

UnitedHealthcare - 2017 Multi-Choice Package E

Louisiana

1- 50 Eligible Employees

UnitedHealthcare Multi-ChoiceSM allows employers to purchase one health plan package that includes multiple benefit design options. Employees can be offered an array of health care coverage options to meet a variety of health care and financial needs. Best of all, our health care plans offer the full spectrum of value-added programs, as well as access to a robust nationwide physician network.

Plan Code	Metallic Tier	Deductible				Plan Coinsurance		Out of Pocket Maximum				Member Copay/Plan Coinsurance								Med Ded Type	Med/Rx Ded Type	Rx
		Network		Non-Network		Net-work	Non-Net-work	Network		Non- Network		Virtual Visits	PCP ¹	SPEC	UC	ER	Major Diag	OP Surg	IP Hosp			
		Single	Family	Single	Family			Single	Family	Single	Family											
Choice Plus - Includes Non-Network benefits																						
9F-X	Platinum	N/A	N/A	\$500	\$1,000	100%	70%	\$2,000	\$4,000	\$3,000	\$6,000	\$25	\$25	\$50	\$75	\$100	\$100	\$350	\$500/admit	Emb	Sep	088
AL-T9	Platinum	\$500	\$1,500	\$1,000	\$3,000	80%	60%	\$1,500	\$4,500	\$3,000	\$9,000	\$15	\$15	\$30	\$75	\$150	80%	80%	80%	Emb	Sep	B7
9F-W	Platinum	\$250	\$500	\$500	\$1,000	90%	70%	\$1,500	\$3,000	\$3,000	\$6,000	\$15	\$15	\$30	\$75	\$150	90%	90%	90%	Emb	Sep	088
AL-UH	Gold	N/A	N/A	\$5,000	\$10,000	100%	50%	\$7,150	\$14,300	\$18,000	\$36,000	\$25	\$30	\$70	\$100	\$400	\$400	\$1,250	\$1,250/day ²	Emb	Sep	437
AL-UJ	Gold	\$500	\$1,000	\$5,000	\$10,000	100%	80%	\$6,600	\$13,200	\$18,000	\$36,000	\$25	\$35	\$60	\$75	\$350	\$200	\$200	\$200/day ³	Emb	Sep	279
AL-UD	Gold	\$1,000	\$3,000	\$2,000	\$6,000	80%	60%	\$4,500	\$9,000	\$13,500	\$27,000	\$25	\$30	\$65	\$100	\$200	80%	80%	80%	Emb	Sep	088
AL-UI	Silver	N/A	N/A	\$5,000	\$10,000	100%	50%	\$7,150	\$14,300	\$18,000	\$36,000	\$25	\$45	\$100	\$125	\$750	\$750	\$2,250	\$2,250/day ⁴	Emb	Sep	436
AL-UC	Silver	\$3,000	\$6,000	\$6,000	\$12,000	80%	60%	\$7,150	\$14,300	\$14,300	\$28,600	\$25	\$50	\$100	80%	80%	80%	80%	80%	Emb	Sep	088
Choice Plus Health Savings Account (HSA)																						
AL-UB	Silver	\$2,500	\$5,000	\$5,000	\$10,000	100%	80%	\$6,500	\$6,850	\$13,000	\$26,000	\$25	\$25	\$50	\$100	\$200	\$350	\$300	\$500/admit	NonEmb	Comb	B7

- 1 Primary Care Physicians include Family Practice, Internal Medicine, Obstetrics-Gynecology, and Pediatrics.
- 2 For AL-UH: IP Copayment of \$1,250 per day to a maximum of \$3,750.
- 3 For AL-UJ: IP Copayment of \$200 per day to a maximum of \$1,000.
- 4 For AL-UI: IP Copayment of \$2,250 per day to a maximum of \$6,750.

In 2017, maximum HSA contribution is \$3,400 single/\$6,750 family. These amounts are subject to change by the IRS and do not include catch-up contributions for subscribers age 55 and over. 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 Optum BankSM, Member 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 Optum

For all medical plans listed deductible applies toward out-of-pocket max.
 All plans have unlimited lifetime max.
 All plans cover in-network preventive care at 100%.

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Plan Code	Metallic Tier	Network Coverage						Non-Network Coverage	Member Copay / Plan Coinsurance					Place-of-Service (Major Diag, Scopic Procedures & OP Surg)		Inpatient Hospital		Med Ded Type	Med/Rx Ded Type	Rx	
		Single Ded	Family Ded	Coins	Coins (without referral)	Single OOPM	Family OOPM		Virtual Visits	PCP ¹	SPEC (with referral) ²	UC	ER	Hospital or Freestanding Facility ³	Per-Occur Ded (Hosp)	IP Coins (with referral) ²	IP Per-Occur Ded				
Navigate- PCP designation required / Network only benefits																					
9H-5	Platinum	\$250	\$500	90%	N/A	\$1,000	\$2,000	N/A	\$20	\$20	\$40	\$75	\$150	90%	\$250	90%	\$250	Emb	Sep	088	
AL-UL	Gold	\$1,000	\$3,000	80%	N/A	\$4,000	\$8,000	N/A	\$25	\$25	\$50	\$100	\$350	80%	\$250	80%	\$250	Emb	Sep	088	
AL-UN	Silver	\$4,250	\$8,500	70%	N/A	\$7,150	\$14,300	N/A	\$25	\$30	\$60	\$100	\$350	70%	\$250	70%	\$250	Emb	Sep	NF	

Place of Service Overview

Service	Description	Member Pays	
		Hospital Setting	Freestanding Facility ³
Lab/X-ray	Routine lab and X-ray	Plan Coinsurance	100% (deductible waived)
Major Diagnostics	Services for CT scans, PET scans, MRIs, MRAs, nuclear medicine, and major diagnostic services received on an outpatient basis at a hospital or alternate facility	\$250 Copayment + Deductible/Coinsurance	Deductible/Coinsurance
Scopic Procedures - Outpatient Diagnostic	Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.		
Surgery - Outpatient	Surgery and related services received on an outpatient basis at a hospital or alternate facility		

Copayments are the charge or set dollar amount that members are required to pay for certain services per their benefit plans. In addition to office visit copayments, members may also be responsible for copayments when they visit a facility or hospital. Facility and hospital copayments are in addition to the calendar-year/policy-year deductible and coinsurance. Facility and hospital copayments do not apply to the deductible and continue to apply after the deductible is satisfied; they do apply to the out-of-pocket maximums. These copayments may be referred to in plan documents as "per-occurrence copayments" or "per-occurrence deductibles."

¹ Primary Care Physicians include Family Practice, Internal Medicine, Obstetrics-Gynecology, and Pediatrics.

² Primary Care Physician referral is required.

³ Freestanding facilities are any of the following: outpatient facility, diagnostic or ambulatory center, physician office or independent laboratory. At a freestanding facility, deductible and coinsurance still apply. See plan benefit information for further details.

For all medical plans listed deductible applies toward out-of-pocket max.

All plans have unlimited lifetime max.

All plans cover in-network preventive care at 100%.

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Plan Code	Metallic Tier	Network Coverage					Member Copay / Plan Coinsurance						Place-of-Service (Major Diag, Scopic Procedures & OP Surg)		Inpatient Hospital			Med Ded Type	Med/Rx Ded Type	Rx
		Single Ded	Family Ded	Coins	Single OOPM	Family OOPM	Virtual Visits	PCP ¹	Prem Desig SPEC ²	SPEC ³	UC	ER	Free-standing or Hosp	Per-Occur (Hospital)	Coins	Prem Desig Per-Occur Ded	Non-Prem Desig Per-Occur Ded			
Choice Advanced - Tiered benefits plan (Specialist, Hospital, Freestanding Facility) / Network only benefits																				
AL-US	Gold	\$500	\$1,000	80%	\$4,500	\$9,000	\$25	\$30	\$60	\$90	\$100	\$350	80%	\$500	80%	\$500	\$1000	Emb	Sep	088
AL-UQ	Gold	\$1,000	\$2,000	80%	\$4,000	\$8,000	\$25	\$30	\$60	\$90	\$100	\$350	80%	\$500	80%	\$500	\$1000	Emb	Sep	088
AL-UR	Silver	\$3,500	\$7,000	80%	\$7,150	\$14,300	\$25	\$30	\$60	\$90	\$100	\$350	80%	\$500	80%	\$500	\$1000	Emb	Sep	030

Place of Service Overview

Service	Description	Member Pays	
		Hospital Setting	Freestanding Facility ^{3,4}
Lab/X-ray	Routine lab and X-ray	Plan Coinsurance	100% (deductible waived)
Major Diagnostics	Services for CT scans, PET scans, MRIs, MRAs, nuclear medicine, and major diagnostic services received on an outpatient basis at a hospital or alternate facility	\$500 Copayment + Deductible/Coinsurance	Deductible/Coinsurance
Scopic Procedures - Outpatient Diagnostic	Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.		
Surgery - Outpatient	Surgery and related services received on an outpatient basis at a hospital or alternate facility		

Copayments are the charge or set dollar amount that members are required to pay for certain services per their benefit plans. In addition to office visit copayments, members may also be responsible for copayments when they visit a facility or hospital. Facility and hospital copayments are in addition to the calendar-year/policy-year deductible and coinsurance. Facility and hospital copayments do not apply to the deductible and continue to apply after the deductible is satisfied; they do apply to the out-of-pocket maximums. These copayments may be referred to in plan documents as "per-occurrence copayments" or "per-occurrence deductibles."

¹ Primary Care Physicians include Family Practice, Internal Medicine, Obstetrics-Gynecology, and Pediatrics.

² This enhanced benefit applies to UnitedHealth Premium specialists.

³ This benefit level applies to physicians in specialties where there is a UnitedHealth Premium program, but the physician is not a Premium Tier 1 specialist; or, where there is no UnitedHealth Premium program available; or, when the physician's specialty is not part of the UnitedHealth Premium program.

⁴ Freestanding facilities are any of the following: outpatient facility, diagnostic or ambulatory center, physician office or independent laboratory. At a freestanding facility, deductible and coinsurance still apply. See plan benefit information for further details.

Cost share will vary based on hospital tier designation. Hospital tier designations can be found at myuhc.com. Cost share will vary based on hospital tier designation. Hospital tier designations can be found at myuhc.com.

For all medical plans listed deductible applies toward out-of-pocket max.
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Plan Code	Metallic Tier	Deductible				Plan Coinsurance			Out of Pocket Maximum				Member Copay/Plan Coinsurance						Med Ded Type	Med/Rx Ded Type	Rx	
		Network		Non-Network					Network		Non- Network											
		Single	Family	Single	Family	Net-work	Other ¹	Non-Net-work	Single	Family	Single	Family	PCP ²	*Deductible first, then member co-payment*								
												SPEC	UC	ER	Major Diag	OP Surg	IP Hosp					
Primary Advantage Plans																						
AM-2I	Gold	\$1,000	\$2,000	\$2,000	\$4,000	100%	80%	70%	\$3,750	\$7,500	\$6,000	\$12,000	\$15	\$30	\$75	\$250	\$100	\$100	\$300	Emb	Sep	274A
AM-2J	Gold	\$1,000	\$2,000	\$1,500	\$3,000	100%	80%	70%	\$4,500	\$9,000	\$10,000	\$20,000	\$20	\$40	\$75	\$500	\$200	\$100	\$250	Emb	Sep	274A
AJ-HM	Silver	\$1,500	\$3,000	\$2,000	\$4,000	100%	80%	70%	\$6,800	\$13,600	\$10,000	\$20,000	\$35	\$70	\$100	\$350	\$500	\$500	\$1,000	Emb	Sep	272A
AM-2K	Silver	\$2,000	\$4,000	\$4,000	\$8,000	100%	80%	70%	\$6,850	\$13,700	\$10,000	\$20,000	\$20	\$50	\$100	\$350	\$300	\$300	\$750	Emb	Sep	272A

Primary Advantage - Advantage Prescription Drug List (PDL)

Rx Plan Code	Member Copay / Plan Coinsurance				Deductible		Mail Service Ratio (x Retail)
	Tier 1	Tier 2	Tier 3	Tier 4	Single	Family	
Separate Medical/Rx Deductible							
274A	\$10	\$35	\$60	\$100	N/A	N/A	3.0
272A	\$15	\$50	\$75	\$125	N/A	N/A	3.0

¹ "Other" coinsurance includes the following service categories: Ambulance, Skilled Nursing Facility, Allergy & Other Injections, Out-patient Chemotherapy, and Hospice. These services when provided in-network will be covered under the "Other" coinsurance category, after the network plan deductible has been satisfied. Eligible expenses will accrue towards the network out-of-pocket maximum.

² Primary Care Physicians (PCP) include Family Practice, Internal Medicine, Obstetrics-Gynecology, and Pediatrics. Services provided at the PCP office are included in the visit copayment. Member pays the copayment before the deductible.

- For all medical plans listed deductible applies toward out-of-pocket max.
- All plans have unlimited lifetime max.
- All plans cover in-network preventive care at 100%.
- Coinsurance percentages reflect plan responsibility.

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PLEASE NOTE: All pharmacy options below may not be available with every medical plan. Please refer to the Rx pairing listed with each medical plan.

Multi-Choice Package E - Pharmacy Plans

Pharmacy Standard Plans - Advantage Prescription Drug List (PDL)

Rx Plan Code	Member Copay / Plan Coinsurance				Deductible		Mail Service Ratio (x Retail)
	Tier 1	Tier 2	Tier 3	Tier 4	Single	Family	
Separate Medical/Rx Deductible							
B7	\$10	\$35	\$60	N/A	N/A	N/A	3.0
030	\$15	\$45	\$85	\$200	N/A	N/A	3.0
Combined Medical/Rx Deductible							
B7	\$10	\$35	\$60	N/A	Same as Medical	Same as Medical	3.0

Pharmacy SMCS Plans - Advantage Prescription Drug List (PDL)

Rx Plan Code	Member Copay / Plan Coinsurance							Deductible		Mail Service Ratio (x Retail)	
	Tier 1	Tier 1 Specialty	Tier 2	Tier 2 Specialty	Tier 3	Tier 3 Specialty	Tier 4	Tier 4 Specialty	Single		Family
Separate Medical/Rx Deductible											
437	\$10	\$10	\$35	\$100	\$60	\$150	N/A	N/A	N/A	N/A	3.0
NF	\$10	\$10	\$35	\$100	\$60	\$150	\$100	\$150	N/A	N/A	3.0
088	\$10	\$10	\$35	10%	\$75	20%	N/A	N/A	N/A	N/A	3.0
279	\$15	\$15	\$45	40%	\$85	45%	\$200	50%	N/A	N/A	3.0
436	\$20	\$20	\$65	\$100	\$100	\$150	\$200	\$150	N/A	N/A	3.0

For Rx plans with a Specialty copayment, please refer to the Specialty Medication Plan Designs for a list of specialty medications and tiers. For the most up-to-date drug coverage information, members may contact Customer Care by using the toll-free member phone number on the back of their health plan ID card; or they may log on to myuhc.com

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your provider's request and there is another drug that is chemically the same available at a lower tier.

For all medical and pharmacy plans, coinsurance percentages reflect plan responsibility.

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Premium rates and/or product forms included herein are subject to approval by regulators. If rates or product forms offered herein are subsequently modified by regulators we will immediately advise you of the change in plan design and retroactively adjust premium in subsequent billings.

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UnitedHealthcare - 2017 Multi-Choice Package F

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Plan Code	Metallic Tier	Deductible				Plan Coinsurance		Out of Pocket Maximum				Member Copay/Plan Coinsurance							Med Ded Type	Med/Rx Ded Type	Rx	
		Network		Non-Network		Net-work	Non-Net-work	Network		Non- Network		Virtual Visits	PCP ¹	SPEC	UC	ER	Major Diag	OP Surg				IP Hosp
		Single	Family	Single	Family			Single	Family	Single	Family											
Choice Plus - Includes Non-Network benefits																						
AL-UH	Gold	N/A	N/A	\$5,000	\$10,000	100%	50%	\$7,150	\$14,300	\$18,000	\$36,000	\$25	\$30	\$70	\$100	\$400	\$400	\$1,250	\$1,250/day ²	Emb	Sep	437
AL-UJ	Gold	\$500	\$1,000	\$5,000	\$10,000	100%	80%	\$6,600	\$13,200	\$18,000	\$36,000	\$25	\$35	\$60	\$75	\$350	\$200	\$200	\$200/day ³	Emb	Sep	279
AL-UD	Gold	\$1,000	\$3,000	\$2,000	\$6,000	80%	60%	\$4,500	\$9,000	\$13,500	\$27,000	\$25	\$30	\$65	\$100	\$200	80%	80%	80%	Emb	Sep	088
AL-UI	Silver	N/A	N/A	\$5,000	\$10,000	100%	50%	\$7,150	\$14,300	\$18,000	\$36,000	\$25	\$45	\$100	\$125	\$750	\$750	\$2,250	\$2,250/day ⁴	Emb	Sep	436
AL-UC	Silver	\$3,000	\$6,000	\$6,000	\$12,000	80%	60%	\$7,150	\$14,300	\$14,300	\$28,600	\$25	\$50	\$100	80%	80%	80%	80%	80%	Emb	Sep	088
AL-UA	Bronze	\$4,500	\$9,000	\$9,000	\$18,000	70%	50%	\$7,150	\$14,300	\$14,300	\$28,600	70%	70%	70%	70%	70%	70%	70%	70%	Emb	Comb	030
AL-UF	Bronze	\$7,150	\$14,300	\$12,000	\$24,000	100%	50%	\$7,150	\$14,300	\$20,000	\$40,000	100%	100%	100%	100%	100%	100%	100%	100%	Emb	Comb	C4
Choice Plus Health Savings Account (HSA)																						
AL-UB	Silver	\$2,500	\$5,000	\$5,000	\$10,000	100%	80%	\$6,500	\$6,850	\$13,000	\$26,000	\$25	\$25	\$50	\$100	\$200	\$350	\$300	\$500/admit	NonEmb	Comb	B7
AL-UE	Bronze	\$5,500	\$11,000	\$11,000	\$22,000	70%	50%	\$6,550	\$13,100	\$13,100	\$26,200	70%	70%	70%	70%	70%	70%	70%	70%	Emb	Comb	088

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- 4 For AL-UI: IP Copayment of \$2,250 per day to a maximum of \$6,750.

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		Single Ded	Family Ded	Coins	Coins (without referral)	Single OOPM	Family OOPM		Virtual Visits	PCP ¹	SPEC (with referral) ²	UC	ER	Hospital or Freestanding Facility ³	Per-Occur Ded (Hosp)	IP Coins (with referral) ²	IP Per-Occur Ded				
Navigate- PCP designation required / Network only benefits																					
AL-UL	Gold	\$1,000	\$3,000	80%	N/A	\$4,000	\$8,000	N/A	\$25	\$25	\$50	\$100	\$350	80%	\$250	80%	\$250	Emb	Sep	088	
AL-UM	Silver	\$2,000	\$4,000	60%	N/A	\$7,150	\$14,300	N/A	\$25	\$40	\$80	\$80	60%	60%	\$500	60%	\$500	Emb	Sep	030	
AL-UN	Silver	\$4,250	\$8,500	70%	N/A	\$7,150	\$14,300	N/A	\$25	\$30	\$60	\$100	\$350	70%	\$250	70%	\$250	Emb	Sep	NF	

Plan Code	Metallic Tier	Network Coverage						Member Copay / Plan Coinsurance						Place-of-Service (Major Diag, Scopic Procedures & OP Surg)		Inpatient Hospital		Med Ded Type	Med/Rx Ded Type	Rx	
		Single Ded	Family Ded	Coins	Single OOPM	Family OOPM	Virtual Visits	PCP ¹ (Desig Net)	PCP ¹	SPEC ² (Desig Net, with referral)	SPEC (with referral) ²	UC	ER	Hospital or Freestanding Facility ³	Per-Occur Ded (Hosp)	IP Coins (with referral) ²	IP Per-Occur Ded				
Navigate – Tiered / PCP designation required / Network only benefits																					
AL-Z3	Gold	\$1,000	\$2,000	80%	\$3,500	\$7,000	\$25	\$25	\$50	\$50	\$75	\$100	\$250	80%	\$500	80%	\$500	Emb	Sep	418	
AL-Z4	Gold	\$2,000	\$4,000	80%	\$4,250	\$8,500	\$25	\$25	\$50	\$50	\$75	\$100	\$250	80%	\$500	80%	\$500	Emb	Sep	418	
AL-Z5	Silver	\$3,750	\$7,500	80%	\$7,150	\$14,300	\$25	\$25	\$50	\$50	\$75	\$100	\$250	80%	\$500	80%	\$500	Emb	Sep	418	

Place of Service Overview

Service	Description	Member Pays	
		Hospital Setting	Freestanding Facility ³
Lab/X-ray	Routine lab and X-ray	Plan Coinsurance	100% (deductible waived)
Major Diagnostics	Services for CT scans, PET scans, MRIs, MRAs, nuclear medicine, and major diagnostic services received on an outpatient basis at a hospital or alternate facility	\$250 Copayment + Deductible/Coinsurance	Deductible/Coinsurance
Scopic Procedures - Outpatient Diagnostic	Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.		
Surgery - Outpatient	Surgery and related services received on an outpatient basis at a hospital or alternate facility		

Copayments are the charge or set dollar amount that members are required to pay for certain services per their benefit plans. In addition to office visit copayments, members may also be responsible for copayments when they visit a facility or hospital. Facility and hospital copayments are in addition to the calendar-year/policy-year deductible and coinsurance. Facility and hospital copayments do not apply to the deductible and continue to apply after the deductible is satisfied; they do apply to the out-of-pocket maximums. These copayments may be referred to in plan documents as "per-occurrence copayments" or "per-occurrence deductibles."

¹ Primary Care Physicians include Family Practice, Internal Medicine, Obstetrics-Gynecology, and Pediatrics.

² Primary Care Physician referral is required.

³ Freestanding facilities are any of the following: outpatient facility, diagnostic or ambulatory center, physician office or independent laboratory. At a freestanding facility, deductible and coinsurance still apply. See plan benefit information for further details.

For all medical plans listed deductible applies toward out-of-pocket max.

All plans have unlimited lifetime max.

All plans cover in-network preventive care at 100%.

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UnitedHealthcare - 2017 Multi-Choice Package F

Louisiana

1- 50 Eligible Employees

UnitedHealthcare Multi-ChoiceSM allows employers to purchase one health plan package that includes multiple benefit design options. Employees can be offered an array of health care coverage options to meet a variety of health care and financial needs. Best of all, our health care plans offer the full spectrum of value-added programs, as well as access to a robust nationwide physician network.

Plan Code	Metallic Tier	Network Coverage					Member Copay / Plan Coinsurance						Place-of-Service (Major Diag, Scopic Procedures & OP Surg)		Inpatient Hospital			Med Ded Type	Med/Rx Ded Type	Rx
		Single Ded	Family Ded	Coins	Single OOPM	Family OOPM	Virtual Visits	PCP ¹	Prem Desig SPEC ²	SPEC ³	UC	ER	Free-standing or Hosp	Per-Occur (Hospital)	Coins	Prem Desig Per-Occur Ded	Non-Prem Desig Per-Occur Ded			
Choice Advanced - Tiered benefits plan (Specialist, Hospital, Freestanding Facility) / Network only benefits																				
AL-US	Gold	\$500	\$1,000	80%	\$4,500	\$9,000	\$25	\$30	\$60	\$90	\$100	\$350	80%	\$500	80%	\$500	\$1000	Emb	Sep	088
AL-UQ	Gold	\$1,000	\$2,000	80%	\$4,000	\$8,000	\$25	\$30	\$60	\$90	\$100	\$350	80%	\$500	80%	\$500	\$1000	Emb	Sep	088
AL-UR	Silver	\$3,500	\$7,000	80%	\$7,150	\$14,300	\$25	\$30	\$60	\$90	\$100	\$350	80%	\$500	80%	\$500	\$1000	Emb	Sep	030
AL-UT	Silver	\$5,500	\$11,000	70%	\$7,150	\$14,300	\$25	\$30	\$60	\$90	\$100	\$500	70%	\$500	70%	\$1,000	\$1,500	Emb	Sep	506

Place of Service Overview

Service	Description	Member Pays	
		Hospital Setting	Freestanding Facility ^{3,4}
Lab/X-ray	Routine lab and X-ray	Plan Coinsurance	100% (deductible waived)
Major Diagnostics	Services for CT scans, PET scans, MRIs, MRAs, nuclear medicine, and major diagnostic services received on an outpatient basis at a hospital or alternate facility	\$500 Copayment + Deductible/Coinsurance	Deductible/Coinsurance
Scopic Procedures - Outpatient Diagnostic	Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.		
Surgery - Outpatient	Surgery and related services received on an outpatient basis at a hospital or alternate facility		

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¹ Primary Care Physicians include Family Practice, Internal Medicine, Obstetrics-Gynecology, and Pediatrics.

² This enhanced benefit applies to UnitedHealth Premium specialists.

³ This benefit level applies to physicians in specialties where there is a UnitedHealth Premium program, but the physician is not a Premium Tier 1 specialist; or, where there is no UnitedHealth Premium program available; or, when the physician's specialty is not part of the UnitedHealth Premium program.

⁴ Freestanding facilities are any of the following: outpatient facility, diagnostic or ambulatory center, physician office or independent laboratory. At a freestanding facility, deductible and coinsurance still apply. See plan benefit information for further details.

Cost share will vary based on hospital tier designation. Hospital tier designations can be found at myuhc.com. Cost share will vary based on hospital tier designation. Hospital tier designations can be found at myuhc.com.

For all medical plans listed deductible applies toward out-of-pocket max.
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UnitedHealthcare - 2017 Multi-Choice Package F

Louisiana

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Plan Code	Metallic Tier	Deductible				Plan Coinsurance			Out of Pocket Maximum				Member Copay/Plan Coinsurance						Med Ded Type	Med/Rx Ded Type	Rx	
		Network		Non-Network					Network		Non- Network		*Deductible first, then member co-payment*									
		Single	Family	Single	Family	Net-work	Other ¹	Non-Net-work	Single	Family	Single	Family	PCP ²	SPEC	UC	ER	Major Diag	OP Surg				IP Hosp
Primary Advantage Plans																						
AM-2I	Gold	\$1,000	\$2,000	\$2,000	\$4,000	100%	80%	70%	\$3,750	\$7,500	\$6,000	\$12,000	\$15	\$30	\$75	\$250	\$100	\$100	\$300	Emb	Sep	274A
AM-2J	Gold	\$1,000	\$2,000	\$1,500	\$3,000	100%	80%	70%	\$4,500	\$9,000	\$10,000	\$20,000	\$20	\$40	\$75	\$500	\$200	\$100	\$250	Emb	Sep	274A
AJ-HM	Silver	\$1,500	\$3,000	\$2,000	\$4,000	100%	80%	70%	\$6,800	\$13,600	\$10,000	\$20,000	\$35	\$70	\$100	\$350	\$500	\$500	\$1,000	Emb	Sep	272A
AM-2K	Silver	\$2,000	\$4,000	\$4,000	\$8,000	100%	80%	70%	\$6,850	\$13,700	\$10,000	\$20,000	\$20	\$50	\$100	\$350	\$300	\$300	\$750	Emb	Sep	272A
AJ-HN	Silver	\$2,500	\$5,000	\$5,000	\$10,000	100%	80%	70%	\$6,000	\$12,000	\$10,000	\$20,000	\$25	\$50	\$100	\$250	\$500	\$500	\$750	Emb	Sep	272A
AM-2L	Bronze	\$4,750	\$9,500	\$5,000	\$10,000	100%	80%	70%	\$7,150	\$14,300	\$10,000	\$20,000	\$50	\$135	\$100	\$500	\$500	\$350	\$1,500	Emb	Sep	248A

Primary Advantage - Advantage Prescription Drug List (PDL)

Rx Plan Code	Member Copay / Plan Coinsurance				Deductible		Mail Service Ratio (x Retail)
	Tier 1	Tier 2	Tier 3	Tier 4	Single	Family	
Separate Medical/Rx Deductible							
274A	\$10	\$35	\$60	\$100	N/A	N/A	3.0
272A	\$15	\$50	\$75	\$125	N/A	N/A	3.0
248A	\$20	\$65	\$100	\$200	N/A	N/A	3.0

¹“Other” coinsurance includes the following service categories: Ambulance, Skilled Nursing Facility, Allergy & Other Injections, Out-patient Chemotherapy, and Hospice. These services when provided in-network will be covered under the “Other” coinsurance category, after the network plan deductible has been satisfied. Eligible expenses will accrue towards the network out-of-pocket maximum.

²Primary Care Physicians (PCP) include Family Practice, Internal Medicine, Obstetrics-Gynecology, and Pediatrics. Services provided at the PCP office are included in the visit copayment. Member pays the copayment before the deductible.

- For all medical plans listed deductible applies toward out-of-pocket max.
- All plans have unlimited lifetime max.
- All plans cover in-network preventive care at 100%.
- Coinsurance percentages reflect plan responsibility.

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UnitedHealthcare - 2017 Multi-Choice Package F

Louisiana

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PLEASE NOTE: All pharmacy options below may not be available with every medical plan. Please refer to the Rx pairing listed with each medical plan.

Multi-Choice Package F - Pharmacy Plans

Pharmacy Standard Plans - Advantage Prescription Drug List (PDL)

Rx Plan Code	Member Copay / Plan Coinsurance				Deductible		Mail Service Ratio (x Retail)
	Tier 1	Tier 2	Tier 3	Tier 4	Single	Family	
Separate Medical/Rx Deductible							
030	\$15	\$45	\$85	\$200	N/A	N/A	3.0
Combined Medical/Rx Deductible							
B7	\$10	\$35	\$60	N/A	Same as Medical	Same as Medical	3.0
030	\$15	\$45	\$85	\$200	Same as Medical	Same as Medical	3.0
C4	\$20	\$65	\$100	\$200	Same as Medical	Same as Medical	3.0

Essential Prescription Drug List (PDL)

Rx Plan Code	Member Copay / Plan Coinsurance				Deductible		Mail Service Ratio (x Retail)
	Tier 1	Tier 2	Tier 3	Tier 4	Single	Family	
Separate Medical/Rx Deductible							
418	\$10	\$40	\$140	\$300	N/A	N/A	3.0

Pharmacy SMCS Plans - Advantage Prescription Drug List (PDL)

Rx Plan Code	Member Copay / Plan Coinsurance							Deductible		Mail Service Ratio (x Retail)	
	Tier 1	Tier 1 Specialty	Tier 2	Tier 2 Specialty	Tier 3	Tier 3 Specialty	Tier 4	Tier 4 Specialty	Single		Family
Separate Medical/Rx Deductible											
437	\$10	\$10	\$35	\$100	\$60	\$150	N/A	N/A	N/A	N/A	3.0
NF	\$10	\$10	\$35	\$100	\$60	\$150	\$100	\$150	N/A	N/A	3.0
088	\$10	\$10	\$35	10%	\$75	20%	N/A	N/A	N/A	N/A	3.0
279	\$15	\$15	\$45	40%	\$85	45%	\$200	50%	N/A	N/A	3.0
436	\$20	\$20	\$65	\$100	\$100	\$150	\$200	\$150	N/A	N/A	3.0

For Rx plans with a Specialty copayment, please refer to the Specialty Medication Plan Designs for a list of specialty medications and tiers. For the most up-to-date drug coverage information, members may contact Customer Care by using the toll-free member phone number on the back of their health plan ID card; or they may log on to myuhc.com

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your provider's request and there is another drug that is chemically the same available at a lower tier.

For all medical and pharmacy plans, coinsurance percentages reflect plan responsibility.

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Premium rates and/or product forms included herein are subject to approval by regulators. If rates or product forms offered herein are subsequently modified by regulators we will immediately advise you of the change in plan design and retroactively adjust premium in subsequent billings.

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UnitedHealthcare - 2017 Multi-Choice Package G

Louisiana

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Plan Code	Metallic Tier	Deductible				Plan Coinsurance		Out of Pocket Maximum				Member Copay/Plan Coinsurance								Med Ded Type	Med/Rx Ded Type	Rx
		Network		Non-Network		Net-work	Non-Net-work	Network		Non- Network		Virtual Visits	PCP ¹	SPEC	UC	ER	Major Diag	OP Surg	IP Hosp			
		Single	Family	Single	Family			Single	Family	Single	Family											
Choice Plus - Includes Non-Network benefits																						
AL-UD	Gold	\$1,000	\$3,000	\$2,000	\$6,000	80%	60%	\$4,500	\$9,000	\$13,500	\$27,000	\$25	\$30	\$65	\$100	\$200	80%	80%	80%	Emb	Sep	088
AL-UC	Silver	\$3,000	\$6,000	\$6,000	\$12,000	80%	60%	\$7,150	\$14,300	\$14,300	\$28,600	\$25	\$50	\$100	80%	80%	80%	80%	80%	Emb	Sep	088
AL-UA	Bronze	\$4,500	\$9,000	\$9,000	\$18,000	70%	50%	\$7,150	\$14,300	\$14,300	\$28,600	70%	70%	70%	70%	70%	70%	70%	70%	Emb	Comb	030
AL-UF	Bronze	\$7,150	\$14,300	\$12,000	\$24,000	100%	50%	\$7,150	\$14,300	\$20,000	\$40,000	100%	100%	100%	100%	100%	100%	100%	100%	Emb	Comb	C4
Choice Plus Health Savings Account (HSA)																						
AL-UB	Silver	\$2,500	\$5,000	\$5,000	\$10,000	100%	80%	\$6,500	\$6,850	\$13,000	\$26,000	\$25	\$25	\$50	\$100	\$200	\$350	\$300	\$500/admit	NonEmb	Comb	B7
AL-UE	Bronze	\$5,500	\$11,000	\$11,000	\$22,000	70%	50%	\$6,550	\$13,100	\$13,100	\$26,200	70%	70%	70%	70%	70%	70%	70%	70%	Emb	Comb	088

1 Primary Care Physicians include Family Practice, Internal Medicine, Obstetrics-Gynecology, and Pediatrics.

In 2017, maximum HSA contribution is \$3,400 single/\$6,750 family. These amounts are subject to change by the IRS and do not include catch-up contributions for subscribers age 55 and over. 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 Optum BankSM, Member 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 Optum

For all medical plans listed deductible applies toward out-of-pocket max.
 All plans have unlimited lifetime max.
 All plans cover in-network preventive care at 100%.

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Plan Code	Metallic Tier	Network Coverage						Non-Network Coverage	Member Copay / Plan Coinsurance					Place-of-Service (Major Diag, Scopic Procedures & OP Surg)		Inpatient Hospital		Med Ded Type	Med/Rx Ded Type	Rx	
		Single Ded	Family Ded	Coins	Coins (without referral)	Single OOPM	Family OOPM		Virtual Visits	PCP ¹	SPEC (with referral) ²	UC	ER	Hospital or Freestanding Facility ³	Per-Occur Ded (Hosp)	IP Coins (with referral) ²	IP Per-Occur Ded				
Navigate- PCP designation required / Network only benefits																					
AL-UL	Gold	\$1,000	\$3,000	80%	N/A	\$4,000	\$8,000	N/A	\$25	\$25	\$50	\$100	\$350	80%	\$250	80%	\$250	Emb	Sep	088	
AL-UM	Silver	\$2,000	\$4,000	60%	N/A	\$7,150	\$14,300	N/A	\$25	\$40	\$80	\$80	60%	60%	\$500	60%	\$500	Emb	Sep	030	
AL-UN	Silver	\$4,250	\$8,500	70%	N/A	\$7,150	\$14,300	N/A	\$25	\$30	\$60	\$100	\$350	70%	\$250	70%	\$250	Emb	Sep	NF	

Place of Service Overview

Service	Description	Member Pays	
		Hospital Setting	Freestanding Facility ³
Lab/X-ray	Routine lab and X-ray	Plan Coinsurance	100% (deductible waived)
Major Diagnostics	Services for CT scans, PET scans, MRIs, MRAs, nuclear medicine, and major diagnostic services received on an outpatient basis at a hospital or alternate facility	\$250 Copayment + Deductible/Coinsurance	Deductible/Coinsurance
Scopic Procedures - Outpatient Diagnostic	Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.		
Surgery - Outpatient	Surgery and related services received on an outpatient basis at a hospital or alternate facility		

Copayments are the charge or set dollar amount that members are required to pay for certain services per their benefit plans. In addition to office visit copayments, members may also be responsible for copayments when they visit a facility or hospital. Facility and hospital copayments are in addition to the calendar-year/policy-year deductible and coinsurance. Facility and hospital copayments do not apply to the deductible and continue to apply after the deductible is satisfied; they do apply to the out-of-pocket maximums. These copayments may be referred to in plan documents as "per-occurrence copayments" or "per-occurrence deductibles."

¹ Primary Care Physicians include Family Practice, Internal Medicine, Obstetrics-Gynecology, and Pediatrics.

² Primary Care Physician referral is required.

³ Freestanding facilities are any of the following: outpatient facility, diagnostic or ambulatory center, physician office or independent laboratory. At a freestanding facility, deductible and coinsurance still apply. See plan benefit information for further details.

For all medical plans listed deductible applies toward out-of-pocket max.
All plans have unlimited lifetime max.
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Plan Code	Metallic Tier	Network Coverage					Member Copay / Plan Coinsurance						Place-of-Service (Major Diag, Scopic Procedures & OP Surg)		Inpatient Hospital			Med Ded Type	Med/Rx Ded Type	Rx
		Single Ded	Family Ded	Coins	Single OOPM	Family OOPM	Virtual Visits	PCP ¹	Prem Desig SPEC ²	SPEC ³	UC	ER	Free-standing or Hosp	Per-Occur (Hospital)	Coins	Prem Desig Per-Occur Ded	Non-Prem Desig Per-Occur Ded			
Choice Advanced - Tiered benefits plan (Specialist, Hospital, Freestanding Facility) / Network only benefits																				
AL-US	Gold	\$500	\$1,000	80%	\$4,500	\$9,000	\$25	\$30	\$60	\$90	\$100	\$350	80%	\$500	80%	\$500	\$1000	Emb	Sep	088
AL-UQ	Gold	\$1,000	\$2,000	80%	\$4,000	\$8,000	\$25	\$30	\$60	\$90	\$100	\$350	80%	\$500	80%	\$500	\$1000	Emb	Sep	088
AL-UR	Silver	\$3,500	\$7,000	80%	\$7,150	\$14,300	\$25	\$30	\$60	\$90	\$100	\$350	80%	\$500	80%	\$500	\$1000	Emb	Sep	030
AL-UT	Silver	\$5,500	\$11,000	70%	\$7,150	\$14,300	\$25	\$30	\$60	\$90	\$100	\$500	70%	\$500	70%	\$1,000	\$1,500	Emb	Sep	506

Place of Service Overview

Service	Description	Member Pays	
		Hospital Setting	Freestanding Facility ^{3,4}
Lab/X-ray	Routine lab and X-ray	Plan Coinsurance	100% (deductible waived)
Major Diagnostics	Services for CT scans, PET scans, MRIs, MRAs, nuclear medicine, and major diagnostic services received on an outpatient basis at a hospital or alternate facility	\$500 Copayment + Deductible/Coinsurance	Deductible/Coinsurance
Scopic Procedures - Outpatient Diagnostic	Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.		
Surgery - Outpatient	Surgery and related services received on an outpatient basis at a hospital or alternate facility		

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² This enhanced benefit applies to UnitedHealth Premium specialists.

³ This benefit level applies to physicians in specialties where there is a UnitedHealth Premium program, but the physician is not a Premium Tier 1 specialist; or, where there is no UnitedHealth Premium program available; or, when the physician's specialty is not part of the UnitedHealth Premium program.

⁴ Freestanding facilities are any of the following: outpatient facility, diagnostic or ambulatory center, physician office or independent laboratory. At a freestanding facility, deductible and coinsurance still apply. See plan benefit information for further details.

Cost share will vary based on hospital tier designation. Hospital tier designations can be found at myuhc.com. Cost share will vary based on hospital tier designation. Hospital tier designations can be found at myuhc.com.

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Plan Code	Metallic Tier	Deductible				Plan Coinsurance			Out of Pocket Maximum				Member Copay/Plan Coinsurance						Med Ded Type	Med/Rx Ded Type	Rx	
		Network		Non-Network					Network		Non- Network		*Deductible first, then member co-payment*									
		Single	Family	Single	Family	Net-work	Other ¹	Non-Net-work	Single	Family	Single	Family	PCP ²	SPEC	UC	ER	Major Diag	OP Surg				IP Hosp
Primary Advantage Plans																						
AM-2I	Gold	\$1,000	\$2,000	\$2,000	\$4,000	100%	80%	70%	\$3,750	\$7,500	\$6,000	\$12,000	\$15	\$30	\$75	\$250	\$100	\$100	\$300	Emb	Sep	274A
AM-2J	Gold	\$1,000	\$2,000	\$1,500	\$3,000	100%	80%	70%	\$4,500	\$9,000	\$10,000	\$20,000	\$20	\$40	\$75	\$500	\$200	\$100	\$250	Emb	Sep	274A
AJ-HM	Silver	\$1,500	\$3,000	\$2,000	\$4,000	100%	80%	70%	\$6,800	\$13,600	\$10,000	\$20,000	\$35	\$70	\$100	\$350	\$500	\$500	\$1,000	Emb	Sep	272A
AM-2K	Silver	\$2,000	\$4,000	\$4,000	\$8,000	100%	80%	70%	\$6,850	\$13,700	\$10,000	\$20,000	\$20	\$50	\$100	\$350	\$300	\$300	\$750	Emb	Sep	272A
AJ-HN	Silver	\$2,500	\$5,000	\$5,000	\$10,000	100%	80%	70%	\$6,000	\$12,000	\$10,000	\$20,000	\$25	\$50	\$100	\$250	\$500	\$500	\$750	Emb	Sep	272A
AM-2L	Bronze	\$4,750	\$9,500	\$5,000	\$10,000	100%	80%	70%	\$7,150	\$14,300	\$10,000	\$20,000	\$50	\$135	\$100	\$500	\$500	\$350	\$1,500	Emb	Sep	248A

Primary Advantage - Advantage Prescription Drug List (PDL)

Rx Plan Code	Member Copay / Plan Coinsurance				Deductible		Mail Service Ratio (x Retail)
	Tier 1	Tier 2	Tier 3	Tier 4	Single	Family	
Separate Medical/Rx Deductible							
274A	\$10	\$35	\$60	\$100	N/A	N/A	3.0
272A	\$15	\$50	\$75	\$125	N/A	N/A	3.0
248A	\$20	\$65	\$100	\$200	N/A	N/A	3.0

¹“Other” coinsurance includes the following service categories: Ambulance, Skilled Nursing Facility, Allergy & Other Injections, Out-patient Chemotherapy, and Hospice. These services when provided in-network will be covered under the “Other” coinsurance category, after the network plan deductible has been satisfied. Eligible expenses will accrue towards the network out-of-pocket maximum.

²Primary Care Physicians (PCP) include Family Practice, Internal Medicine, Obstetrics-Gynecology, and Pediatrics. Services provided at the PCP office are included in the visit copayment. Member pays the copayment before the deductible.

- For all medical plans listed deductible applies toward out-of-pocket max.
- All plans have unlimited lifetime max.
- All plans cover in-network preventive care at 100%.
- Co-insurance percentages reflect plan responsibility.

Please Note: The information in this grid is provided for informational purposes only and is not intended for use as a contract. For a complete listing of coverage and exclusions please refer to the Certificate of Coverage or talk to your UnitedHealthcare representative for additional details that could impact the benefits. Different UnitedHealthcare plans may have varying approaches to whether pharmacy costs are included or excluded from the medical deductible.

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UnitedHealthcare - 2017 Multi-Choice Package G

Louisiana

1- 50 Eligible Employees

UnitedHealthcare Multi-ChoiceSM allows employers to purchase one health plan package that includes multiple benefit design options. Employees can be offered an array of health care coverage options to meet a variety of health care and financial needs. Best of all, our health care plans offer the full spectrum of value-added programs, as well as access to a robust nationwide physician network.

PLEASE NOTE: All pharmacy options below may not be available with every medical plan. Please refer to the Rx pairing listed with each medical plan.

Multi-Choice Package G - Pharmacy Plans

Pharmacy Standard Plans - Advantage Prescription Drug List (PDL)

Rx Plan Code	Member Copay / Plan Coinsurance				Deductible		Mail Service Ratio (x Retail)
	Tier 1	Tier 2	Tier 3	Tier 4	Single	Family	
Separate Medical/Rx Deductible							
030	\$15	\$45	\$85	\$200	N/A	N/A	3.0
Combined Medical/Rx Deductible							
B7	\$10	\$35	\$60	N/A	Same as Medical	Same as Medical	3.0
030	\$15	\$45	\$85	\$200	Same as Medical	Same as Medical	3.0
C4	\$20	\$65	\$100	\$200	Same as Medical	Same as Medical	3.0

Pharmacy SMCS Plans - Advantage Prescription Drug List (PDL)

Rx Plan Code	Member Copay / Plan Coinsurance							Deductible		Mail Service Ratio (x Retail)	
	Tier 1	Tier 1 Specialty	Tier 2	Tier 2 Specialty	Tier 3	Tier 3 Specialty	Tier 4	Tier 4 Specialty	Single		Family
Separate Medical/Rx Deductible											
NF	\$10	\$10	\$35	\$100	\$60	\$150	\$100	\$150	N/A	N/A	3.0
088	\$10	\$10	\$35	10%	\$75	20%	N/A	N/A	N/A	N/A	3.0
506	\$20	\$20	\$65	40%	\$100	45%	\$200	50%	N/A	N/A	3.0
Combined Medical/Rx Deductible											
088	\$10	\$10	\$35	10%	\$75	20%	N/A	N/A	Same as Medical	Same as Medical	3.0

For Rx plans with a Specialty copayment, please refer to the Specialty Medication Plan Designs for a list of specialty medications and tiers. For the most up-to-date drug coverage information, members may contact Customer Care by using the toll-free member phone number on the back of their health plan ID card; or they may log on to myuhc.com

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your provider's request and there is another drug that is chemically the same available at a lower tier.

For all medical and pharmacy plans, coinsurance percentages reflect plan responsibility.

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Premium rates and/or product forms included herein are subject to approval by regulators. If rates or product forms offered herein are subsequently modified by regulators we will immediately advise you of the change in plan design and retroactively adjust premium in subsequent billings.

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