%	50%	\$5,000	\$10,000	\$10,000	\$20,000	\$40	\$60	\$125	\$250	50%	50%	IW
J3-J	40/1500/70%	\$1,500	\$4,500	\$3,000	\$9,000	Embedded	70%	50%	\$5,000	\$10,000	\$10,000	\$20,000	\$40	\$60	\$125	\$250	30%	30%	IW
6Z-B**	40/2000/50%	\$2,000	\$6,000	\$4,000	\$12,000	Embedded	50%	50%	\$6,000	\$12,000	\$12,000	\$24,000	\$40	\$60	\$125	\$250	50%	50%	IW
6Z-C	30/3000/70%	\$3,000	\$6,000	\$3,000	\$6,000	Embedded	70%	50%	\$5,000	\$10,000	\$10,000	\$20,000	\$30	\$50	\$125	\$250	30%	30%	UC
6Z-D	40/4000/60%	\$4,000	\$8,000	\$4,000	\$8,000	Embedded	60%	50%	\$6,000	\$12,000	\$12,000	\$24,000	\$40	\$60	\$125	\$250	40%	40%	UC
6Z-E	50/5000/50%	\$5,000	\$10,000	\$5,000	\$10,000	Embedded	50%	50%	\$7,000	\$14,000	\$14,000	\$28,000	\$50	\$70	\$125	\$250	50%	50%	UC

## Balanced Value Plans – Affordable plans for employers seeking benefit alternatives that include non-embedded deductibles

Plan Code	Plan Description	Deductible**				Medical Deductible Type	Plan Coinsurance		Out-of-Pocket Maximum***				In-Network Copay*						Pharmacy Plan
		In		Out			In	Out	In		Out		PCP	Spec	UC	ER	OP Surg	IP Hosp	
		Single	Family	Single	Family				Single	Family	Single	Family							
6Z-G**	40/1000/70%	\$1,000	\$3,000	\$2,000	\$6,000	Non-Emb	70%	50%	\$5,000	\$10,000	\$10,000	\$20,000	\$40	\$60	\$125	\$250	30%	30%	UD
6Z-H**	40/1500/70%	\$1,500	\$4,500	\$3,000	\$9,000	Non-Emb	70%	50%	\$5,000	\$10,000	\$10,000	\$20,000	\$40	\$60	\$125	\$250	30%	30%	UD
6Z-F**	40/2000/50%	\$2,000	\$6,000	\$4,000	\$12,000	Non-Emb	50%	50%	\$6,000	\$12,000	\$12,000	\$24,000	\$40	\$60	\$125	\$250	50%	50%	UD
6Z-I**	40/5000/70%	\$5,000	\$10,000	\$5,000	\$10,000	Non-Emb	70%	50%	\$10,000	\$20,000	\$15,000	\$30,000	\$40	\$60	\$125	\$250	70%	70%	UD

## Consumer-Driven Health Plans – Innovative plans offering option to pair with HSA or HRA

Plan Code	Plan Description	Deductible				Medical Deductible Type	Plan Coinsurance		Out-of-Pocket Maximum				In-Network Copay*						Pharmacy Plan
		In		Out			In	Out	In		Out		PCP	Spec	UC	ER	OP Surg	IP Hosp	
		Single	Family	Single	Family				Single	Family	Single	Family							
<b>Health Savings Account (HSA) Plans</b>																			
J3-1	1500/80%	\$1,500	\$3,000	\$3,000	\$6,000	Non-Emb	80%	50%	\$3,000	\$6,000	\$6,000	\$12,000	20%	20%	20%	20%	20%	20%	IV
J3-N	2000/100%	\$2,000	\$4,000	\$4,000	\$8,000	Non-Emb	100%	70%	\$4,000	\$8,000	\$8,000	\$16,000	0%	0%	0%	0%	0%	0%	IV
6Z-J	2000/90%	\$2,000	\$4,000	\$4,000	\$8,000	Non-Emb	90%	60%	\$4,000	\$8,000	\$8,000	\$16,000	10%	10%	10%	10%	10%	10%	IV
J3-Z	2000/80%	\$2,000	\$4,000	\$4,000	\$8,000	Non-Emb	80%	50%	\$4,000	\$8,000	\$8,000	\$16,000	20%	20%	20%	20%	20%	20%	IV
J3-O	3000/100%	\$3,000	\$6,000	\$6,000	\$12,000	Non-Emb	100%	70%	\$5,000	\$10,000	\$10,000	\$20,000	0%	0%	0%	0%	0%	0%	IV
6Z-K	3000/90%	\$3,000	\$6,000	\$6,000	\$12,000	Non-Emb	90%	60%	\$5,000	\$10,000	\$10,000	\$20,000	10%	10%	10%	10%	10%	10%	IV
J3-L	3000/80%	\$3,000	\$6,000	\$6,000	\$12,000	Non-Emb	80%	50%	\$5,000	\$10,000	\$10,000	\$20,000	20%	20%	20%	20%	20%	20%	IV
J3-M	4000/80%	\$4,000	\$8,000	\$8,000	\$16,000	Non-Emb	80%	50%	\$5,000	\$10,000	\$10,000	\$20,000	20%	20%	20%	20%	20%	20%	IV
<b>Health Reimbursement Account (HRA) Plans</b>																			
J3-V	2000/70%	\$2,000	\$4,000	\$4,000	\$8,000	Embedded	70%	50%	\$5,000	\$10,000	\$10,000	\$20,000	30%	30%	30%	30%	30%	30%	IY
J3-W	3000/70%	\$3,000	\$6,000	\$6,000	\$12,000	Embedded	70%	50%	\$6,000	\$12,000	\$12,000	\$24,000	30%	30%	30%	30%	30%	30%	IY

## Non-Differential PPO Plan – Comprehensive plan for employers with out-of-area employees

Plan Code	Plan Description	Deductible				Medical Deductible Type	Plan Coinsurance		Out-of-Pocket Maximum				In-Network Copay*						Pharmacy Plan
		Individual		Family			In	Out	Individual		Family		PCP	Spec	UC	ER	OP Surg	IP Hosp	
		In	Out	In	Out				In	Out	In	Out							
6H-H	2000/80%	\$2,000		\$6,000		Embedded	80%	80%	\$4,000		\$12,000		20%	20%	20%	20%	20%	20%	IW

## Pharmacy Plans – Full-service pharmacy management solutions that help to stem rising costs

Plan Code	Deductible			Base Pharmacy Plan			Specialty Pharmacy Plan			Mail Service Ratio	
	Single	Family	Applicable Tiers	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3		
IV	None	None	Not applicable	\$15	\$35	\$60	\$15	25%	30%	2.5	
IW	\$150	\$450	Tiers 2 & 3	\$15	\$35	\$60	\$15	25%	30%	2.5	
IY	\$250	\$750	Tiers 2 & 3	\$15	\$35	\$60	\$15	25%	30%	2.5	
UC	\$300	\$900	Tiers 2 & 3	\$15	\$35	\$60	\$15	25%	30%	2.5	
UD	\$300	\$900	All Tiers	\$20	\$40	\$60	\$20	25%	30%	2.5	
<b>Combined medical/pharmacy plan</b>											
IV	Medical Deductible			All Tiers	\$15	\$35	\$60	\$15	25%	30%	2.5

\* Benefits with coinsurance (%) responsibility are subject to the Deductible.  
 \*\* A Per Occurrence Deductible applies to Inpatient Hospital Services and Outpatient Surgery. It is separate from the Annual Deductible and does not accrue toward the Out-of-Pocket Maximum.  
 \*\*\* The Out-of-Pocket Maximum does not include the Annual Deductible.

### UnitedHealthcare SignatureValue™ (HMO) Plans –

Well-defined plans with choice of a Primary Care Physician from the full HMO network

Plan Code	Plan Description	Deductible		Medical Deductible Type	Plan Coinsurance	Out-of-Pocket Maximum		Copay						Pharmacy Plan
		Single	Family			Single	Family	PCP	Spec	UC	ER	OP Surg	IP Hosp	
PC-F	10-30/100%	None	None	N/A	N/A	\$1,500	\$4,500	\$10	\$30	\$75	\$150	Paid in full		B9
PC-G	15-30/300a	None	None	N/A	N/A	\$1,500	\$4,500	\$15	\$30	\$75	\$150	\$250	\$300/admit	EX
PD-I	20-40/300d	None	None	N/A	N/A	\$2,000	\$6,000	\$20	\$40	\$75	\$150	\$300	\$300/day, max 2 days	EX
PD-J	30-40/500d	None	None	N/A	N/A	\$3,000	\$9,000	\$30	\$40	\$75	\$150	\$400	\$500/day, max 4 days	EV
PD-K	40-60/800d	None	None	N/A	N/A	\$4,000	\$12,000	\$40	\$60	\$75	\$150	\$500	\$800/day, max 4 days	EV
PC-K	20-40/1500ded	\$1,500	\$3,000	Embedded	N/A	\$4,000	\$8,000	\$20	\$40	\$75	\$150	ded+\$300	ded+\$500/day	EV
PC-C	40-60/60%	None	None	N/A	60%	\$5,000	\$10,000	\$40	\$60	\$75	\$150	40%	40%	EV
PD-M	20-40/70%/1500ded	\$1,500	\$3,000	Embedded	70%	\$5,000	\$10,000	\$20	\$40	\$75	\$150	ded+30%	ded+30%	EV
PD-N	40-60/70%/2000ded	\$2,000	\$4,000	Embedded	70%	\$5,000	\$10,000	\$40	\$60	\$75	\$150	ded+30%	ded+30%	EV

### UnitedHealthcare SignatureValue™ Advantage (HMO) Plans –

Lower-cost plans with choice of a Primary Care Physician from a select HMO network of physicians and specialists

Plan Code	Plan Description	Deductible		Medical Deductible Type	Plan Coinsurance	Out-of-Pocket Maximum		Copay						Pharmacy Plan
		Single	Family			Single	Family	PCP	Spec	UC	ER	OP Surg	IP Hosp	
PC-L	10-30/100%	None	None	N/A	N/A	\$1,500	\$4,500	\$10	\$30	\$75	\$150	Paid in full		B9
PC-M	15-30/300a	None	None	N/A	N/A	\$1,500	\$4,500	\$15	\$30	\$75	\$150	\$250	\$300/admit	EX
PD-T	20-40/300d	None	None	N/A	N/A	\$2,000	\$6,000	\$20	\$40	\$75	\$150	\$300	\$300/day, max 2 days	EX
PD-O	30-40/500d	None	None	N/A	N/A	\$3,000	\$9,000	\$30	\$40	\$75	\$150	\$400	\$500/day, max 4 days	EV
PD-P	40-60/800d	None	None	N/A	N/A	\$4,000	\$12,000	\$40	\$60	\$75	\$150	\$500	\$800/day, max 4 days	EV
PC-Q	20-40/1500ded	\$1,500	\$3,000	Embedded	N/A	\$4,000	\$8,000	\$20	\$40	\$75	\$150	ded+\$300	ded+\$500/day	EV
PC-R	40-60/2000ded	\$2,000	\$6,000	Embedded	N/A	\$5,000	\$15,000	\$40	\$60	\$75	\$150	\$1,000	ded, then Paid in full	EV
PC-1	40-60/60%	None	None	N/A	60%	\$5,000	\$10,000	\$40	\$60	\$75	\$150	40%	40%	EV
PD-R	20-40/70%/1500ded	\$1,500	\$3,000	Embedded	70%	\$5,000	\$10,000	\$20	\$40	\$75	\$150	ded+30%	ded+30%	EV
PD-S	40-60/70%/2000ded	\$2,000	\$4,000	Embedded	70%	\$5,000	\$10,000	\$40	\$60	\$75	\$150	ded+30%	ded+30%	EV

### UnitedHealthcare SignatureValue™ Flex (HMO) Plans –

Tiered network plans with choice of a Primary Care Physician from one of the three distinct provider networks

Plan Code	Plan Description	Deductible		Medical Deductible Type	Plan Coinsurance	Out-of-Pocket Maximum		Copay						Pharmacy Plan
		Single	Family			Single	Family	PCP	Spec	UC	ER	OP Surg	IP Hosp	
CB-3	15-30/300a	None	None	N/A	N/A	\$1,500	\$3,000	\$15	\$30	\$75	\$150	\$250	\$300/admit	EX
CB-4	20-40/300d	None	None	N/A	N/A	\$2,000	\$4,000	\$20	\$40	\$75	\$150	\$300	\$300/day, max 2 days	EV
CB-5	30-40/500d	None	None	N/A	N/A	\$3,000	\$6,000	\$30	\$40	\$75	\$150	\$400	\$500/day, max 4 days	EV
CB-T	20-40/300d	None	None	N/A	N/A	\$2,000	\$4,000	\$20	\$40	\$75	\$150	\$300	\$300/day, max 2 days	EX
CB-U	30-40/500d	None	None	N/A	N/A	\$3,000	\$6,000	\$30	\$40	\$75	\$150	\$400	\$500/day, max 4 days	EV
CB-V	40-60/800d	None	None	N/A	N/A	\$4,000	\$8,000	\$40	\$60	\$75	\$150	\$500	\$800/day, max 4 days	EV
CB-W	30-40/500d	None	None	N/A	N/A	\$3,000	\$6,000	\$30	\$40	\$75	\$150	\$400	\$500/day, max 4 days	EX
CB-X	40-60/800d	None	None	N/A	N/A	\$4,000	\$8,000	\$40	\$60	\$75	\$150	\$500	\$800/day, max 4 days	EV
CB-Y	40-60/60%	None	None	N/A	60%	\$5,000	\$10,000	\$40	\$60	\$75	\$150	40%	40%	EV
CB-Z	40-60/800d	None	None	N/A	N/A	\$4,000	\$8,000	\$40	\$60	\$75	\$150	\$500	\$800/day, max 4 days	EX
CB-1	40-60/60%	None	None	N/A	60%	\$5,000	\$10,000	\$40	\$60	\$75	\$150	40%	40%	EV
CB-2	20-40/70%/1500ded	\$1,500	\$3,000	Embedded	70%	\$5,000	\$10,000	\$20	\$40	\$75	\$150	ded+30%	ded+30%	EV

### UnitedHealthcare SignatureValue™ featuring the HealthCare Partners Network (HMO) Plans –

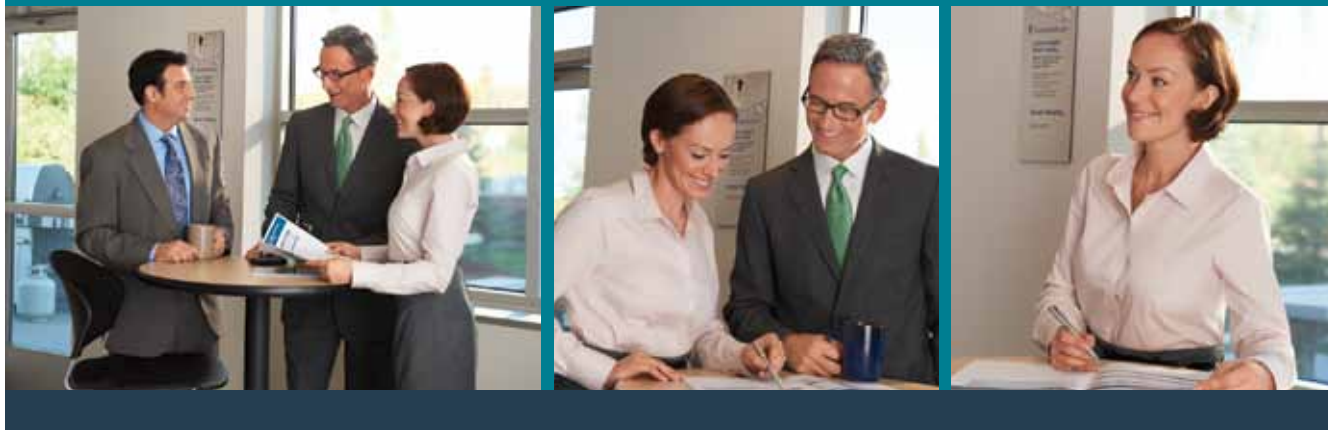
Economical plans with choice of a Primary Care Physician from the HealthCare Partners network

Plan Code	Plan Description	Deductible		Medical Deductible Type	Plan Coinsurance	Out-of-Pocket Maximum		Copay						Pharmacy Plan
		Single	Family			Single	Family	PCP	Spec	UC	ER	OP Surg	IP Hosp	
PD-F	25-75/500ded	\$500	\$1,000	Embedded	N/A	\$1,500	\$3,000	\$25	\$75	ded+20%	ded+20%	ded+20%	ded+20%	EX
PD-G	25-50/500ded	\$500	\$1,000	Embedded	N/A	\$4,000	\$8,000	\$25	\$50	ded+20%	ded+20%	ded+20%	ded+20%	EX
PD-H	25-75/1500ded	\$1,500	\$3,000	Embedded	N/A	\$4,000	\$8,000	\$25	\$75	ded+40%	ded+40%	ded+40%	ded+40%	EX

### Pharmacy Plans –

Plans that focus on clinical quality and total patient care while promoting the most appropriate use of medications

Plan Code	Deductible		Pharmacy Plan			Mail Service Ratio
	Per Member	Applicable Tiers	Tier 1	Tier 2	Tier 3	
B9	None	Not applicable	\$10	\$25	\$50	2.0
EX	\$150	Brand-name drugs only	\$15	\$35	\$50	2.0
EV	\$150	Brand-name drugs only	\$20	\$35	\$50	2.0



# UnitedHealthcare Multi-Choice<sup>SM</sup>

## Video Explanation

### UnitedHealthcare Multi-Choice<sup>SM</sup> offers more options to suit the diverse needs of small businesses

A well-designed, flexible health plan, supported by streamlined administration and employee-focused wellness programs, can help small businesses create a long-term strategy to manage health care costs now and in the future.

UnitedHealthcare Multi-Choice<sup>SM</sup> allows employers with five or more enrolling employees to purchase one health plan package that includes multiple benefit design options. They can offer their employees an array of health care coverage options to meet a variety of health care and financial needs. Our Multi-Choice packages include different plan options, ranging from HMOs to Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs).

#### Here's how it works:

**Step 1:** Decide on a package option for your employees. You may choose to offer one, some or all plans available within the selected package.

Choose from several different options.

**UnitedHealthcare Multi-Choice with UnitedHealthcare SignatureValue (HMO) or UnitedHealthcare SignatureValue Advantage (HMO):**

- ✓ UnitedHealthcare SignatureValue or UnitedHealthcare SignatureValue Advantage plans
- ✓ UnitedHealthcare Choice Plus plans, including Traditional, Balanced and Balanced Value plans
- ✓ UnitedHealthcare HSA plans
- ✓ UnitedHealthcare HRA plans

**UnitedHealthcare Multi-Choice with UnitedHealthcare SignatureValue (HMO) and UnitedHealthcare SignatureValue Advantage (HMO):**

- ✓ Three UnitedHealthcare SignatureValue plans
- ✓ UnitedHealthcare SignatureValue Advantage plans
- ✓ UnitedHealthcare Choice Plus plans, including Traditional, Balanced and Balanced Value plans

- ✓ UnitedHealthcare HSA plans
- ✓ UnitedHealthcare HRA plans

**UnitedHealthcare Multi-Choice with UnitedHealthcare SignatureValue Flex (HMO):**

- ✓ Four sets of UnitedHealthcare SignatureValue Flex plans, with each set featuring three distinct networks
- ✓ UnitedHealthcare Choice Plus plans, including Traditional, Balanced and Balanced Value plans
- ✓ UnitedHealthcare HSA plans
- ✓ UnitedHealthcare HRA plans
- ✓ UnitedHealthcare SignatureValue plans, available for employees outside the SignatureValue Flex network service area

**UnitedHealthcare PremierSource<sup>SM</sup>:**

- ✓ Three UnitedHealthcare Choice Plus plans
- ✓ Three UnitedHealthcare HSA plans
- ✓ Three UnitedHealthcare SignatureValue or UnitedHealthcare SignatureValue Advantage plans
- ✓ One staff model HMO from another carrier

**UnitedHealthcare Multi-Choice with HealthCare Partners (HMO):**

- ✓ UnitedHealthcare SignatureValue featuring the HealthCare Partners Network plans
- ✓ UnitedHealthcare Choice Plus Balanced Value plans
- ✓ UnitedHealthcare HSA plans
- ✓ UnitedHealthcare SignatureValue or UnitedHealthcare SignatureValue Advantage plans, available for employees outside the HealthCare Partners Network service area

**Step 2:** Direct your employees to choose the benefit design option that best meets their individual needs from the selected package.

**Step 3:** As you renew with us, you can keep or change your plan offerings with your package year after year, ensuring that your health plan benefits will evolve with the changing needs of your business and your employees.

**For more information, please refer to the UnitedHealthcare Multi-Choice product brochure.**

UnitedHealthcare Multi-Choice is available to groups with 5 or more enrolling employees.

# California Small Business (5-50) Multi-Choice Plan Options

**Stand-Alone Plan Options or Flex Package Only: Groups with less than 5 enrolling employees are eligible for the SignatureValue Flex plan benefit options only (Flex A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z).**

UnitedHealthcare Plan	Plan Description	Plan Code	with UnitedHealthcare SignatureValue or UnitedHealthcare SignatureValue Advantage <sup>3</sup>	with UnitedHealthcare SignatureValue and UnitedHealthcare SignatureValue Advantage	with UnitedHealthcare SignatureValue Flex A <sup>3, 5</sup>
Choice Plus Traditional	20/250/90%	J3-A	•	•	•
Choice Plus Traditional	30/250/80%	J3-D	•	•	•
Choice Plus Traditional	30/500/80%	J3-F	•	•	•
Choice Plus Traditional	40/500/70%	J3-K	•	•	•
Choice Plus Balanced	30/1000/80%	J3-C	•	•	•
Choice Plus Balanced	40/1000/70%	J3-I	•	•	•
Choice Plus Balanced	40/1500/70%	J3-J	•	•	•
Choice Plus Balanced	40/1000/50%	6Z-A	•	•	•
Choice Plus Balanced	40/2000/50%	6Z-B	•	•	•
Choice Plus Balanced	30/3000/70%	6Z-C	•	•	•
Choice Plus Balanced	40/4000/60%	6Z-D	•	•	•
Choice Plus Balanced	50/5000/50%	6Z-E	•	•	•
Choice Plus Balanced Value	40/1000/70%	6Z-G	•	•	•
Choice Plus Balanced Value	40/1500/70%	6Z-H	•	•	•
Choice Plus Balanced Value	40/2000/50%	6Z-F	•	•	•
Choice Plus Balanced Value	40/5000/70%	6Z-I	•	•	•
Choice Plus HSA	2000/100%	J3-N	•	•	•
Choice Plus HSA	3000/100%	J3-O	•	•	•
Choice Plus HSA	2000/90%	6Z-J	•	•	•
Choice Plus HSA	3000/90%	6Z-K	•	•	•
Choice Plus HSA	1500/80%	J3-1	•	•	•
Choice Plus HSA	2000/80%	J3-Z	•	•	•
Choice Plus HSA	3000/80%	J3-L	•	•	•
Choice Plus HSA	4000/80%	J3-M	•	•	•
Choice Plus HRA	2000/70% <sup>4</sup>	J3-V	•	•	•
Choice Plus HRA	3000/70% <sup>4</sup>	J3-W	•	•	•
Non-Differential PPO	2000/80%	6H-H			
			<b>And</b>	<b>And</b>	
SignatureValue (HMO)	10-30/100%	PC-F	•		
SignatureValue (HMO)	15-30/300a	PC-G	•		•
SignatureValue (HMO)	20-40/300d <sup>1</sup>	PD-I	•		•
SignatureValue (HMO)	30-40/500d <sup>1</sup>	PD-J	•		•
SignatureValue (HMO)	40-60/800d <sup>1</sup>	PD-K	•		
SignatureValue (HMO)	20-40/1500ded <sup>1</sup>	PC-K	•		
SignatureValue (HMO)	40-60/60% <sup>1</sup>	PC-C	•	•	
SignatureValue (HMO)	20-40/70%/1500ded <sup>1</sup>	PD-M	•	•	
SignatureValue (HMO)	40-60/70%/2000ded <sup>1</sup>	PD-N	•	•	
			<b>Or</b>	<b>And</b>	
SignatureValue Advantage (HMO)	10-30/100%	PC-L	•	•	
SignatureValue Advantage (HMO)	15-30/300a	PC-M	•	•	
SignatureValue Advantage (HMO)	20-40/300d <sup>1</sup>	PD-T	•	•	
SignatureValue Advantage (HMO)	30-40/500d <sup>1</sup>	PD-O	•	•	
SignatureValue Advantage (HMO)	40-60/800d <sup>1</sup>	PD-P	•	•	
SignatureValue Advantage (HMO)	20-40/1500ded <sup>1</sup>	PC-Q	•	•	
SignatureValue Advantage (HMO)	40-60/2000ded <sup>1</sup>	PC-R	•	•	
SignatureValue Advantage (HMO)	40-60/60% <sup>1</sup>	PC-1	•	•	
SignatureValue Advantage (HMO)	20-40/70%/1500ded <sup>1</sup>	PD-R	•	•	
SignatureValue Advantage (HMO)	40-60/70%/2000ded <sup>1</sup>	PD-S	•	•	
					<b>And</b>
SignatureValue Flex A (HMO) Network 1	15-30/300a	CB-3			•
SignatureValue Flex A (HMO) Network 2	20-40/300d <sup>1</sup>	CB-4			
SignatureValue Flex A (HMO) Network 3	30-40/500d <sup>1</sup>	CB-5			
SignatureValue Flex B (HMO) Network 1	20-40/300d <sup>1</sup>	CB-T			
SignatureValue Flex B (HMO) Network 2	30-40/500d <sup>1</sup>	CB-U			
SignatureValue Flex B (HMO) Network 3	40-60/800d <sup>1</sup>	CB-V			
SignatureValue Flex C (HMO) Network 1	30-40/500d <sup>1</sup>	CB-W			
SignatureValue Flex C (HMO) Network 2	40-60/800d <sup>1</sup>	CB-X			
SignatureValue Flex C (HMO) Network 3	40-60/60% <sup>1</sup>	CB-Y			
SignatureValue Flex D (HMO) Network 1	40-60/800d <sup>1</sup>	CB-Z			
SignatureValue Flex D (HMO) Network 2	40-60/60% <sup>1</sup>	CB-1			
SignatureValue Flex D (HMO) Network 3	20-40/70%/1500ded <sup>1</sup>	CB-2			
SignatureValue HealthCare Partners Network (HMO)	25-75/500ded <sup>1</sup>	PD-F			
SignatureValue HealthCare Partners Network (HMO)	25-50/500ded <sup>1</sup>	PD-G			
SignatureValue HealthCare Partners Network (HMO)	25-75/1500ded <sup>1</sup>	PD-H			

<sup>1</sup> By electing this plan, the Group has chosen not to offer Infertility Services to its employees. The Group understands that UnitedHealthcare covers Infertility Services in other Small Business plans.  
<sup>2</sup> When offered alongside the SignatureValue featuring HealthCare Partners network product, the SignatureValue or SignatureValue Advantage product is only available to employees who do not live and do not work in the HealthCare Partners network service area.



## UnitedHealthcare Products

Our UnitedHealthcare portfolio of products includes familiar plans, such as HMOs and PPOs, and our innovative consumer-driven health plans:

- **Choice Plus Traditional plans** come with deductibles up to \$500 for members who seek care from our network of physicians and health care professionals.
- **Choice Plus Balanced and Choice Plus Balanced Value plans** were designed to lower costs while giving members the freedom to see any physician or specialist without a referral.
- **Consumer-driven health plans** are popular among employees who prefer to manage their own health care decisions and health care dollars. Our HSA and HRA health plans are paired with a Health Savings Account (HSA) or Health Reimbursement Account (HRA), which are funded on a pre-tax basis, and employees can withdraw funds to pay for eligible expenses.
- **Non-Differential PPO** provides coverage for employees who do not have ready access to our PPO network. No referrals are required to see a physician.
- **UnitedHealthcare SignatureValue™ (HMO) plans** allow members to choose a primary care physician who will manage their health care and refer them to specialists when needed.
- **UnitedHealthcare SignatureValue™ Advantage (HMO) plans** come at a lower premium than traditional UnitedHealthcare SignatureValue plans but offer the same level of coverage. The difference is that UnitedHealthcare SignatureValue Advantage plans offer access to a select network of contracting physicians and specialists.
- **UnitedHealthcare SignatureValue Flex (HMO)** is a new HMO option that promotes consumer engagement by giving members more information and flexibility in how they spend their health care dollars. The plan provides the same level of coverage as the traditional UnitedHealthcare plans. The difference is in the distinct network choices. UnitedHealthcare SignatureValue Flex arranges providers into distinct networks, based on objective measurements of their ability to deliver quality care at lower costs. Members pay reduced premiums when they select doctors from a specific network, or tier. And to help them select the doctors who will best fit their needs, members are provided with tools to help them find and research everyone in our network.
- **UnitedHealthcare SignatureValue™ featuring the HealthCare Partners Network (HMO) plans** offer members access to the HealthCare Partners network in Southern California. UnitedHealthcare SignatureValue plans provide first-dollar coverage for primary and specialist care. With predictable health care costs, these plans help employees manage their health care spending and lower costs for themselves and their employers.

# Choice Plus Traditional Plans

	20/250/90%		30/250/80%		30/500/80%		40/500/70%	
	Network	Non-Network <sup>1</sup>	Network	Non-Network <sup>1</sup>	Network	Non-Network <sup>1</sup>	Network	Non-Network <sup>1</sup>
<b>Deductibles and Policy Maximums</b>								
Annual Deductible <sup>2</sup>								
Individual	\$250	\$500	\$250	\$500	\$500	\$1,000	\$500	\$1,000
Family	\$750	\$1,500	\$750	\$1,500	\$1,500	\$3,000	\$1,500	\$3,000
Out-of-Pocket Maximum <sup>3</sup>								
Individual	\$3,000	\$6,000	\$4,000	\$8,000	\$4,000	\$8,000	\$4,000	\$8,000
Family	\$6,000	\$12,000	\$8,000	\$16,000	\$8,000	\$16,000	\$8,000	\$16,000
Maximum Policy Benefit	Unlimited		Unlimited		Unlimited		Unlimited	
<b>Outpatient Services</b>								
Physician's Office Services	\$20 per visit <sup>4</sup> \$40 per Specialist visit <sup>4</sup>	30% of Eligible Expenses	\$30 per visit <sup>4</sup> \$50 per Specialist visit <sup>4</sup>	40% of Eligible Expenses	\$30 per visit <sup>4</sup> \$50 per Specialist visit <sup>4</sup>	40% of Eligible Expenses	\$40 per visit <sup>4</sup> \$60 per Specialist visit <sup>4</sup>	50% of Eligible Expenses
Preventive Care	No copayment <sup>4</sup>	No Benefits	No copayment <sup>4</sup>	No Benefits	No copayment <sup>4</sup>	No Benefits	No copayment <sup>4</sup>	No Benefits
Maternity Services Prenatal care	\$20 per visit <sup>4,5</sup>	30% of Eligible Expenses	\$30 per visit <sup>4,5</sup>	40% of Eligible Expenses	\$30 per visit <sup>4,5</sup>	40% of Eligible Expenses	\$40 per visit <sup>4,5</sup>	50% of Eligible Expenses
Injections Received in a Physician's Office	\$20 per visit <sup>4</sup>	30% per injection	\$30 per visit <sup>4</sup>	40% per injection	\$30 per visit <sup>4</sup>	40% per injection	\$40 per visit <sup>4</sup>	50% per injection
Outpatient Surgery	10% of Eligible Expenses	30% of Eligible Expenses	20% of Eligible Expenses	40% of Eligible Expenses	20% of Eligible Expenses	40% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
Outpatient Diagnostic Services Lab and Radiology/X-ray	10% of Eligible Expenses 100% coverage for preventive diagnostic services <sup>4</sup>	30% of Eligible Expenses	20% of Eligible Expenses 100% coverage for preventive diagnostic services <sup>4</sup>	40% of Eligible Expenses	20% of Eligible Expenses 100% coverage for preventive diagnostic services <sup>4</sup>	40% of Eligible Expenses	30% of Eligible Expenses 100% coverage for preventive diagnostic services <sup>4</sup>	50% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services – CT Scans, Pet Scans, MRI, and Nuclear Medicine	10% of Eligible Expenses	30% of Eligible Expenses	20% of Eligible Expenses	40% of Eligible Expenses	20% of Eligible Expenses	40% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
<b>Hospitalization Services</b>								
Inpatient Hospital Stay	10% of Eligible Expenses	30% of Eligible Expenses	20% of Eligible Expenses	40% of Eligible Expenses	20% of Eligible Expenses	40% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
Professional Fees for Surgical and Medical Services	10% of Eligible Expenses	30% of Eligible Expenses	20% of Eligible Expenses	40% of Eligible Expenses	20% of Eligible Expenses	40% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
Skilled Nursing Facility Benefits limited to 60 days per year	10% of Eligible Expenses	30% of Eligible Expenses	20% of Eligible Expenses	40% of Eligible Expenses	20% of Eligible Expenses	40% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
<b>Emergency Health Coverage</b>								
Emergency Health Services	\$250 per visit <sup>4</sup>	Same as Network Benefit	\$250 per visit <sup>4</sup>	Same as Network Benefit	\$250 per visit <sup>4</sup>	Same as Network Benefit	\$250 per visit <sup>4</sup>	Same as Network Benefit
Urgent Care Center Services	\$125 per visit <sup>4</sup>	30% of Eligible Expenses	\$125 per visit <sup>4</sup>	40% of Eligible Expenses	\$125 per visit <sup>4</sup>	40% of Eligible Expenses	\$125 per visit <sup>4</sup>	50% of Eligible Expenses
Ambulance Services Emergency only	10% of Eligible Expenses	Same as Network Benefit	20% of Eligible Expenses	Same as Network Benefit	20% of Eligible Expenses	Same as Network Benefit	30% of Eligible Expenses	Same as Network Benefit
<b>Durable Medical Equipment</b>								
Durable Medical Equipment Benefits limited to \$2,500 per year	10% of Eligible Expenses	30% of Eligible Expenses	20% of Eligible Expenses	40% of Eligible Expenses	20% of Eligible Expenses	40% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
<b>Mental Health and Substance Use Disorder Services<sup>6</sup></b>								
Inpatient and Intermediate Benefits limited to 30 days per year	10% of Eligible Expenses	30% of Eligible Expenses	20% of Eligible Expenses	40% of Eligible Expenses	20% of Eligible Expenses	40% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
Outpatient – Benefits limited to 20 visits per year	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
Severe Mental Illness Services	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service
<b>Home Health Services</b>								
Home Health Care – Benefits limited to 100 visits per year	10% of Eligible Expenses	30% of Eligible Expenses	20% of Eligible Expenses	40% of Eligible Expenses	20% of Eligible Expenses	40% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
<b>Other Services</b>								
Infertility Services – Benefits limited to \$2,000 per lifetime	10% of Eligible Expenses	30% of Eligible Expenses	20% of Eligible Expenses	40% of Eligible Expenses	20% of Eligible Expenses	40% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
<b>Outpatient Prescription Drugs</b>								
Tier I Copayment	\$15		\$15		\$15		\$15	
Tier II Copayment	\$35 (25% for Specialty Medications)		\$35 (25% for Specialty Medications)		\$35 (25% for Specialty Medications)		\$35 (25% for Specialty Medications)	
Tier III Copayment	\$60 (30% for Specialty Medications)		\$60 (30% for Specialty Medications)		\$60 (30% for Specialty Medications)		\$60 (30% for Specialty Medications)	
Deductible (Individual/Family)	None		None		None		None	

<sup>1</sup> Reimbursement for Non-Network treatment is based on a percentage of the published rates allowed by Medicare for the same or similar services.

<sup>2</sup> The Family Annual Deductible includes an embedded individual deductible. When a member of a family unit satisfies the Individual Annual Deductible amount for the Calendar or Plan Year, no further deductible will be required for him or her for that Calendar or Plan Year.

<sup>3</sup> The Out-of-Pocket Maximum includes the Annual Deductible.

<sup>4</sup> Not subject to the Annual Deductible.

<sup>5</sup> No Copayment applies to Physician office visits for prenatal care after the first visit.

<sup>6</sup> Mental Health Parity supplemental benefits available for groups with less than 51 total employees. Mental Health Parity benefits and associated premium rates automatically apply to groups with 51 or more total employees.

# Choice Plus Balanced Plans

	30/1000/80%		40/1000/70%		40/1000/50%	
	Network	Non-Network <sup>1</sup>	Network	Non-Network <sup>1</sup>	Network	Non-Network <sup>1</sup>
<b>Deductibles and Policy Maximums</b>						
Annual Deductible <sup>2</sup>						
Individual	\$1,000	\$2,000	\$1,000	\$2,000	\$1,000	\$2,000
Family	\$3,000	\$6,000	\$3,000	\$6,000	\$3,000	\$6,000
Out-of-Pocket Maximum <sup>3</sup>						
Individual	\$5,000	\$10,000	\$5,000	\$10,000	\$5,000	\$10,000
Family	\$10,000	\$20,000	\$10,000	\$20,000	\$10,000	\$20,000
Maximum Policy Benefit	Unlimited		Unlimited		Unlimited	
<b>Outpatient Services</b>						
Physician's Office Services	\$30 per visit <sup>4</sup> \$50 per Specialist visit <sup>4</sup>	40% of Eligible Expenses	\$40 per visit <sup>4</sup> \$60 per Specialist visit <sup>4</sup>	50% of Eligible Expenses	\$40 per visit <sup>4</sup> \$60 per Specialist visit <sup>4</sup>	50% of Eligible Expenses
Preventive Care	No copayment <sup>4</sup>	No Benefits	No copayment <sup>4</sup>	No Benefits	No copayment <sup>4</sup>	No Benefits
Maternity Services <i>Prenatal care</i>	\$30 per visit <sup>4,5</sup>	40% of Eligible Expenses	\$40 per visit <sup>4,5</sup>	50% of Eligible Expenses	\$40 per visit <sup>4,5</sup>	50% of Eligible Expenses
Injections Received in a Physician's Office	\$30 per visit <sup>4</sup>	40% per injection	\$40 per visit <sup>4</sup>	50% per injection	\$40 per visit <sup>4</sup>	50% per injection
Outpatient Surgery <sup>6</sup>	20% of Eligible Expenses	40% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses	\$250 Per Occurrence Deductible, then 50% of Eligible Expenses	\$250 Per Occurrence Deductible, then 50% of Eligible Expenses
Outpatient Diagnostic Services Lab and Radiology/X-ray	20% of Eligible Expenses 100% coverage for preventive diagnostic services <sup>4</sup>	40% of Eligible Expenses	30% of Eligible Expenses 100% coverage for preventive diagnostic services <sup>4</sup>	50% of Eligible Expenses	50% of Eligible Expenses 100% coverage for preventive diagnostic services <sup>4</sup>	50% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services – CT Scans, Pet Scans, MRI, and Nuclear Medicine	20% of Eligible Expenses	40% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
<b>Hospitalization Services</b>						
Inpatient Hospital Stay <sup>6</sup>	20% of Eligible Expenses	40% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses	\$500 Per Occurrence Deductible, then 50% of Eligible Expenses	\$500 Per Occurrence Deductible, then 50% of Eligible Expenses
Professional Fees for Surgical and Medical Services	20% of Eligible Expenses	40% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
Skilled Nursing Facility <i>Benefits limited to 60 days per year</i>	20% of Eligible Expenses	40% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
<b>Emergency Health Coverage</b>						
Emergency Health Services	\$250 per visit <sup>4</sup>	Same as Network Benefit	\$250 per visit <sup>4</sup>	Same as Network Benefit	\$250 per visit <sup>4</sup>	Same as Network Benefit
Urgent Care Center Services	\$125 per visit <sup>4</sup>	40% of Eligible Expenses	\$125 per visit <sup>4</sup>	50% of Eligible Expenses	\$125 per visit <sup>4</sup>	50% of Eligible Expenses
Ambulance Services <i>Emergency Only</i>	20% of Eligible Expenses	Same as Network Benefit	30% of Eligible Expenses	Same as Network Benefit	50% of Eligible Expenses	Same as Network Benefit
<b>Durable Medical Equipment</b>						
Durable Medical Equipment <i>Benefits limited to \$2,500 per year</i>	20% of Eligible Expenses	40% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
<b>Mental Health and Substance Use Disorder Services<sup>7</sup></b>						
Inpatient and Intermediate <i>Benefits limited to 30 days per year</i>	20% of Eligible Expenses	40% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
Outpatient <i>Benefits limited to 20 visits per year</i>	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
Severe Mental Illness Services	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service
<b>Home Health Services</b>						
Home Health Care <i>Benefits limited to 100 visits per year</i>	20% of Eligible Expenses	40% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
<b>Other Services</b>						
Infertility Services <i>Benefits limited to \$2,000 per lifetime</i>	20% of Eligible Expenses	40% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
<b>Outpatient Prescription Drugs</b>						
Tier I Copayment	\$15		\$15		\$15	
Tier II Copayment	\$35 (25% for Specialty Medications)		\$35 (25% for Specialty Medications)		\$35 (25% for Specialty Medications)	
Tier III Copayment	\$60 (30% for Specialty Medications)		\$60 (30% for Specialty Medications)		\$60 (30% for Specialty Medications)	
Deductible (Individual/Family)	\$150/\$450 deductible on Tier II and Tier III drugs		\$150/\$450 deductible on Tier II and Tier III drugs		\$150/\$450 deductible on Tier II and Tier III drugs	

<sup>1</sup> Reimbursement for Non-Network treatment is based on a percentage of the published rates allowed by Medicare for the same or similar services.

<sup>2</sup> The Family Annual Deductible includes an embedded individual deductible. When a member of a family unit satisfies the Individual Annual Deductible amount for the Calendar or Plan Year, no further deductible will be required for him or her for that Calendar or Plan Year.

<sup>3</sup> The Out-of-Pocket Maximum includes the Annual Deductible.

40/1500/70%		40/2000/50%		30/3000/70%		40/4000/60%		50/5000/50%	
Network	Non-Network <sup>1</sup>	Network	Non-Network <sup>1</sup>	Network	Non-Network <sup>1</sup>	Network	Non-Network <sup>1</sup>	Network	Non-Network <sup>1</sup>
\$1,500	\$3,000	\$2,000	\$4,000	\$3,000	\$3,000	\$4,000	\$4,000	\$5,000	\$5,000
\$4,500	\$9,000	\$6,000	\$12,000	\$6,000	\$6,000	\$8,000	\$8,000	\$10,000	\$10,000
\$5,000	\$10,000	\$6,000	\$12,000	\$5,000	\$10,000	\$6,000	\$12,000	\$7,000	\$14,000
\$10,000	\$20,000	\$12,000	\$24,000	\$10,000	\$20,000	\$12,000	\$24,000	\$14,000	\$28,000
Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
\$40 per visit <sup>4</sup> \$60 per Specialist visit <sup>4</sup>	50% of Eligible Expenses	\$40 per visit <sup>4</sup> \$60 per Specialist visit <sup>4</sup>	50% of Eligible Expenses	\$30 per visit <sup>4</sup> \$50 per Specialist visit <sup>4</sup>	50% of Eligible Expenses	\$40 per visit <sup>4</sup> \$60 per Specialist visit <sup>4</sup>	50% of Eligible Expenses	\$50 per visit <sup>4</sup> \$70 per Specialist visit <sup>4</sup>	50% of Eligible Expenses
No copayment <sup>4</sup>	No Benefits	No copayment <sup>4</sup>	No Benefits	No copayment <sup>4</sup>	No Benefits	No copayment <sup>4</sup>	No Benefits	No copayment <sup>4</sup>	No Benefits
\$40 per visit <sup>4,5</sup>	50% of Eligible Expenses	\$40 per visit <sup>4,5</sup>	50% of Eligible Expenses	\$30 per visit <sup>4,5</sup>	50% of Eligible Expenses	\$40 per visit <sup>4,5</sup>	50% of Eligible Expenses	\$50 per visit <sup>4,5</sup>	50% of Eligible Expenses
\$40 per visit <sup>4</sup>	50% per injection	\$40 per visit <sup>4</sup>	50% per injection	\$30 per visit <sup>4</sup>	50% per injection	\$40 per visit <sup>4</sup>	50% per injection	\$50 per visit <sup>4</sup>	50% per injection
30% of Eligible Expenses	50% of Eligible Expenses	\$250 Per Occurrence Deductible, then 50% of Eligible Expenses	\$250 Per Occurrence Deductible, then 50% of Eligible Expenses	\$250 Per Occurrence Deductible, then 30% of Eligible Expenses	\$250 Per Occurrence Deductible, then 50% of Eligible Expenses	\$250 Per Occurrence Deductible, then 40% of Eligible Expenses	\$250 Per Occurrence Deductible, then 50% of Eligible Expenses	\$250 Per Occurrence Deductible, then 50% of Eligible Expenses	\$250 Per Occurrence Deductible, then 50% of Eligible Expenses
30% of Eligible Expenses 100% coverage for preventive diagnostic services <sup>4</sup>	50% of Eligible Expenses	50% of Eligible Expenses 100% coverage for preventive diagnostic services <sup>4</sup>	50% of Eligible Expenses	30% of Eligible Expenses 100% coverage for preventive diagnostic services <sup>4</sup>	50% of Eligible Expenses	40% of Eligible Expenses 100% coverage for preventive diagnostic services <sup>4</sup>	50% of Eligible Expenses	50% of Eligible Expenses 100% coverage for preventive diagnostic services <sup>4</sup>	50% of Eligible Expenses
30% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses	40% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
30% of Eligible Expenses	50% of Eligible Expenses	\$500 Per Occurrence Deductible, then 50% of Eligible Expenses	\$500 Per Occurrence Deductible, then 50% of Eligible Expenses	\$500 Per Occurrence Deductible, then 30% of Eligible Expenses	\$500 Per Occurrence Deductible, then 50% of Eligible Expenses	\$500 Per Occurrence Deductible, then 40% of Eligible Expenses	\$500 Per Occurrence Deductible, then 50% of Eligible Expenses	\$500 Per Occurrence Deductible, then 50% of Eligible Expenses	\$500 Per Occurrence Deductible, then 50% of Eligible Expenses
30% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses	40% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
30% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses	40% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
\$250 per visit <sup>4</sup>	Same as Network Benefit	\$250 per visit <sup>4</sup>	Same as Network Benefit	\$250 per visit <sup>4</sup>	Same as Network Benefit	\$250 per visit <sup>4</sup>	Same as Network Benefit	\$250 per visit <sup>4</sup>	Same as Network Benefit
\$125 per visit <sup>4</sup>	50% of Eligible Expenses	\$125 per visit <sup>4</sup>	50% of Eligible Expenses	\$125 per visit <sup>4</sup>	50% of Eligible Expenses	\$125 per visit <sup>4</sup>	50% of Eligible Expenses	\$125 per visit <sup>4</sup>	50% of Eligible Expenses
30% of Eligible Expenses	Same as Network Benefit	50% of Eligible Expenses	Same as Network Benefit	30% of Eligible Expenses	Same as Network Benefit	40% of Eligible Expenses	Same as Network Benefit	50% of Eligible Expenses	Same as Network Benefit
30% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses	40% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
30% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses	40% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service
30% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses	40% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
30% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses	40% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15
\$35 (25% for Specialty Medications)	\$35 (25% for Specialty Medications)	\$35 (25% for Specialty Medications)	\$35 (25% for Specialty Medications)	\$35 (25% for Specialty Medications)	\$35 (25% for Specialty Medications)	\$35 (25% for Specialty Medications)	\$35 (25% for Specialty Medications)	\$35 (25% for Specialty Medications)	\$35 (25% for Specialty Medications)
\$60 (30% for Specialty Medications)	\$60 (30% for Specialty Medications)	\$60 (30% for Specialty Medications)	\$60 (30% for Specialty Medications)	\$60 (30% for Specialty Medications)	\$60 (30% for Specialty Medications)	\$60 (30% for Specialty Medications)	\$60 (30% for Specialty Medications)	\$60 (30% for Specialty Medications)	\$60 (30% for Specialty Medications)
\$150/\$450 deductible on Tier II and Tier III drugs	\$150/\$450 deductible on Tier II and Tier III drugs	\$150/\$450 deductible on Tier II and Tier III drugs	\$150/\$450 deductible on Tier II and Tier III drugs	\$300/\$900 deductible on Tier II and Tier III drugs	\$300/\$900 deductible on Tier II and Tier III drugs	\$300/\$900 deductible on Tier II and Tier III drugs	\$300/\$900 deductible on Tier II and Tier III drugs	\$300/\$900 deductible on Tier II and Tier III drugs	\$300/\$900 deductible on Tier II and Tier III drugs

<sup>4</sup> Not subject to the Annual Deductible.

<sup>5</sup> No Copayment applies to Physician office visits for prenatal care after the first visit.

<sup>6</sup> Per Occurrence Deductible for Outpatient Surgery and Inpatient Hospital Services does not accrue toward the Annual Deductible or the Out-of-Pocket Maximum.

<sup>7</sup> Mental Health Parity supplemental benefits available for groups with less than 51 total employees. Mental Health Parity benefits and associated premium rates automatically apply to groups with 51 or more total employees.

# Choice Plus Balanced Value Plans

	40/1000/70%		40/1500/70%	
	Network	Non-Network <sup>1</sup>	Network	Non-Network <sup>1</sup>
<b>Deductibles and Policy Maximums</b>				
Annual Deductible <sup>2</sup>				
<i>Individual</i>	\$1,000	\$2,000	\$1,500	\$3,000
<i>Family</i>	\$3,000	\$6,000	\$4,500	\$9,000
Out-of-Pocket Maximum <sup>3</sup>				
<i>Individual</i>	\$5,000	\$10,000	\$5,000	\$10,000
<i>Family</i>	\$10,000	\$20,000	\$10,000	\$20,000
Maximum Policy Benefit	Unlimited		Unlimited	
<b>Outpatient Services</b>				
Physician's Office Services	\$40 per visit <sup>4</sup> \$60 per Specialist visit <sup>4</sup>	50% of Eligible Expenses	\$40 per visit <sup>4</sup> \$60 per Specialist visit <sup>4</sup>	50% of Eligible Expenses
Preventive Care	No copayment <sup>4</sup>	No Benefits	No copayment <sup>4</sup>	No Benefits
Maternity Services <i>Prenatal care</i>	\$40 per visit <sup>4,5</sup>	50% of Eligible Expenses	\$40 per visit <sup>4,5</sup>	50% of Eligible Expenses
Injections Received in a Physician's Office	\$40 per visit <sup>4</sup>	50% per injection	\$40 per visit <sup>4</sup>	50% per injection
Outpatient Surgery <sup>6</sup>	\$500 Per Occurrence Deductible, then 30% of Eligible Expenses	\$500 Per Occurrence Deductible, then 50% of Eligible Expenses	\$500 Per Occurrence Deductible, then 30% of Eligible Expenses	\$500 Per Occurrence Deductible, then 50% of Eligible Expenses
Outpatient Diagnostic Services Lab and Radiology/X-ray	30% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services – CT Scans, Pet Scans, MRI, and Nuclear Medicine	30% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
<b>Hospitalization Services</b>				
Inpatient Hospital Stay <sup>6</sup>	\$1,000 Per Occurrence Deductible, then 30% of Eligible Expenses	\$1,000 Per Occurrence Deductible, then 50% of Eligible Expenses	\$1,000 Per Occurrence Deductible, then 30% of Eligible Expenses	\$1,000 Per Occurrence Deductible, then 50% of Eligible Expenses
Professional Fees for Surgical and Medical Services	30% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
Skilled Nursing Facility <i>Benefits limited to 60 days per year</i>	30% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
<b>Emergency Health Coverage</b>				
Emergency Health Services	\$250 per visit <sup>4</sup>	Same as Network Benefit	\$250 per visit <sup>4</sup>	Same as Network Benefit
Urgent Care Center Services	\$125 per visit <sup>4</sup>	50% of Eligible Expenses	\$125 per visit <sup>4</sup>	50% of Eligible Expenses
Ambulance Services <i>Emergency Only</i>	30% of Eligible Expenses	Same as Network Benefit	30% of Eligible Expenses	Same as Network Benefit
<b>Durable Medical Equipment</b>				
Durable Medical Equipment <i>Benefits limited to \$2,500 per year</i>	30% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
<b>Mental Health and Substance Use Disorder Services<sup>7</sup></b>				
Inpatient and Intermediate <i>Benefits limited to 30 days per year</i>	30% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
Outpatient <i>Benefits limited to 20 visits per year</i>	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
Severe Mental Illness Services	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service
<b>Home Health Services</b>				
Home Health Care <i>Benefits limited to 100 visits per year</i>	30% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
<b>Other Services</b>				
Infertility Services <i>Benefits limited to \$2,000 per lifetime</i>	30% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
<b>Outpatient Prescription Drugs</b>				
Tier I Copayment	\$20		\$20	
Tier II Copayment	\$40 (25% for Specialty Medications)		\$40 (25% for Specialty Medications)	
Tier III Copayment	\$60 (30% for Specialty Medications)		\$60 (30% for Specialty Medications)	
Deductible (Individual/Family)	\$300/\$900 deductible		\$300/\$900 deductible	

<sup>1</sup> Reimbursement for Non-Network treatment is based on a percentage of the published rates allowed by Medicare for the same or similar services.

<sup>2</sup> The Family Annual Deductible does not include an embedded individual deductible.

<sup>3</sup> The Out-of-Pocket Maximum does not include the Annual Deductible.

40/2000/50%		40/5000/70%	
Network	Non-Network <sup>1</sup>	Network	Non-Network <sup>1</sup>
\$2,000	\$4,000	\$5,000	\$5,000
\$6,000	\$12,000	\$10,000	\$10,000
\$6,000	\$12,000	\$10,000	\$15,000
\$12,000	\$24,000	\$20,000	\$30,000
Unlimited		Unlimited	
\$40 per visit <sup>4</sup> \$60 per Specialist visit <sup>4</sup>	50% of Eligible Expenses	\$40 per visit <sup>4</sup> \$60 per Specialist visit <sup>4</sup>	50% of Eligible Expenses
No copayment <sup>4</sup>	No Benefits	No copayment <sup>4</sup>	No Benefits
\$40 per visit <sup>4,5</sup>	50% of Eligible Expenses	\$40 per visit <sup>4,5</sup>	50% of Eligible Expenses
\$40 per visit <sup>4</sup>	50% per injection	\$40 per visit <sup>4</sup>	50% per injection
\$500 Per Occurrence Deductible, then 50% of Eligible Expenses	\$500 Per Occurrence Deductible, then 50% of Eligible Expenses	\$500 Per Occurrence Deductible, then 30% of Eligible Expenses	\$500 Per Occurrence Deductible, then 50% of Eligible Expenses
50% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
50% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
\$1,000 Per Occurrence Deductible, then 50% of Eligible Expenses	\$1,000 Per Occurrence Deductible, then 50% of Eligible Expenses	\$1,000 Per Occurrence Deductible, then 30% of Eligible Expenses	\$1,000 Per Occurrence Deductible, then 50% of Eligible Expenses
50% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
50% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
\$250 per visit <sup>4</sup>	Same as Network Benefit	\$250 per visit <sup>4</sup>	Same as Network Benefit
\$125 per visit <sup>4</sup>	50% of Eligible Expenses	\$125 per visit <sup>4</sup>	50% of Eligible Expenses
50% of Eligible Expenses	Same as Network Benefit	30% of Eligible Expenses	Same as Network Benefit
50% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
50% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service
50% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
50% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
\$20		\$20	
\$40 (25% for Specialty Medications)		\$40 (25% for Specialty Medications)	
\$60 (30% for Specialty Medications)		\$60 (30% for Specialty Medications)	
\$300/\$900 deductible		\$300/\$900 deductible	

<sup>4</sup> Not subject to the Annual Deductible.

<sup>5</sup> No Copayment applies to Physician office visits for prenatal care after the first visit.

<sup>6</sup> Per Occurrence Deductible for Outpatient Surgery and Inpatient Hospital Services does not accrue toward the Annual Deductible or the Out-of-Pocket Maximum.

<sup>7</sup> Mental Health Parity supplemental benefits available for groups with less than 51 total employees. Mental Health Parity benefits and associated premium rates automatically apply to groups with 51 or more total employees.

# Choice Plus Health Savings Account (HSA) Plans

	1500/80%		2000/100%		2000/90%	
	Network	Non-Network <sup>1</sup>	Network	Non-Network <sup>1</sup>	Network	Non-Network <sup>1</sup>
<b>Deductibles and Policy Maximums</b>						
Annual Deductible (Combined Medical and Pharmacy) <sup>2</sup>	\$1,500	\$3,000	\$2,000	\$4,000	\$2,000	\$4,000
<i>Individual Coverage</i>						
<i>Family Coverage</i>						
Out-of-Pocket Maximum (Combined Medical and Pharmacy) <sup>3</sup>	\$3,000	\$6,000	\$4,000	\$8,000	\$4,000	\$8,000
<i>Individual</i>						
<i>Family</i>	\$6,000	\$12,000	\$8,000	\$16,000	\$8,000	\$16,000
Maximum Policy Benefit	Unlimited		Unlimited		Unlimited	
<b>Outpatient Services</b>						
Physician's Office Services	20% of Eligible Expenses	50% of Eligible Expenses	0% of Eligible Expenses	30% of Eligible Expenses	10% of Eligible Expenses	40% of Eligible Expenses
Preventive Care	No copayment <sup>4</sup>	No Benefits	No copayment <sup>4</sup>	No Benefits	No copayment <sup>4</sup>	No Benefits
Maternity Services <i>Prenatal care</i>	20% of Eligible Expenses	50% of Eligible Expenses	0% of Eligible Expenses	30% of Eligible Expenses	10% of Eligible Expenses	40% of Eligible Expenses
Injections Received in a Physician's Office	20% per injection	50% per injection	0% per injection	30% per injection	10% per injection	40% per injection
Outpatient Surgery	20% of Eligible Expenses	50% of Eligible Expenses	0% of Eligible Expenses	30% of Eligible Expenses	10% of Eligible Expenses	40% of Eligible Expenses
Outpatient Diagnostic Services Lab and Radiology/X-ray	20% of Eligible Expenses 100% coverage for preventive diagnostic services <sup>4</sup>	50% of Eligible Expenses No benefits for preventive diagnostic services	0% of Eligible Expenses 100% coverage for preventive diagnostic services <sup>4</sup>	30% of Eligible Expenses No benefits for preventive diagnostic services	10% of Eligible Expenses 100% coverage for preventive diagnostic services <sup>4</sup>	40% of Eligible Expenses No benefits for preventive diagnostic services
Outpatient Diagnostic/Therapeutic Services - CT scans, Pet Scans, MRI and Nuclear Medicine	20% of Eligible Expenses	50% of Eligible Expenses	0% of Eligible Expenses	30% of Eligible Expenses	10% of Eligible Expenses	40% of Eligible Expenses
<b>Hospitalization Services</b>						
Inpatient Hospital Stay	20% of Eligible Expenses	50% of Eligible Expenses	0% of Eligible Expenses	30% of Eligible Expenses	10% of Eligible Expenses	40% of Eligible Expenses
Professional Fees for Surgical and Medical Services	20% of Eligible Expenses	50% of Eligible Expenses	0% of Eligible Expenses	30% of Eligible Expenses	10% of Eligible Expenses	40% of Eligible Expenses
Skilled Nursing Facility <i>Benefits limited to 60 days per year</i>	20% of Eligible Expenses	50% of Eligible Expenses	0% of Eligible Expenses	30% of Eligible Expenses	10% of Eligible Expenses	40% of Eligible Expenses
<b>Emergency Health Coverage</b>						
Emergency Health Services	20% of Eligible Expenses	Same as Network Benefit	0% of Eligible Expenses	Same as Network Benefit	10% of Eligible Expenses	Same as Network Benefit
Urgent Care Center Services	20% of Eligible Expenses	50% of Eligible Expenses	0% of Eligible Expenses	30% of Eligible Expenses	10% of Eligible Expenses	40% of Eligible Expenses
Ambulance Services <i>Emergency only</i>	20% of Eligible Expenses	Same as Network Benefit	0% of Eligible Expenses	Same as Network Benefit	10% of Eligible Expenses	Same as Network Benefit
<b>Durable Medical Equipment</b>						
Durable Medical Equipment <i>Benefits limited to \$2,500 per year</i>	20% of Eligible Expenses	50% of Eligible Expenses	0% of Eligible Expenses	30% of Eligible Expenses	10% of Eligible Expenses	40% of Eligible Expenses
<b>Mental Health and Substance Use Disorder Services<sup>5</sup></b>						
Inpatient and Intermediate <i>Benefits limited to 30 days per year</i>	20% of Eligible Expenses	50% of Eligible Expenses	0% of Eligible Expenses	30% of Eligible Expenses	10% of Eligible Expenses	40% of Eligible Expenses
Outpatient <i>Benefits limited to 20 visits per year</i>	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
Severe Mental Illness Services	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service
<b>Home Health Services</b>						
Home Health Care <i>Benefits limited to 100 visits per year</i>	20% of Eligible Expenses	50% of Eligible Expenses	0% of Eligible Expenses	30% of Eligible Expenses	10% of Eligible Expenses	40% of Eligible Expenses
<b>Other Services</b>						
Infertility Services <i>Benefits limited to \$2,000 per lifetime</i>	20% of Eligible Expenses	50% of Eligible Expenses	0% of Eligible Expenses	30% of Eligible Expenses	10% of Eligible Expenses	40% of Eligible Expenses
<b>Outpatient Prescription Drugs</b>						
Tier I Copayment	\$15		\$15		\$15	
Tier II Copayment	\$35 (25% for Specialty Medications)		\$35 (25% for Specialty Medications)		\$35 (25% for Specialty Medications)	
Tier III Copayment	\$60 (30% for Specialty Medications)		\$60 (30% for Specialty Medications)		\$60 (30% for Specialty Medications)	
Deductible	Combined medical and drug Annual Deductible		Combined medical and drug Annual Deductible		Combined medical and drug Annual Deductible	

<sup>1</sup> Reimbursement for Non-Network treatment is based on a percentage of the published rates allowed by Medicare for the same or similar services.

<sup>2</sup> The Family Annual Deductible does not include an embedded individual deductible. This combined medical and pharmacy deductible must be satisfied before the medical coinsurance and pharmacy copayments apply.

<sup>3</sup> The Out-of-Pocket Maximum includes the Annual Deductible.

<sup>4</sup> Not subject to the Annual Deductible.

<sup>5</sup> Mental Health Parity supplemental benefits available for groups with less than 51 total employees. Mental Health Parity benefits and associated premium rates automatically apply to groups with 51 or more total employees.



# Choice Plus Health Reimbursement Account (HRA) Plans

	2000/70%		3000/70%	
	Network	Non-Network <sup>1</sup>	Network	Non-Network <sup>1</sup>
<b>Deductibles and Policy Maximums</b>				
Annual Deductible <sup>2</sup>				
<i>Individual Coverage</i>	\$2,000	\$4,000	\$3,000	\$6,000
<i>Family Coverage</i>	\$4,000	\$8,000	\$6,000	\$12,000
Out-of-Pocket Maximum <sup>3</sup>				
<i>Individual</i>	\$5,000	\$10,000	\$6,000	\$12,000
<i>Family</i>	\$10,000	\$20,000	\$12,000	\$24,000
Maximum Policy Benefit	Unlimited		Unlimited	
<b>Outpatient Services</b>				
Physician's Office Services	30% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
Preventive Care	No copayment <sup>4</sup>	No Benefits	No copayment <sup>4</sup>	No Benefits
Maternity Services <i>Prenatal care</i>	30% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
Injections Received in a Physician's Office	30% per injection	50% per injection	30% per injection	50% per injection
Outpatient Surgery	30% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
Outpatient Diagnostic Services <i>Lab and Radiology/X-ray</i>	30% of Eligible Expenses 100% coverage for preventive diagnostic services <sup>4</sup>	50% of Eligible Expenses No Benefits for preventive diagnostic services	30% of Eligible Expenses 100% coverage for preventive diagnostic services <sup>4</sup>	50% of Eligible Expenses No Benefits for preventive diagnostic services
Outpatient Diagnostic/Therapeutic Services – CT Scans, Pet Scans, MRI and Nuclear Medicine	30% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
<b>Hospitalization Services</b>				
Inpatient Hospital Stay	30% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
Professional Fees for Surgical and Medical Services	30% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
Skilled Nursing Facility <i>Benefits limited to 60 days per year</i>	30% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
<b>Emergency Health Coverage</b>				
Emergency Health Services	30% of Eligible Expenses	Same as Network Benefit	30% of Eligible Expenses	Same as Network Benefit
Urgent Care Center Services	30% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
Ambulance Services <i>Emergency Only</i>	30% of Eligible Expenses	Same as Network Benefit	30% of Eligible Expenses	Same as Network Benefit
<b>Durable Medical Equipment</b>				
Durable Medical Equipment <i>Benefits limited to \$2,500 per year</i>	30% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
<b>Mental Health and Substance Use Disorder Services<sup>5</sup></b>				
Inpatient and Intermediate <i>Benefits limited to 30 days per year</i>	30% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
Outpatient – <i>Benefits limited to 20 visits per year</i>	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses	50% of Eligible Expenses
Severe Mental Illness Services	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service	Same as any other Covered Health Service
<b>Home Health Services</b>				
Home Health Care – <i>Benefits limited to 100 visits per year</i>	30% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
<b>Other Services</b>				
Infertility Services – <i>Benefits limited to \$2,000 per lifetime</i>	30% of Eligible Expenses	50% of Eligible Expenses	30% of Eligible Expenses	50% of Eligible Expenses
<b>Outpatient Prescription Drugs</b>				
Tier I Copayment	\$15		\$15	
Tier II Copayment	\$35 (25% for Specialty Medications)		\$35 (25% for Specialty Medications)	
Tier III Copayment	\$60 (30% for Specialty Medications)		\$60 (30% for Specialty Medications)	
Deductible (Individual/Family)	\$250/\$750 deductible on Tier II and Tier III drugs		\$250/\$750 deductible on Tier II and Tier III drugs	

<sup>1</sup> Reimbursement for Non-Network treatment is based on a percentage of the published rates allowed by Medicare for the same or similar services.

<sup>2</sup> The Family Annual Deductible includes an embedded individual deductible. When a member of a family unit satisfies the Individual Annual Deductible amount for the Calendar or Plan Year, no further deductible will be required for him or her for that Calendar or Plan Year.

<sup>3</sup> The Out-of-Pocket Maximum includes the Annual Deductible.

<sup>4</sup> Not subject to the Annual Deductible.

<sup>5</sup> Mental Health Parity supplemental benefits available for groups with less than 51 total employees. Mental Health Parity benefits and associated premium rates automatically apply to groups with 51 or more total employees.

# Non-Differential PPO Plan

	2000/80% <sup>1</sup>
	Network & Non-Network
<b>Deductibles and Policy Maximums</b>	
Annual Deductible <sup>2</sup>	
<i>Individual</i>	\$2,000
<i>Family</i>	\$6,000
Out-of-Pocket Maximum	
<i>Individual</i>	\$4,000
<i>Family</i>	\$12,000
Maximum Policy Benefit	Unlimited
<b>Outpatient Services</b>	
Physician's Office Services	20% of Eligible Expenses
Preventive Care	No Copayment No Benefits for Non-Network services
Maternity Services <i>Prenatal care</i>	20% of Eligible Expenses
Injections Received in a Physician's Office	20% of Eligible Expenses
Outpatient Surgery	20% of Eligible Expenses
Outpatient Diagnostic Services Lab and Radiology/X-ray	20% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services – CT Scans, Pet Scans, MRI, and Nuclear Medicine	20% of Eligible Expenses
<b>Hospitalization Services</b>	
Inpatient Hospital Stay	20% of Eligible Expenses
Professional Fees for Surgical and Medical Services	20% of Eligible Expenses
Skilled Nursing Facility <i>Benefits limited to 60 days per year</i>	20% of Eligible Expenses
<b>Emergency Health Coverage</b>	
Emergency Health Services	20% of Eligible Expenses
Urgent Care Center Services	20% of Eligible Expenses
Ambulance Services <i>Emergency only</i>	20% of Eligible Expenses
<b>Durable Medical Equipment</b>	
Durable Medical Equipment <i>Benefits limited to \$2,500 per year</i>	20% of Eligible Expenses
<b>Mental Health and Substance Use Disorder Services<sup>3</sup></b>	
Inpatient and Intermediate <i>Benefits limited to 30 days per year</i>	20% of Eligible Expenses
Outpatient <i>Benefits limited to 20 visits per year</i>	50% of Eligible Expenses
Severe Mental Illness Services	Same as any other Covered Health Service
<b>Home Health Services</b>	
Home Health Care <i>Benefits limited to 100 visits per year</i>	20% of Eligible Expenses
<b>Other Services</b>	
Infertility Services <i>Benefits limited to \$2,000 per lifetime</i>	20% of Eligible Expenses
<b>Outpatient Prescription Drugs</b>	
Tier I Copayment	\$15
Tier II Copayment	\$35 (25% for Specialty Medications)
Tier III Copayment	\$60 (30% for Specialty Medications)
Deductible (Individual/Family)	\$150/\$450 deductible on Tier II and Tier III drugs

<sup>1</sup> Out-of-area plan available outside of our contracted network service areas. Subject to underwriting guidelines.

<sup>2</sup> Annual Deductible applies to the Out-of-Pocket Maximum. The Family Annual Deductible includes an embedded individual deductible. When an individual member of a family unit satisfies the Individual Annual Deductible amount for the Calendar or Plan Year, no further deductible will be required for him or her for that Calendar or Plan Year.

<sup>3</sup> Mental Health Parity supplemental benefits available for groups with less than 51 total employees. Mental Health Parity benefits and associated premium rates automatically apply to groups with 51 or more total employees.

# UnitedHealthcare SignatureValue™ (HMO) and UnitedHealthcare SignatureValue™ Advantage (HMO) Plans

	10-30/100%	15-30/300a	20-40/300d	30-40/500d
<b>Annual Deductible</b> (individual/family)	None	None	None	None
<b>Lifetime Maximum</b>	None	None	None	None
<b>Annual Copayment Maximum<sup>1</sup></b> (individual/family)	\$1,500/\$4,500	\$1,500/\$4,500	\$2,000/\$6,000	\$3,000/\$9,000
<b>Annual Out-of-Pocket Maximum<sup>2</sup></b> (individual/family)	NA	NA	NA	NA
<b>Professional Services</b>				
<b>Office Visits</b> (PCP/Specialist)	\$10/\$30 Copayment <sup>3</sup>	\$15/\$30 Copayment <sup>3</sup>	\$20/\$40 Copayment <sup>3</sup>	\$30/\$40 Copayment <sup>3</sup>
<b>Periodic Health Evaluations</b>	Paid in full	Paid in full	Paid in full	Paid in full
<b>Refractions and Hearing Exams</b>	\$10/\$30 Copayment <sup>3</sup>	\$15/\$30 Copayment <sup>3</sup>	\$20/\$40 Copayment <sup>3</sup>	\$30/\$40 Copayment <sup>3</sup>
<b>Laboratory and Radiology</b> (standard)	Paid in full	Paid in full	Paid in full	Paid in full
<b>Maternity Care</b>	Paid in full	Paid in full	Paid in full	Paid in full
<b>Well-Baby Care</b> (up to age 2)	Paid in full	Paid in full	Paid in full	Paid in full
<b>Well-Woman Care</b>	Paid in full	Paid in full	Paid in full	Paid in full
<b>Outpatient Services</b>				
<b>Outpatient Surgery</b>	Paid in full	\$250 per admission	\$300 per admission	\$400 per admission
<b>Hospitalization Services</b>				
<b>Inpatient Hospital Benefits</b>	Paid in full	\$300 per admission	\$300 per day, up to 2 days per admission	\$500 per day, up to 4 days per admission
<b>Inpatient Physician Care</b>	Paid in full	Paid in full	Paid in full	Paid in full
<b>Skilled Nursing Facility Care</b> (up to 100 consecutive calendar days from first treatment per disability)	Paid in full	\$100 per day	\$200 per day	\$200 per day
<b>Emergency Health Coverage</b>				
<b>Emergency Services</b> (Copayment waived if admitted)	\$150 Copayment	\$150 Copayment	\$150 Copayment	\$150 Copayment
<b>Urgently Needed Services</b> (Copayment waived if admitted)	\$75 Copayment	\$75 Copayment	\$75 Copayment	\$75 Copayment
<b>Ambulance Services</b>	Paid in full	Paid in full	\$50 Copayment	\$50 Copayment
<b>Durable Medical Equipment</b>				
<b>Durable Medical Equipment</b> (\$2,000 Maximum Benefit per Calendar Year. The annual DME benefit maximum does not apply to nebulizers, masks, tubing and peak flow meters for the treatment of asthma for Dependent children under the age of 19.)	\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>
<b>Mental Health Services</b>				
<b>Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED)<sup>5</sup></b>				
■ Inpatient	Paid in full	\$250 per admission	\$250 per admission	\$250 per admission
■ Outpatient	\$30 Copayment	\$30 Copayment	\$40 Copayment	\$40 Copayment
<b>Home Health Services</b>				
<b>Home Health Care: Home Visits by a Licensed Professional</b> (Up to 100 visits per Calendar Year)	\$15 per visit	\$15 per visit	\$15 per visit	\$15 per visit
<b>Other Services</b>				
<b>Infertility Services</b>	50% of cost Copayment <sup>6</sup>	50% of cost Copayment <sup>6</sup>	Not covered	Not covered
<b>Injectable Drugs</b> (Copayment not applicable to allergy serum, immunizations, birth control, infertility and insulin)	\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup>
<b>Outpatient Prescription Drug Coverage<sup>7</sup></b>				
<b>Generic Formulary/Brand-Name Formulary/Non-Formulary</b>	\$10/\$25/\$50	\$15/\$35/\$50	\$15/\$35/\$50	\$20/\$35/\$50
<b>Calendar Year Deductible</b> (per member)	None	\$150 brand-name deductible	\$150 brand-name deductible	\$150 brand-name deductible
<b>Optional Group Coverage</b>				
<b>Chiropractic/Acupuncture Offered Through OptumHealth Care Solutions, Inc.</b> (maximum 30 visits per Calendar Year)	\$10 Copayment	\$10 Copayment	\$10 Copayment	\$10 Copayment
<b>Substance Use Disorder Services</b> Offered Through U.S. Behavioral Health Plan, California				
■ Inpatient	Paid in full	\$250 per admission	\$250 per admission	\$250 per admission
■ Outpatient	\$30 Copayment	\$30 Copayment	\$40 Copayment	\$40 Copayment

1 Annual Copayment Maximum does not include Copayments for durable medical equipment (except for diabetic supplies and nebulizers, peak flow meters, face masks and tubing Medically Necessary for the treatment of pediatric asthma), pharmacy and supplemental benefits.

2 Copayments for certain types of Covered Services do not apply toward the Out-of-Pocket Maximum. Please refer to the Schedule of Benefits to determine applicability to the plan. The Out-of-Pocket Maximum does not include Copayments for durable medical equipment (except for diabetic supplies and nebulizers, peak flow meters, face masks and tubing Medically Necessary for the treatment of pediatric asthma), pharmacy and supplemental benefits.

3 Copayment for audiologist and podiatrist visits will be the same as for the PCP.

40-60/800d	20-40/1500ded	40-60/2000ded (Advantage only)	40-60/60%	20-40/70%/1500ded	40-60/70%/2000ded
None	\$1,500/\$3,000	\$2,000/\$6,000 (Inpatient hospital only)	None	\$1,500/\$3,000	\$2,000/\$4,000
None	None	None	None	None	None
\$4,000/\$12,000	NA	NA	\$5,000/\$10,000	NA	NA
NA	\$4,000/\$8,000	\$5,000/\$15,000	NA	\$5,000/\$10,000	\$5,000/\$10,000
\$40/\$60 Copayment <sup>3</sup>	\$20/\$40 Copayment <sup>3</sup>	\$40/\$60 Copayment <sup>3</sup>	\$40/\$60 Copayment <sup>3</sup>	\$20/\$40 Copayment <sup>3</sup>	\$40/\$60 Copayment <sup>3</sup>
Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
\$40/\$60 Copayment <sup>3</sup>	\$20/\$40 Copayment <sup>3</sup>	\$40/\$60 Copayment <sup>3</sup>	\$40/\$60 Copayment <sup>3</sup>	\$20/\$40 Copayment <sup>3</sup>	\$40/\$60 Copayment <sup>3</sup>
Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
Paid in full	Paid in full	\$40 Copayment	Paid in full	Paid in full	Paid in full
Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
\$500 per admission	\$300 per admission after Deductible	\$1,000 per admission	40% Copayment <sup>6</sup>	30% Copayment <sup>6</sup> after Deductible	30% Copayment <sup>6</sup> after Deductible
\$800 per day, up to 4 days per admission	\$500 per day after Deductible	Paid in full after Deductible	40% Copayment <sup>6</sup>	30% Copayment <sup>6</sup> after Deductible	30% Copayment <sup>6</sup> after Deductible
Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
\$200 per day	\$200 per day	\$300 per day	40% Copayment <sup>6</sup>	30% Copayment <sup>6</sup> after Deductible	30% Copayment <sup>6</sup> after Deductible
\$150 Copayment	\$150 Copayment	\$150 Copayment	\$150 Copayment	\$150 Copayment	\$150 Copayment
\$75 Copayment	\$75 Copayment	\$75 Copayment	\$75 Copayment	\$75 Copayment	\$75 Copayment
\$50 Copayment	\$50 Copayment	\$50 Copayment	\$50 Copayment	\$50 Copayment	\$50 Copayment
\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>	\$70 Copayment per item <sup>4</sup> (\$5,000 maximum benefit per Calendar Year)	\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>
\$250 per admission	\$250 per admission	\$250 per admission	40% Copayment <sup>6</sup>	30% Copayment <sup>6</sup>	30% Copayment <sup>6</sup>
\$40 Copayment	\$40 Copayment	\$40 Copayment	\$40 Copayment	\$40 Copayment	\$40 Copayment
\$15 per visit	\$15 per visit	\$15 per visit	\$15 per visit	\$15 per visit	\$15 per visit
Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup> after Deductible	\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup>
\$20/\$35/\$50	\$20/\$35/\$50	\$20/\$35/\$50	\$20/\$35/\$50	\$20/\$35/\$50	\$20/\$35/\$50
\$150 brand-name deductible	\$150 brand-name deductible	\$150 brand-name deductible	\$150 brand-name deductible	\$150 brand-name deductible	\$150 brand-name deductible
\$10 Copayment	\$10 Copayment	\$10 Copayment	\$10 Copayment	\$10 Copayment	\$10 Copayment
\$250 per admission	\$250 per admission	\$250 per admission	40% Copayment <sup>6</sup>	30% Copayment <sup>6</sup>	30% Copayment <sup>6</sup>
\$40 Copayment	\$40 Copayment	\$40 Copayment	\$40 Copayment	\$40 Copayment	\$40 Copayment

4 In instances where the contracted rate is less than your Copayment, you will pay only the contracted rate.

5 Refer to the Supplement to the Combined Evidence of Coverage and Disclosure Form for Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED) for coverage details.

6 Percentage Copayment amounts are based upon UnitedHealthcare's contracted rate.

7 Refer to the Supplement to the Combined Evidence of Coverage and Disclosure Form and Pharmacy Schedule of Benefits for Outpatient Prescription Drug Benefits for coverage details.

# New – UnitedHealthcare SignatureValue™ Flex (HMO) Plans

SignatureValue Flex Plans	SignatureValue Flex Package A			SignatureValue Flex Package B
	15-30/300a	20-40/300d	30-40/500d	20-40/300d
<b>Annual Deductible</b> (individual/family)	None	None	None	None
<b>Lifetime Maximum</b>	None	None	None	None
<b>Annual Copayment Maximum<sup>1</sup></b> (individual/family)	\$1500/\$3000	\$2000/\$4000	\$3000/\$6000	\$2000/\$4000
<b>Annual Out-of-Pocket Maximum<sup>2</sup></b> (individual/family)	NA	NA	NA	NA
<b>Professional Services</b>				
<b>Office Visits</b> (PCP/Specialist)	\$15/\$30 Copayment <sup>3</sup>	\$20/\$40 Copayment <sup>3</sup>	\$30/\$40 Copayment <sup>3</sup>	\$20/\$40 Copayment <sup>3</sup>
<b>Periodic Health Evaluations</b>	\$15 Copayment	\$20 Copayment	\$30 Copayment	\$20 Copayment
<b>Vision and Hearing Screening</b>	\$15/\$30 Copayment <sup>3</sup>	\$20/\$40 Copayment <sup>3</sup>	\$30/\$40 Copayment <sup>3</sup>	\$20/\$40 Copayment <sup>3</sup>
<b>Laboratory and Radiology</b> (standard)	Paid in full	Paid in full	Paid in full	Paid in full
<b>Maternity Care</b>	Paid in full	Paid in full	Paid in full	Paid in full
<b>Well-Baby Care</b> (up to age 2)	Paid in full	Paid in full	Paid in full	Paid in full
<b>Well-Woman Care</b>	\$15 Copayment	\$20 Copayment	\$30 Copayment	\$20 Copayment
<b>Outpatient Services</b>				
<b>Outpatient Surgery</b>	\$250 per admission	\$300 per admission	\$400 per admission	\$300 per admission
<b>Hospitalization Services</b>				
<b>Inpatient Hospital Benefits</b>	\$300 per admission	\$300 per day, up to 2 days per admission	\$500 per day, up to 4 days per admission	\$300 per day, up to 2 days per admission
<b>Inpatient Physician Care</b>	Paid in full	Paid in full	Paid in full	Paid in full
<b>Skilled Nursing Facility Care</b> (up to 100 consecutive calendar days from first treatment per disability)	\$100 per day	\$200 per day	\$200 per day	\$200 per day
<b>Emergency Health Coverage</b>				
<b>Emergency Services</b> (Copayment waived if admitted)	\$150 Copayment	\$150 Copayment	\$150 Copayment	\$150 Copayment
<b>Urgently Needed Services</b> (Copayment waived if admitted)	\$75 Copayment	\$75 Copayment	\$75 Copayment	\$75 Copayment
<b>Ambulance Services</b>	Paid in full	\$50 Copayment	\$50 Copayment	\$50 Copayment
<b>Durable Medical Equipment (DME)</b>				
<b>Durable Medical Equipment</b> (\$2,000 Maximum Benefit per Calendar Year. The annual DME benefit maximum does not apply to nebulizers, masks, tubing and peak flow meters for the treatment of asthma for Dependent children under the age of 19.)	\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>
<b>Mental Health Services</b>				
<b>Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED)<sup>5</sup></b>				
■ Inpatient	\$250 per admission	\$250 per admission	\$250 per admission	\$250 per admission
■ Outpatient	\$30 Copayment	\$40 Copayment	\$40 Copayment	\$40 Copayment
<b>Substance Use Disorder Services</b>				
<b>Substance Use Disorder</b> (Detoxification only)				
■ Inpatient	\$300 per admission	\$300 per day, up to 2 days per admission	\$500 per day, up to 4 days per admission	\$300 per day, up to 2 days per admission
■ Outpatient	\$30 Copayment	\$40 Copayment	\$40 Copayment	\$40 Copayment
<b>Home Health Services</b>				
<b>Home Health Care: Home Visits by a Licensed Professional</b> (Up to 100 visits per Calendar Year)	\$15 per visit	\$15 per visit	\$15 per visit	\$15 per visit
<b>Other Services</b>				
<b>Infertility Services</b>	50% of cost Copayment <sup>6</sup>	Not covered	Not covered	Not covered
<b>Injectable Drugs</b> (Copayment not applicable to allergy serum, immunizations, birth control, infertility and insulin)	\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup>
<b>Outpatient Prescription Drug Coverage<sup>7</sup></b>				
<b>Generic Formulary/Brand-Name Formulary/Non-Formulary</b>	\$15/\$35/\$50	\$20/\$35/\$50	\$20/\$35/\$50	\$15/\$35/\$50
<b>Calendar Year Deductible</b> (per member)	\$150 Brand-Name deductible	\$150 Brand-Name deductible	\$150 Brand-Name deductible	\$150 Brand-Name deductible
<b>Optional Group Coverage</b>				
<b>Chiropractic/Acupuncture Offered Through OptumHealth Care Solutions, Inc.</b> (maximum 30 visits per Calendar Year)	\$10 Copayment	\$10 Copayment	\$10 Copayment	\$10 Copayment
<b>Substance Use Disorder Services</b> Offered Through U.S. Behavioral Health Plan, California				
■ Inpatient	\$250 per admission	\$250 per admission	\$250 per admission	\$250 per admission
■ Outpatient	\$30 Copayment	\$40 Copayment	\$40 Copayment	\$40 Copayment

<sup>1</sup> Annual Copayment Maximum does not include Copayments for durable medical equipment (except for diabetic supplies and nebulizers, peak flow meters, face masks and tubing for the medically necessary treatment of pediatric asthma), pharmacy and supplemental benefits.

<sup>2</sup> Copayments for certain types of Covered Services do not apply toward the Out-of-Pocket Maximum. Please refer to the Schedule of Benefits to determine applicability to the plan. The Out-of-Pocket Maximum does not include Copayments for durable medical equipment (except for diabetic supplies and nebulizers, peak flow meters, face masks and tubing for the medically necessary treatment of pediatric asthma), pharmacy and supplemental benefits.

SignatureValue Flex Package B		SignatureValue Flex Package C			SignatureValue Flex Package D		
30-40/500d	40-60/800d	30-40/500d	40-60/800d	40-60/60%	40-60/800d	40-60/60%	20-40/70%/1500ded
None	None	None	None	None	None	None	\$1500/\$3000
None	None	None	None	None	None	None	None
\$3000/\$6000	\$4000/\$8000	\$3000/\$6000	\$4000/\$8000	\$5000/\$10,000	\$4000/\$8000	\$5000/\$10,000	NA
NA	NA	NA	NA	NA	NA	NA	\$5000/\$10,000
\$30/\$40 Copayment <sup>3</sup>	\$40/\$60 Copayment <sup>3</sup>	\$30/\$40 Copayment <sup>3</sup>	\$40/\$60 Copayment <sup>3</sup>	\$40/\$60 Copayment <sup>3</sup>	\$40/\$60 Copayment <sup>3</sup>	\$40/\$60 Copayment <sup>3</sup>	\$20/\$40 Copayment <sup>3</sup>
\$30 Copayment	\$40 Copayment	\$30 Copayment	\$40 Copayment	\$40 Copayment	\$40 Copayment	\$40 Copayment	\$20 Copayment
\$30/\$40 Copayment <sup>3</sup>	\$40/\$60 Copayment <sup>3</sup>	\$30/\$40 Copayment <sup>3</sup>	\$40/\$60 Copayment <sup>3</sup>	\$40/\$60 Copayment <sup>3</sup>	\$40/\$60 Copayment <sup>3</sup>	\$40/\$60 Copayment <sup>3</sup>	\$20/\$40 Copayment <sup>3</sup>
Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
\$30 Copayment	\$40 Copayment	\$30 Copayment	\$40 Copayment	\$40 Copayment	\$40 Copayment	\$40 Copayment	\$20 Copayment
\$400 per admission	\$500 per admission	\$400 per admission	\$500 per admission	40% Copayment <sup>6</sup>	\$500 per admission	40% Copayment <sup>6</sup>	30% Copayment <sup>6</sup> after Deductible
\$500 per day, up to 4 days per admission	\$800 per day, up to 4 days per admission	\$500 per day, up to 4 days per admission	\$800 per day, up to 4 days per admission	40% Copayment <sup>6</sup>	\$800 per day, up to 4 days per admission	40% Copayment <sup>6</sup>	30% Copayment <sup>6</sup> after Deductible
Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
\$200 per day	\$200 per day	\$200 per day	\$200 per day	40% Copayment <sup>6</sup>	\$200 per day	40% Copayment <sup>6</sup>	30% Copayment <sup>6</sup> after Deductible
\$150 Copayment	\$150 Copayment	\$150 Copayment	\$150 Copayment	\$150 Copayment	\$150 Copayment	\$150 Copayment	\$150 Copayment
\$75 Copayment	\$75 Copayment	\$75 Copayment	\$75 Copayment	\$75 Copayment	\$75 Copayment	\$75 Copayment	\$75 Copayment
\$50 Copayment	\$50 Copayment	\$50 Copayment	\$50 Copayment	\$50 Copayment	\$50 Copayment	\$50 Copayment	\$50 Copayment
\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>
\$250 per admission	\$250 per admission	\$250 per admission	\$250 per admission	\$250 per admission	\$250 per admission	\$250 per admission	\$250 per admission
\$40 Copayment	\$60 Copayment	\$40 Copayment	\$60 Copayment	\$60 Copayment	\$60 Copayment	\$60 Copayment	\$40 Copayment
\$500 per day, up to 4 days per admission	\$800 per day, up to 4 days per admission	\$500 per day, up to 4 days per admission	\$800 per day, up to 4 days per admission	40% Copayment <sup>6</sup>	\$800 per day, up to 4 days per admission	40% Copayment <sup>6</sup>	30% Copayment <sup>6</sup> after Deductible
\$40 Copayment	\$60 Copayment	\$40 Copayment	\$60 Copayment	\$60 Copayment	\$60 Copayment	\$60 Copayment	\$40 Copayment
\$15 per visit	\$15 per visit	\$15 per visit	\$15 per visit	\$15 per visit	\$15 per visit	\$15 per visit	\$15 per visit
Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup>	\$150 Copayment <sup>4</sup>
\$20/\$35/\$50	\$20/\$35/\$50	\$15/\$35/\$50	\$20/\$35/\$50	\$20/\$35/\$50	\$15/\$35/\$50	\$20/\$35/\$50	\$20/\$35/\$50
\$150 Brand-Name deductible	\$150 Brand-Name deductible	\$150 Brand-Name deductible	\$150 Brand-Name deductible	\$150 Brand-Name deductible	\$150 Brand-Name deductible	\$150 Brand-Name deductible	\$150 Brand-Name deductible
\$10 Copayment	\$10 Copayment	\$10 Copayment	\$10 Copayment	\$10 Copayment	\$10 Copayment	\$10 Copayment	\$10 Copayment
\$250 per admission	\$250 per admission	\$250 per admission	\$250 per admission	40% Copayment <sup>6</sup>	\$250 per admission	40% Copayment <sup>6</sup>	30% Copayment <sup>6</sup>
\$40 Copayment	\$40 Copayment	\$40 Copayment	\$40 Copayment	\$40 Copayment	\$40 Copayment	\$40 Copayment	\$40 Copayment

<sup>3</sup> Copayment for audiologist and podiatrist visits will be the same as for the PCP.

<sup>4</sup> In instances where the contracted rate is less than your Copayment, you will pay only the contracted rate.

<sup>5</sup> Refer to the Supplement to the Combined Evidence of Coverage and Disclosure Form for Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED) for coverage details.

<sup>6</sup> Percentage Copayment amounts are based upon PacifiCare's contracted rate.

<sup>7</sup> Refer to the Supplement to the Combined Evidence of Coverage and Disclosure Form and Pharmacy Schedule of Benefits for Outpatient Prescription Drug Benefits for coverage details.

# UnitedHealthcare SignatureValue™ featuring the HealthCare Partners Network (HMO) Plans

	25-75/500ded	25-50/500ded	25-75/1500ded
<b>Annual Deductible</b> (individual/family)	\$500/\$1000	\$500/\$1000	\$1500/\$3000
<b>Lifetime Maximum</b>	None	None	None
<b>Annual Copayment Maximum</b> (individual/family)	NA	NA	NA
<b>Annual Out-of-Pocket Maximum<sup>1</sup></b> (individual/family)	\$1500/\$3000	\$4000/\$8000	\$4000/\$8000
<b>PCP Office Visit Deductible Maximum<sup>2</sup></b>	\$85 Deductible Maximum per visit	\$50 Deductible Maximum per visit	\$85 Deductible Maximum per visit
<b>Specialist Office Visit Deductible Maximum<sup>2</sup></b>	\$200 Deductible Maximum per visit	\$100 Deductible Maximum per visit	\$200 Deductible Maximum per visit
<b>Professional Services</b>			
<b>Office Visits</b> (PCP/Specialist)	\$25/\$75 Copayment <sup>3</sup> after Deductible	\$25/\$50 Copayment <sup>3</sup> after Deductible	\$25/\$75 Copayment <sup>3</sup> after Deductible
<b>Periodic Health Evaluations</b>	Paid in full	Paid in full	Paid in full
<b>Refractions and Hearing Exams</b>	\$25/\$75 Copayment <sup>3</sup> after Deductible	\$25/\$50 Copayment <sup>3</sup> after Deductible	\$25/\$75 Copayment <sup>3</sup> after Deductible
<b>Laboratory and Radiology</b> (standard)	Paid in full	Paid in full	Paid in full
<b>Maternity Care</b>	\$25 Copayment	\$25 Copayment	\$25 Copayment
<b>Well-Baby Care</b> (up to age 2)	Paid in full	Paid in full	Paid in full
<b>Well-Woman Care</b>	Paid in full	Paid in full	Paid in full
<b>Outpatient Services</b>			
<b>Outpatient Surgery</b>	20% of cost Copayment <sup>6</sup> after Deductible	20% of cost Copayment <sup>6</sup> after Deductible	40% of cost Copayment <sup>6</sup> after Deductible
<b>Hospitalization Services</b>			
<b>Inpatient Hospital Benefits</b>	20% of cost Copayment <sup>6</sup> after Deductible	20% of cost Copayment <sup>6</sup> after Deductible	40% of cost Copayment <sup>6</sup> after Deductible
<b>Inpatient Physician Care</b>	Paid in full	Paid in full	Paid in full
<b>Skilled Nursing Facility Care</b> (up to 100 consecutive calendar days from first treatment per disability)	20% of cost Copayment <sup>6</sup> after Deductible	20% of cost Copayment <sup>6</sup> after Deductible	40% of cost Copayment <sup>6</sup> after Deductible
<b>Emergency Health Coverage</b>			
<b>Emergency Services</b> (Copayment waived if admitted)	20% of cost Copayment <sup>6</sup> after Deductible	20% of cost Copayment <sup>6</sup> after Deductible	40% of cost Copayment <sup>6</sup> after Deductible
<b>Urgently Needed Services</b> (Copayment waived if admitted)	20% of cost Copayment <sup>6</sup> after Deductible	20% of cost Copayment <sup>6</sup> after Deductible	40% of cost Copayment <sup>6</sup> after Deductible
<b>Ambulance Services</b>	\$50 Copayment	\$50 Copayment	\$50 Copayment
<b>Durable Medical Equipment</b>			
<b>Durable Medical Equipment</b> (\$2,000 Maximum Benefit per Calendar Year. The annual DME benefit maximum does not apply to nebulizers, masks, tubing and peak flow meters for the treatment of asthma for Dependent children under the age of 19.)	\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>	\$50 Copayment per item <sup>4</sup>
<b>Mental Health Services</b>			
<b>Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED)<sup>5</sup></b>			
■ Inpatient	20% of cost Copayment <sup>6</sup>	20% of cost Copayment <sup>6</sup>	40% of cost Copayment <sup>6</sup>
■ Outpatient	\$40 Copayment	\$40 Copayment	\$40 Copayment
<b>Home Health Services</b>			
<b>Home Health Care: Home Visits by a Licensed Professional</b> (up to 100 visits per Calendar Year)	\$15 per visit	\$15 per visit	\$15 per visit
<b>Other Services</b>			
<b>Infertility Services</b>	Not covered	Not covered	Not covered
<b>Injectable Drugs</b> (Copayment not applicable to allergy serum, immunizations, birth control, infertility and insulin)	\$100 Copayment <sup>4</sup> after Deductible	\$100 Copayment <sup>4</sup> after Deductible	\$200 Copayment <sup>4</sup> after Deductible
<b>Outpatient Prescription Drug Coverage<sup>7</sup></b>			
<b>Generic Formulary/Brand-Name Formulary/Non-Formulary</b>	\$15/\$35/\$50	\$15/\$35/\$50	\$15/\$35/\$50
<b>Calendar Year Deductible</b> (per member)	\$150 brand-name deductible	\$150 brand-name deductible	\$150 brand-name deductible
<b>Optional Group Coverage</b>			
<b>Chiropractic/Acupuncture Offered Through OptumHealth Care Solutions, Inc.</b> (maximum 30 visits per Calendar Year)	\$10 Copayment	\$10 Copayment	\$10 Copayment
<b>Substance Use Disorder Services</b> Offered Through U.S. Behavioral Health Plan, California			
■ Inpatient	20% of cost Copayment <sup>6</sup>	20% of cost Copayment <sup>6</sup>	40% of cost Copayment <sup>6</sup>
■ Outpatient	\$40 Copayment	\$40 Copayment	\$40 Copayment

1 Copayments for certain types of Covered Services do not apply toward the Out-of-Pocket Maximum. Please refer to the *Schedule of Benefits* to determine applicability to the plan. The Out-of-Pocket Maximum does not include Copayments for durable medical equipment (except for diabetic supplies and nebulizers, peak flow meters, face masks and tubing Medically Necessary for the treatment of pediatric asthma), infertility services, pharmacy and supplemental benefits.

2 When the calendar year deductible has not been met, only the applicable PCP Office Visit Deductible Maximum or Specialist Office Visit Deductible Maximum will be required per office visit. When the calendar year deductible is met, the specified office visit Copayment will apply. If the actual cost of the services received from the PCP or Specialist is below the PCP or Specialist Office Visit Deductible Maximum, the lower amount will be charged.

3 Copayment for audiologist and podiatrist visits will be the same as for the PCP.

4 In instances where the contracted rate is less than your Copayment, you will pay only the contracted rate.

5 Refer to the *Supplement to the Combined Evidence of Coverage and Disclosure Form* for Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED) for coverage details.

6 Percentage Copayment amounts are based upon UnitedHealthcare's contracted rate.

7 Refer to the *Supplement to the Combined Evidence of Coverage and Disclosure Form* and *Pharmacy Schedule of Benefits* for Outpatient Prescription Drug Benefits for coverage details.

# Notes

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The UnitedHealthcare Health Savings Account (HSA) high deductible health plan (HDHP) is designed to comply with IRS requirements so eligible enrollees may open a Health Savings Account with a bank of their choice or through OptumHealth Bank, Member of FDIC. "UnitedHealthcare HSA" refers generally to the UnitedHealthcare HSA product, which includes a HDHP, although at times "UnitedHealthcare HSA" may refer only and specifically to the UnitedHealthcare Health Savings Account, provided in conjunction with OptumHealth Bank and not to the associated HDHP. UnitedHealthcare's Health Reimbursement Account, or HRA, combines the flexibility of a medical benefit plan with an employer-funded reimbursement account.

Health plan coverage provided by or through UnitedHealthcare Insurance Company and UnitedHealthcare of California. Administrative services provided by PacifiCare Health Plan Administrators, Inc., Prescription Solutions or OptumHealth Care Solutions, Inc. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

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