MEDICAL BENEFITS

MEDICAL

	UnitedHealthcare SignatureValue HMO (26R) CA Residents Only	UnitedHealthcare Select Plus PPO 4000 (CQI8)	
Benefits	In Network	In Network	Out of Network
Lifetime Maximum Benefit	Unlimited	Unlimited	
Deductible			
- Individual	$2,500	$4,000	$12,000
- Family	$5,000	$8,000	$24,000
Out of Pocket Maximum	Includes deductible	Includes deductible	
- Individual	$6,000	$7,000	$21,000
- Family	$12,000	$14,000	$42,000
Coinsurance	30%	30%	50%
Office Visit (primary / specialist)	$35 / $70	$35 / $70	Ded + 50%
Urgent Care	$35	$50	Ded + 50%
Preventive Services / Well Baby Care	No charge	No Charge	Not covered
Lab and X-Ray	$25	Ded + 30%	Lab testing: not covered/ X-Ray: Ded + 50%
MRI/CT/PET	$150	Ded + 30%	Ded + 50%
Hospitalization	Ded + 30%	Ded + 30%	Ded + 50%
Outpatient Surgery	Ded + 30%	Ded + 30%	Ded + 50%
Emergency Room	Ded + 30%	Ded + 30%	
Acupuncture (20 per year, combined with chiropractic)	$15	$30	Not covered
Chiropractic Services (20 per year, combined with acupuncture)	$15	$30	Ded + 50%
Mental Health Outpatient	$70	$30	Ded + 50%
Prescriptions			
- Rx Deductible	There is no pharmacy deductible	There is no pharmacy deductible	
- Generic	$10	$10	$10
- Brand	$45	$35	$35
- Non-formulary	$80	$70	$70
EMPLOYEE CONTRIBUTION PER MONTH			
Employee Only	$339.35	$499.10	
Employee & Spouse	$1,017.74	$1,496.86	
Employee & Child(ren)	$791.84	$1,164.62	
Family	$1,527.10	$2,245.97	

The benefits illustrated above are meant to serve as a summary of the benefits available under the carrier's plan. Should any discrepancy arise, the carrier's documents supersede this illustration. Once enrolled, you will receive a Combined Evidence of Coverage and Disclosure Form that explains the exclusions and limitations, as well as the full range of covered services of your plan, in detail.

DENTAL & VISION BENEFITS

DENTAL

	UnitedHealthcare	
	In Network	Out Of Network
Annual Max	$1,500	
Orthodontia Lifetime Max	not covered	
Deductible		
Preventive	$0	
Basic (Individual/Family)	$50/$150	$50/$150
Major (Individual/Family)	$50/$150	$50/$150
Coinsurance		
Preventive	100%	
Basic	80%	80%
Major	50%	50%
Orthodontia	not covered	
Important Provisions		
Endodontic Services	basic	
Periodontal Maintenance	basic	
Periodontal Surgery	basic	
Oral Surgery (Simple Extractions)	basic	
Oral Surgery (Complex Extractions)	basic	
Usual & Customary	negotiated fee	90th percentile

EMPLOYEE CONTRIBUTION PER MONTH	FULL PLAN DESCRIPTION
Employee only	$58.77
Employee + spouse	$111.96
Employee + child/ren	$141.83
Employee + family	$203.47

VISION

	United Healthcare	
	in network	out of network
Office visit copay	$10	n/a
Materials copay	$25	n/a
Eye exam reimbursement	100%	up to $45
Lenses		
Single vision	covered after copay	$30
Bifocal		$50
Trifocal		$65
Contact lenses	$130	$105
Frames allowance	$130 + 20%	$70
Eye exam	every 12 months	
Lenses	every 12 months	
Contact lenses	every 12 months	
Frames	every 24 months	

EMPLOYEE CONTRIBUTION PER MONTH	FULL PLAN DESCRIPTION
Employee only	$6.76
Employee + spouse	$11.50
Employee + child/ren	$12.18
Employee + family	$18.26