UnitedHealthcare Medical Summaries - Portfolio A

Plans effective October 1, 2024-September 30, 2025

Customers may pick plans from **either** Portfolio A **or** Portfolio B - plans cannot be mixed across Portfolios

Plan Details	UHC Essential	UHC Basic	UHC Basic Plus	UHC HDHP 2100	UHC HDHP 3500
Network:	UHC Choice Plus	UHC Choice Plus	UHC Choice Plus	UHC Choice Plus	UHC Choice Plus
	In-Network	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Primary Care/Specialist Copay:	$30/ $50	$30/ $50	$25/ $50	10% after deductible	0% after deductible
Calendar Year Deductible (Individual/Family):	$3,000/ $9,000	$1,000/ $3,000	$500/ $1,000	$2,100/ $4,200	$3,500/ $7,000
Coinsurance (% Plan Pays):	80%	80%	90%	90%	100%
OOP Max including Deductible (Individual/Family):	$5,000/ $15,000	$5,000/ $12,700	$3,000/ $6,000	$4,000/ $8,000	$6,450/ $12,900
Inpatient Hospital Copay or Coinsurance:	20% after deductible	20% after deductible	10% after deductible	10% after deductible	0% after deductible
Outpatient Hospital Copay or Coinsurance:	20% after deductible	20% after deductible	10% after deductible	10% after deductible	0% after deductible
	Out-of-Network	**Out-of-Network**	**Out-of-Network**	**Out-of-Network**	**Out-of-Network**
Calendar Year Deductible (Individual/Family):	$5,000/ $15,000	$3,000/ $9,000	$1,000/ $3,000	$2,100/ $4,200	$5,000/ $10,000
Coinsurance (% Plan Pays):	60%	60%	70%	70%	70%
Reimbursement Level:	70th Percentile Usual & Customary	70th Percentile Usual & Customary	70th Percentile Usual & Customary	70th Percentile Usual & Customary	70th Percentile Usual & Customary
OOP Max including Deductible (Individual/Family):	$10,000/ $30,000	$10,000/ $30,000	$5,000/ $15,000	$5,500/ $11,000	$10,000/ $20,000
Inpatient Hospital Copay:	40% after deductible	40% after deductible	30% after deductible	30% after deductible	30% after deductible
Outpatient Hospital Copay:	40% after deductible	40% after deductible	30% after deductible	30% after deductible	30% after deductible
	General	**General**	**General**	**General**	**General**
ER Copay (waived if admitted):	$200	$200	$200	10% after deductible	0% after deductible
Advanced Infertility Coverage (IVF):	3 cycles per lifetime	3 cycles per lifetime	3 cycles per lifetime	3 cycles per lifetime	3 cycles per lifetime
Routine Eye Exam Coverage:	Covered 1x per 24 months at $30 co-pay	Covered 1x per 24 months at $30 co-pay	Covered 1x per 24 months at $25 co-pay	Covered 1x per 24 months after deductible & coinsurance	Covered 1x per 24 months after deductible & coinsurance
Visit Limit for Physical, Speech, Occupational Therapies:	60 per calendar year	60 per calendar year	60 per calendar year	60 per calendar year	60 per calendar year
Prescriptions (Tier 1 / Tier 2 / Tier 3):	$10/ $35/ $70	$10/ $35/ $60	$10/ $30/ $50	$10/ $30/ $50 after deductible	$10/ $35/ $60 after deductible
Mail Order Prescription:	$25/ $87.50/ $175	$25/ $87.50/ $150	$25/ $75/ $125	$25/ $75/ $125 after deductible	$25/ $87.50/ $150 after deductible
Lifetime Max:	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
PCP Referral:	Open Access	Open Access	Open Access	Open Access	Open Access
Q4 Deductible Carryover:	Yes	Yes	Yes	Yes	No
Deductible Embedded/Non-Embedded:	Embedded [1]	Embedded [1]	Embedded [1]	Non-Embedded [2]	Embedded [1]
Plan issued from:	New York	New York	New York	New York	New York
States where not available:	HI, MA, NV,SC, PR	HI, NV,SC, PR	HI, NV,SC,PR	HI, NV,SC, PR	HI, NV,SC, PR

[1] **Embedded deductible:** Individual deductible DOES count toward satisfaction of the family deductible.

[2] **Non-Embedded deductible:** Individual deductible does NOT count toward satisfaction of the family deductible. For any tier with dependent coverage, all covered family members are subject only to the family deductible. Once the family deductible has been satisfied, the plan starts paying benefits.

UnitedHealthcare Medical Summaries - Portfolio A *(Continued)*

Plans effective October 1, 2024-September 30, 2025
Customers may pick plans from either Portfolio A or Portfolio B - plans cannot be mixed across Portfolios

Plan Details	UHC Basic EPO	UHC Standard EPO	UHC Standard	UHC Enhanced	UHC Premium
Network:	UHC Choice	UHC Choice	UHC Choice Plus	UHC Choice Plus	UHC Choice Plus
	In-Network	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Primary Care/Specialist Copay:	$25/ $50	$25/ $50	$25/ $35	$20/ $30	$15/ $15
Calendar Year Deductible (Individual/Family):	$500/ $1,500	None	None	None	None
Coinsurance (% Plan Pays):	90%	100%	100%	100%	100%
OOP Max including Deductible (Individual/Family):	$3,000/ $9,000	$4,000/ $12,000	$4,000/ $12,000	$4,000/ $12,000	$4,000/ $12,000
Inpatient Hospital Copay or Coinsurance:	10% after deductible	$500	$500	$500	$500
Outpatient Hospital Copay or Coinsurance:	10% after deductible	$125	$125	$100	$100
	Out-of-Network	**Out-of-Network**	**Out-of-Network**	**Out-of-Network**	**Out-of-Network**
Calendar Year Deductible (Individual/Family):	Not Covered	Not Covered	$1,000/ $2,500	$500/ $1,500	$300/ $900
Coinsurance (% Plan Pays):	Not Covered	Not Covered	70%	80%	80%
Reimbursement Level:	Not Covered	Not Covered	70th Percentile Usual & Customary	80th Percentile Usual & Customary	90th Percentile Usual & Customary
OOP Max including Deductible (Individual/Family):	Not Covered	Not Covered	$5,000/ $15,000	$2,000/ $4,000	$2,000/ $4,000
Inpatient Hospital Copay:	Not Covered	Not Covered	30% after deductible	20% after deductible	20% after deductible
Outpatient Hospital Copay:	Not Covered	Not Covered	30% after deductible	20% after deductible	20% after deductible
	General	**General**	**General**	**General**	**General**
ER Copay (waived if admitted):	$200	$200	$150	$150	$150
Advanced Infertility Coverage (IVF):	3 cycles per lifetime	3 cycles per lifetime	3 cycles per lifetime	3 cycles per lifetime	3 cycles per lifetime
Routine Eye Exam Coverage:	Covered 1x per 24 months at $25 co-pay	Covered 1x per 24 months at $25 co-pay	Covered 1x per 24 months at $25 co-pay	Covered 1x per 24 months at $20 co-pay	Covered 1x per 24 months at $15 co-pay
Visit Limit for Physical, Speech, Occupational Therapies:	60 per calendar year	60 per calendar year	60 per calendar year	60 per calendar year	60 per calendar year
Prescriptions (Tier 1 / Tier 2 / Tier 3):	$10/ $30/ $50	$10/ $30/ $50	$10/ $30/ $50	$10/ $30/ $50	$10/ $30/ $50
Mail Order Prescription:	$25/ $75/ $125	$25/ $75/ $125	$25/ $75/ $125	$25/ $75/ $125	$25/ $75/ $125
Lifetime Max:	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
PCP Referral:	Open Access	Open Access	Open Access	Open Access	Open Access
Q4 Deductible Carryover:	Yes	N/A	Yes	Yes	Yes
Deductible Embedded/Non-Embedded:	Embedded [1]	N/A	Embedded [1]	Embedded [1]	Embedded [1]
Plan issued from:	New York	New York	New York	New York	New York
States where not available:	AK, AL, AR, AZ, HI, KS, LA, MN, MS, NC, NH, NV, NM, OK, PR, SC, VT, WY	AK, AL, AR, AZ, HI, KS, LA, MN, MS, NC, NH, NV, NM, OK, PR, SC, VT, WY	HI, NV,SC, PR,	HI, NV,SC, PR	HI, NV,SC, PR

[1] **Embedded deductible:** Individual deductible DOES count toward satisfaction of the family deductible.

[2] **Non-Embedded deductible:** Individual deductible does NOT count toward satisfaction of the family deductible. For any tier with dependent coverage, all covered family members are subject only to the family deductible. Once the family deductible has been satisfied, the plan starts paying benefits.

UnitedHealthcare Medical Summaries - Portfolio A Hawaii, Nevada, South Carolina, Puerto Rico, U.S. Territories

Plans effective October 1, 2024-September 30, 2025

Plan Details	UHC Hawaii	UHC Standard NV	UHC HDHP 2100 NV	UHC Basic NV	UHC Standard SC
Network:	Options PPO	UHC Choice Plus	UHC Choice Plus	UHC Choice Plus	UHC Choice Plus
	In-Network	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Primary Care/Specialist Copay:	10%	$25/ $35	10% after deductible	$30/ $50	$25/ $35
Calendar Year Deductible (Individual/Family):	$100/ $300	None	$2,100/ $4,200	$1,000/$3,000	None
Coinsurance (% Plan Pays):	90%	100%	90%	80%	100%
OOP Max including Deductible (Individual/Family):	$2,500/ $7,500	$4,000/ $12,000	$4,000/ $8,000	$5,000/ $12,700	$4,000/ $12,000
Inpatient Hospital Copay or Coinsurance:	10%	$500	10% after deductible	20% after deductible	$500
Outpatient Hospital Copay or Coinsurance:	10%	$125	10% after deductible	20% after deductible	$125
	Out-of-Network	**Out-of-Network**	**Out-of-Network**	**Out-of-Network**	**Out-of-Network**
Calendar Year Deductible (Individual/Family):	$100/ $300	$1,000/ $2,500	$2,100/ $4,200	$3,000/ $9,000	$1,000/ $2,500
Coinsurance (% Plan Pays):	70%	70%	70%	60%	70%
Reimbursement Level:	90th Percentile Usual & Customary	70th Percentile Usual & Customary	70th Percentile Usual & Customary	70th Percentile Usual & Customary	70th Percentile Usual & Customary
OOP Max including Deductible (Individual/Family):	$2,500/ $7,500	$5,000/ $10,000	$5,500/ $11,000	$10,000/ $30,000	$5,000/ $10,000
Inpatient Hospital Copay:	30% after deductible	30% after deductible	30% after deductible	40% after deductible	30% after deductible
Outpatient Hospital Copay:	30% after deductible	30% after deductible	30% after deductible	40% after deductible	30% after deductible
	General	**General**	**General**	**General**	**General**
ER Coinsurance or ER Copay (waived if admitted):	10%	$150	10% after deductible	$200	$150
Advanced Infertility Coverage (IVF):	1 per Lifetime	Not Covered	Not Covered	Not Covered	Not Covered
Routine Eye Exam Coverage:	Covered 1x per 12 months after deductible and coinsurance	Covered 1x per 24 months at $25 co-pay	Covered 1x per 24 months after deductible & coinsurance	Covered 1x per 24 months at $30 co-pay	Covered 1x per 24 months at $35 co-pay
Visit Limit for Physical, Speech, Occupational Therapies:	60 per calendar year	60 per calendar year	60 per calendar year	60 per calendar year	60 per calendar year
Prescriptions (Tier 1 / Tier 2 / Tier 3):	$10/ $30/ $50	$10/ $30/ $50	$10/ $30/ $50 after deductible	$10/ $35/ $60	$10/ $30/ $50
Mail Order Prescription:	$30/ $90/ $150	$25/ $75/ $125	$25/ $75/ $125 after deductible	$25/ $87.50/ $150	$25/ $75/ $125
Lifetime Max:	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
PCP Referral:	Open Access	Open Access	Open Access	Open Access	Open Access
Q4 Deductible Carryover:	No	Yes	Yes	Yes	Yes
Deductible Embedded/Non-Embedded:	Embedded [1]	Embedded [1]	Non-Embedded [2]	Embedded [1]	Embedded [1]
Plan issued from:	Hawaii	Nevada	Nevada	Nevada	South Carolina

[1] **Embedded deductible:** Individual deductible DOES count toward satisfaction of the family deductible.

[2] **Non-Embedded deductible:** Individual deductible does NOT count toward satisfaction of the family deductible. For any tier with dependent coverage, all covered family members are subject only to the family deductible. Once the family deductible has been satisfied, the plan starts paying benefits.

UnitedHealthcare Medical Summaries - Portfolio A Hawaii, Nevada, South Carolina, Puerto Rico, U.S. Territories (Continued)

Plan Details	UHC HDHP 2100 SC	UHC Basic SC	UHC Puerto Rico	U.S. Territories
Network:	UHC Choice Plus	UHC Choice Plus	MAPFRE in Puerto Rico; UHC Choice Plus on mainland U.S.	Options PPO
	In-Network	**In-Network**	**In-Network**	**In-Network**
Primary Care/Specialist Copay:	10% after deductible	$30/ $50	$25/ $35	20% after deductible
Calendar Year Deductible (Individual/Family):	$2,100/ $4,200	$1,000/ $3,000	None	$500/$1000
Coinsurance (% Plan Pays):	90%	80%	100%	80%
OOP Max including Deductible (Individual/Family):	$4,000/ $8,000	$5,000/ $12,700	$4,000/ $12,000	$3,000/ $6,000
Inpatient Hospital Copay or Coinsurance:	10% after deductible	20% after deductible	$500	20% after deductible
Outpatient Hospital Copay or Coinsurance:	10% after deductible	20% after deductible	$125	20% after deductible
	Out-of-Network	**Out-of-Network**	**Out-of-Network**	**Out-of-Network**
Calendar Year Deductible (Individual/Family):	$2,100/ $4,200	$3,000/ $9,000	$1,000/ $2,500	$500/$1000
Coinsurance (% Plan Pays):	70%	60%	70%	80%
Reimbursement Level:	70th Percentile Usual & Customary	70th Percentile Usual & Customary	70th Percentile Usual & Customary	70th Percentile Usual & Customary
OOP Max including Deductible (Individual/Family):	$5,500/ $11,000	$10,000/ $30,000	$5,000/ $15,000	$3,000/ $6,000
Inpatient Hospital Copay:	30% after deductible	40% after deductible	$500	20% after deductible
Outpatient Hospital Copay:	30% after deductible	40% after deductible	$125	20% after deductible
	General	**General**	**General**	**General**
ER Coinsurance or ER Copay (waived if admitted):	10% after deductible	$200	$150	20% after deductible
Advanced Infertility Coverage (IVF):	Not Covered	Not Covered	3 cycles per lifetime	3 cycles per lifetime
Routine Eye Exam Coverage:	Covered 1x per 24 months after deductible & coinsurance	Covered 1x per 24 months at $30 co-pay	Covered 1x per 24 months at $25 co-pay	Not Covered
Visit Limit for Physical, Speech, Occupational Therapies:	60 per calendar year	60 per calendar year	60 per calendar year	20 per calendar year
Prescriptions (Tier 1 / Tier 2 / Tier 3):	$10/ $30/ $50 after deductible	$10/ $35/ $60	$10/ $30/ $50	$10/ $30/ $50
Mail Order Prescription:	$25/ $75/ $125 after deductible	$25/ $87.50/ $150	$25/ $75/ $125	$25/ $75/ $125
Lifetime Max:	Unlimited	Unlimited	Unlimited	Unlimited
PCP Referral:	Open Access	Open Access	Open Access	Open Access
Q4 Deductible Carryover:	Yes	Yes	Yes	Yes
Deductible Embedded/Non-Embedded:	Non-Embedded [2]	Embedded [1]	Embedded [1]	Embedded [1]
Plan issued from:	South Carolina	South Carolina	New York	New York

[1] **Embedded deductible:** Individual deductible DOES count toward satisfaction of the family deductible.

[2] **Non-Embedded deductible:** Individual deductible does NOT count toward satisfaction of the family deductible. For any tier with dependent coverage, all covered family members are subject only to the family deductible. Once the family deductible has been satisfied, the plan starts paying benefits.

UnitedHealthcare Medical Summaries - Portfolio B

Plans effective October 1, 2024-September 30, 2025

Customers may pick plans from either Portfolio A or Portfolio B - plans cannot be mixed across Portfolios

Portfolio B is not available to clients headquartered in New York state

Plan Details	UHC Choice Plus 3000/80	UHC Choice Plus 1000/80	UHC Choice Plus 500/90	UHC HDHP 5500	UHC HDHP 2100/90
Network:	UHC Choice Plus	UHC Choice Plus	UHC Choice Plus	UHC Choice Plus	UHC Choice Plus
	In-Network	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Primary Care/Specialist Copay:	$30/ $50	$30/ $50	$25/ $50	0% after deductible	10% after deductible
Calendar Year Deductible (Individual/Family):	$3,000/ $9,000	$1,000/ $3,000	$500/ $1,000	$5,500/ $11,000	$2,100/ $4,200
Coinsurance (% Plan Pays):	80%	80%	90%	100% after deductible	90%
OOP Max including Deductible (Individual/Family):	$5,000/ $15,000	$5,000/ $12,700	$3,000/ $6,000	$6,400/ $12,800	$4,000/ $8,000
Inpatient Hospital Copay or Coinsurance:	20% after deductible	20% after deductible	10% after deductible	0% after deductible	10% after deductible
Outpatient Hospital Copay or Coinsurance:	20% after deductible	20% after deductible	10% after deductible	0% after deductible	10% after deductible
	Out-of-Network	**Out-of-Network**	**Out-of-Network**	**Out-of-Network**	**Out-of-Network**
Calendar Year Deductible (Individual/Family):	$5,000/ $15,000	$3,000/ $9,000	$1,000/ $3,000	$15,000/ $30,000	$2,100/ $4,200
Coinsurance (% Plan Pays):	60%	60%	70%	70%	70%
Reimbursement Level:	100% of Medicare allowed amount for professional services and facilities	100% of Medicare allowed amount for professional services and facilities	100% of Medicare allowed amount for professional services and facilities	100% of Medicare allowed amount for professional services and facilities	100% of Medicare allowed amount for professional services and facilities
OOP Max including Deductible (Individual/Family):	$10,000/ $30,000	$10,000/ $30,000	$5,000/ $15,000	$20,000/ $40,000	$5,500/ $11,000
Inpatient Hospital Copay:	40% after deductible	40% after deductible	30% after deductible	30% after deductible	30% after deductible
Outpatient Hospital Copay:	40% after deductible	40% after deductible	30% after deductible	30% after deductible	30% after deductible
	General	**General**	**General**	**General**	**General**
ER Copay (waived if admitted):	$200	$200	$200	0% after deductible	10% after deductible
Advanced Infertility Coverage (IVF):	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Routine Eye Exam Coverage:	Not Covered; except for preventive screening to Age 5 only	Not Covered; except for preventive screening to Age 5 only	Not Covered; except for preventive screening to Age 5 only	Not Covered; except for preventive screening to Age 5 only	Not Covered; except for preventive screening to Age 5 only
Visit Limit for Physical, Speech, Occupational Therapies:	20 per calendar year	20 per calendar year	20 per calendar year	20 per calendar year	20 per calendar year
Prescriptions (Tier 1 / Tier 2 / Tier 3 / Tier 4):	$15/ $45/ $75/ 25% to max. of $125	$15/ $45/ $75/ 25% to max of $125	$15/ $45/ $75/ 25% to max. of $125	$15/ $45/ $75/ 25% to max. of $125 after deductible	$15/ $45/ $75/ 25% to max. of $125 after deductible
Mail Order Prescription:	$37.50/ $112.50/ $187.50/ $312.50	$37.50/ $112.50/ $187.50/ $312.50	$37.50/ $112.50/ $187.50/ $312.50	$37.50/ $112.50/ $187.50/ $312.50 after deductible	$37.50/ $112.50/ $187.50/$312.50 after deductible
Lifetime Max:	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
PCP Referral:	Open Access	Open Access	Open Access	Open Access	Open Access
Q4 Deductible Carryover:	Yes	Yes	Yes	Yes	Yes
Deductible Embedded/Non-Embedded:	Embedded [1]	Embedded [1]	Embedded [1]	Embedded [1]	Non-Embedded [2]
Plan issued from:	Florida	Florida	Florida	Florida	Florida
States where not available:	HI, MA, NV, SC, PR	HI, NV,SC, PR	HI, NV, SC, PR	HI, NV,SC, PR	HI, NV,SC, PR

[1] **Embedded deductible:** Individual deductible DOES count toward satisfaction of the family deductible.

[2] **Non-Embedded deductible:** Individual deductible does NOT count toward satisfaction of the family deductible. For any tier with dependent coverage, all covered family members are subject only to the family deductible. Once the family deductible has been satisfied, the plan starts paying benefits.

UnitedHealthcare Medical Summaries - Portfolio B *(Continued)*

Plans effective October 1, 2024-September 30, 2025
Customers may pick plans from either Portfolio A or Portfolio B - plans cannot be mixed across Portfolios
Portfolio B is not available to clients headquartered in New York state

Plan Details	UHC Choice EPO 500	UHC Choice EPO 0	UHC Choice Plus 0/25	UHC Choice Plus 0/20
Network:	UHC Choice	UHC Choice	UHC Choice Plus	UHC Choice Plus
	In-Network	**In-Network**	**In-Network**	**In-Network**
Primary Care/Specialist Copay:	$25/ $50	$25/ $50	$25/ $35	$20/ $30
Calendar Year Deductible (Individual/Family):	$500/ $1,500	None	None	None
Coinsurance (% Plan Pays):	90%	100%	100%	100%
OOP Max including Deductible (Individual/Family):	$3,000/ $9,000	$4,000/ $12,000	$4,000/ $12,000	$4,000/ $12,000
Inpatient Hospital Copay or Coinsurance:	10% after deductible	$500	$500	$500
Outpatient Hospital Copay or Coinsurance:	10% after deductible	$125	$125	$100
	Out-of-Network	**Out-of-Network**	**Out-of-Network**	**Out-of-Network**
Calendar Year Deductible (Individual/Family):	Not Covered	Not Covered	$1,000/ $3,000	$500/ $1,500
Coinsurance (% Plan Pays):	Not Covered	Not Covered	70%	80%
Reimbursement Level:	Not Covered	Not Covered	100% of Medicare allowed amount for professional services and facilities	100% of Medicare allowed amount for professional services and facilities
OOP Max including Deductible (Individual/Family):	Not Covered	Not Covered	$5,000/ $15,000	$5,000/ $15,000
Inpatient Hospital Copay:	Not Covered	Not Covered	30% after deductible	20% after deductible
Outpatient Hospital Copay:	Not Covered	Not Covered	30% after deductible	20% after deductible
	General	**General**	**General**	**General**
ER Copay (waived if admitted):	$200	$200	$150	$150
Advanced Infertility Coverage (IVF):	Not Covered	Not Covered	Not Covered	Not Covered
Routine Eye Exam Coverage	Not Covered; except for preventive screening to Age 5 only	Not Covered; except for preventive screening to Age 5 only	Not Covered; except for preventive screening to Age 5 only	Not Covered; except for preventive screening to Age 5 only
Visit Limit for Physical, Speech, Occupational Therapies:	20 per calendar year	20 per calendar year	20 per calendar year	20 per calendar year
Prescriptions (Tier 1 / Tier 2 / Tier 3 / Tier 4):	$15/ $45/ $75/ 25% to max. of $125	$15/ $45/ $75/ 25% to max. of $125	$15/ $45/ $75/ 25% to max. of $125	$15/ $45/ $75/ 25% to max. of $125
Mail Order Prescription:	$37.50/ $112.50/ $187.50/ $312.50	$37.50/ $112.50/ $187.50/ $312.50	$37.50/ $112.50/ $187.50/ $312.50	$37.50/ $112.50/ $187.50/ $312.50
Lifetime Max:	Unlimited	Unlimited	Unlimited	Unlimited
PCP Referral:	Open Access	Open Access	Open Access	Open Access
Q4 Deductible Carryover:	Yes	N/A	Yes	Yes
Deductible Embedded/Non-Embedded:	Embedded [1]	N/A	Embedded [1]	Embedded [1]
Plan issued from:	Florida	Florida	Florida	Florida
States where not available:	AK, AL, AR, AZ, HI, KS, LA, MN, MS, NC, NH, NV, NM, OK, PR, SC, VT, WY	AK, AL, AR, AZ, HI, KS, LA, MN, MS, NC, NH, NV, NM, OK, PR, SC, VT, WY	HI, NV,SC, PR	HI, NV,SC, PR

[1] **Embedded deductible:** Individual deductible DOES count toward satisfaction of the family deductible.

[2] **Non-Embedded deductible:** Individual deductible does NOT count toward satisfaction of the family deductible. For any tier with dependent coverage, all covered family members are subject only to the family deductible. Once the family deductible has been satisfied, the plan starts paying benefits.

UnitedHealthcare Medical Summaries - Portfolio B Hawaii, Nevada, South Carolina, Puerto Rico, U.S. Territories

Plans effective October 1, 2024-September 30, 2025

Customers may pick plans from either Portfolio A or Portfolio B - plans cannot be mixed across Portfolios

Portfolio B is not available to clients headquartered in New York state

Plan Details	UHC Hawaii 100/90	UHC Choice Plus 0/25 NV	UHC Choice Plus 1000/80 NV	UHC HDHP 5500 NV	UHC Choice Plus 0/25 SC
Network:	Options PPO	UHC Choice Plus	UHC Choice Plus	UHC Choice Plus	UHC Choice Plus
	In-Network	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Primary Care/Specialist Coinsurance:	10%	$25/ $35	$30/ $50	0% after deductible	$25/ $35
Calendar Year Deductible (Individual/Family):	$100/ $300	None	$1,000/ $3,000	$5,500/ $11,000	None
Coinsurance (% Plan Pays):	90%	100%	80%	100% after deductible	100%
OOP Max including Deductible (Individual/Family):	$2,500/ $7,500	$4,000/ $12,000	$5,000/ $12,700	$6,400/ $12,800	$4,000/ $12,000
Inpatient Hospital Copay or Coinsurance:	10%	$500	20% after deductible	0% after deductible	$500
Outpatient Hospital Copay or Coinsurance:	10%	$125	20% after deductible	0% after deductible	$125
	Out-of-Network	**Out-of-Network**	**Out-of-Network**	**Out-of-Network**	**Out-of-Network**
Calendar Year Deductible (Individual/Family):	$100/ $300	$1,000/ $2,500	$3,000/ $9,000	$15,000/ $30,000	$1,000/ $2,000
Coinsurance (% Plan Pays):	70%	70%	60%	70%	70%
Reimbursement Level:	80th Percentile Usual & Customary	100% of Medicare allowed amount for professional services and facilities	100% of Medicare allowed amount for professional services and facilities	100% of Medicare allowed amount for professional services and facilities	100% of Medicare allowed amount for professional services and facilities
OOP Max including Deductible (Individual/Family):	$2,500/ $7,500	$5,000/ $10,000	$10,000/ $30,000	$20,000/ $40,000	$5,000/ $15,000
Inpatient Hospital Copay:	30% after deductible	30% after deductible	40% after deductible	30% after deductible	30% after deductible
Outpatient Hospital Copay:	30% after deductible	30% after deductible	40% after deductible	30% after deductible	30% after deductible
	General	**General**	**General**	**General**	**General**
ER Coinsurance or ER Copay (waived if admitted):	10%	$150	$200	0% after deductible	$150
Advanced Infertility Coverage (IVF):	1 per Lifetime	Not Covered	Not Covered	Not Covered	Not Covered
Routine Eye Exam Coverage:	Not Covered; except for preventive screening to Age 5 only	Not Covered; except for preventive screening to Age 5 only	Not Covered; except for preventive screening to Age 5 only	Not Covered; except for preventive screening to Age 5 only	Not Covered; except for preventive screening to Age 5 only
Visit Limit for Physical, Speech, Occupational Therapies:	60 per calendar year	20 per calendar year	20 per calendar year	25 per calendar year	20 per calendar year
Prescriptions (Tier 1 / Tier 2 / Tier 3 / Tier 4):	$10/ $30/ $50 after $100/ $300 Rx deductible	$15/ $45/ $75/ 25% to max. of $125	$15/ $45/ $75/ 25% to max. of $125	$15/ $45/ $75/ 25% to max. of $125 after deductible	$15/ $45/ $75/ 25% to max. of $125
Mail Order Prescription:	$30/ $90/ $150 after $100/ $300 Rx deductible	$37.50/ $112.50/ $187.50/$312.50	$37.50/ $112.50/ $187.50/ $312.50	$37.50/ $112.50/ $187.50/$312.50 after deductible	$37.50/ $112.50/ $187.50/$312.50
Lifetime Max:	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
PCP Referral:	Open Access	Open Access	Open Access	Open Access	Open Access
Q4 Deductible Carryover:	No	Yes	Yes	Yes	Yes
Deductible Embedded/Non-Embedded:	Embedded [1]	Embedded [1]	Embedded [1]	Embedded [1]	Embedded [1]
Plan issued from:	Hawaii	Nevada	Nevada	Nevada	South Carolina

[1] **Embedded deductible:** Individual deductible DOES count toward satisfaction of the family deductible.

[2] **Non-Embedded deductible:** Individual deductible does NOT count toward satisfaction of the family deductible. For any tier with dependent coverage, all covered family members are subject only to the family deductible. Once the family deductible has been satisfied, the plan starts paying benefits.

Plan Details	UHC Choice Plus 0/25 SC	UHC Choice Plus 1000/80 SC	UHC HDHP 5500 SC	UHC Puerto Rico 500/80	UHC U.S. Territories 500/80
Network:	UHC Choice Plus	UHC Choice Plus	UHC Choice Plus	MAPFRE in Puerto Rico; Options PPO on mainland U.S.	Options PPO
	In-Network	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Primary Care/Specialist Coinsurance:	$25/ $35	$30/ $50	0% after deductible	20% coinsurance	20% coinsurance
Calendar Year Deductible (Individual/Family):	None	$1,000/ $3,000	$5,500/ $11,000	$500/ $1,000	$500/ $1,000
Coinsurance (% Plan Pays):	100%	80%	100% after deductible	80%	80%
OOP Max including Deductible (Individual/Family):	$4,000/ $12,000	$5,000/ $12,700	$6,400/ $12,800	$3,000/ $6,000	$3,000/ $6,000
Inpatient Hospital Copay or Coinsurance:	$500	20% after deductible	0% after deductible	20% after deductible	20% after deductible
Outpatient Hospital Copay or Coinsurance:	$125	20% after deductible	0% after deductible	20% after deductible	20% after deductible
	Out-of-Network	**Out-of-Network**	**Out-of-Network**	**Out-of-Network**	**Out-of-Network**
Calendar Year Deductible (Individual/Family):	$1,000/ $2,000	$3,000/ $9,000	$15,000/ $30,000	$500/ $1,000	$500/ $1,000
Coinsurance (% Plan Pays):	70%	60%	70%	80%	80%
Reimbursement Level:	100% of Medicare allowed amount for professional services and facilities	100% of Medicare allowed amount for professional services and facilities	100% of Medicare allowed amount for professional services and facilities	100% of Medicare allowed amount for professional services and facilities	100% of Medicare allowed amount for professional services and facilities
OOP Max including Deductible (Individual/Family):	$5,000/ $15,000	$10,000/ $30,000	$20,000/ $40,000	$3,000/ $6,000	$3,000/ $6,000
Inpatient Hospital Copay:	30% after deductible	40% after deductible	30% after deductible	20% after deductible	20% after deductible
Outpatient Hospital Copay:	30% after deductible	40% after deductible	30% after deductible	20% after deductible	20% after deductible
	General	**General**	**General**	**General**	**General**
ER Coinsurance or ER Copay (waived if admitted):	$150	$200	0% after deductible	20% after deductible	20% after deductible
Advanced Infertility Coverage (IVF):	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Routine Eye Exam Coverage:	Not Covered; except for preventive screening to Age 5 only	Not Covered; except for preventive screening to Age 5 only	Not Covered; except for preventive screening to Age 5 only	Not Covered; except for preventive screening to Age 5 only	Not Covered; except for preventive screening to Age 5 only
Visit Limit for Physical, Speech, Occupational Therapies:	20 per calendar year	20 per calendar year	20 per calendar year	20 per calendar year	20 per calendar year
Prescriptions (Tier 1 / Tier 2 / Tier 3 / Tier 4):	$15/ $45/ $75/ 25% to max. of $125	$15/ $45/ $75/ 25% to max. of $125	$15/ $45/ $75/ 25% to max. of $125 after deductible	$15/ $45/ $75/ 25% to max. of $125	$15/ $45/ $75/ 25% to max. of $125
Mail Order Prescription:	$37.50/ $112.50/ $187.50/$312.50	$37.50/ $112.50/ $187.50/$312.50	$37.50/ $112.50/ $187.50/ $312.50 after deductible	37.50/ $112.50/ $187.50/$312.50	37.50/ $112.50/ $187.50/$312.50
Lifetime Max:	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
PCP Referral:	Open Access	Open Access	Open Access	Open Access	Open Access
Q4 Deductible Carryover:	Yes	Yes	Yes	Yes	Yes
Deductible Embedded/Non-Embedded:	Embedded [1]	Embedded [1]	Embedded [1]	Embedded [1]	Embedded [1]
Plan issued from:	South Carolina	South Carolina	South Carolina	Florida	Florida

[1] **Embedded deductible:** Individual deductible DOES count toward satisfaction of the family deductible.

[2] **Non-Embedded deductible:** Individual deductible does NOT count toward satisfaction of the family deductible. For any tier with dependent coverage, all covered family members are subject only to the family deductible. Once the family deductible has been satisfied, the plan starts paying benefits.

Kaiser Medical Summaries - California

Plans effective October 1, 2024-September 30, 2025

Plan Details	Kaiser HMO-20	Kaiser HMO-30	Kaiser HMO-1000 (DHMO)
Network:	HMO Network	HMO Network	HMO Network
	In-Network	**In-Network**	**In-Network**
Primary Care/Specialist Copay:	$20/ $35	$30/ $30	$30/ $45
Calendar Year Deductible (Individual/Family):	None	None	$1,000/ $2,000
Coinsurance (% Plan Pays):	100%	100%	80%
OOP Max including Deductible (Individual/Family):	$1,500/ $3,000	$1,500/ $3,000	$2,000/ $4,000
Inpatient Hospital Copay or Coinsurance:	$250	$500	20% after deductible
Outpatient Hospital Copay or Coinsurance:	$35	$200	20% after deductible
	Out-of-Network	**Out-of-Network**	**Out-of-Network**
Calendar Year Deductible (Individual/Family):	Not Covered	Not Covered	Not Covered
Coinsurance (% Plan Pays):	Not Covered	Not Covered	Not Covered
Reimbursement Level:	Not Covered	Not Covered	Not Covered
OOP Max including Deductible (Individual/Family):	Not Covered	Not Covered	Not Covered
Inpatient Hospital Copay:	Not Covered	Not Covered	Not Covered
Outpatient Hospital Copay:	Not Covered	Not Covered	Not Covered
	General	**General**	**General**
ER Copay (waived if admitted):	$100	$100	20% after deductible
Prescriptions (Tier 1 / Tier 2 / Tier 3 / Tier 4):	$10/ $35/ $35 Specialty Drugs: 20% ($150 max)	$15/ $35/ $35 Specialty Drugs: 20% ($150 max)	$10/ $35/ $35 Specialty Drugs: 20% ($150 max)
Mail Order Prescriptions:	$20/ $70/ $70	$30/ $70/ $70	$20/ $70/ $70
Lifetime Max:	Unlimited	Unlimited	Unlimited
PCP Referral:	Referrals may be required	Referrals may be required	Referrals may be required
Plan issued from:	California	California	California

Worksite employees who reside in the following counties will receive the Northern CA rates:
Alameda, Amador (partial), Contra Costa, El Dorado (partial), Fresno (partial), Kings (partial), Madera (partial), Marin, Mariposa (partial), Napa, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Sutter, Tulare (partial), Yolo, Yuba.

Worksite employees who reside in the following counties will receive the Southern CA rates:
Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Tulare (partial), Ventura.

Note: Kaiser may not be available to all worksite employees in California.