UnitedHealthcare
High Deductible Health Plan

Non-Medicare Enrollment Service Area: **Nationwide**

Benefit Description	Non-Medicare Qualified HDHP Plan *	
	In-Network	Out-of-Network
Eligible Providers	Preferred physicians and facilities	Any licensed physician or facility
	MEMBER PAYS:	
Calendar Year Medical & Pharmacy Deductible	$3,000 per individual If enrolled as a family, a total of $6,000 for all members combined [1]	
Calendar Year Medical & Pharmacy Out-of-Pocket Maximum	$6,650 per individual $13,300 per family	
Preventive Care	▪ Covered in full per ACA guidelines	▪ 40% after deductible per ACA guidelines
Inpatient Care		
▪ Inpatient Hospital Care	▪ 20% after deductible	▪ 40% after deductible
▪ Skilled Nursing	▪ 20% after deductible	▪ 40% after deductible
Outpatient Care		
▪ Physician Office Visits	▪ 20% after deductible	▪ 40% after deductible
▪ Specialist Office Visits	▪ 20% after deductible	▪ 40% after deductible
▪ Outpatient Surgery	▪ 20% after deductible	▪ 40% after deductible
▪ Ambulance (air-ground)	▪ 20% after deductible	▪ **20%** after deductible
▪ Emergency Services	▪ 20% after deductible	▪ **20%** after deductible
▪ Urgent Care	▪ 20% after deductible	▪ 40% after deductible
▪ DME	▪ 20% after deductible	▪ 40% after deductible
▪ Lab Test	▪ 20% after deductible	▪ 40% after deductible
▪ X-Ray	▪ 20% after deductible	▪ 40% after deductible
▪ Diagnostic Imaging (CT/MRI)	▪ 20% after deductible	▪ 40% after deductible
▪ OT/PT/ST Therapies	▪ 20% after deductible [2]	▪ 40% after deductible [2]
Other Services		
▪ Alternative Care	▪ 20% after deductible [3]	▪ 40% after deductible [3]
Prescription Drugs		
▪ Brand	▪ 20% after deductible	
▪ Generic	▪ 20% after deductible	
▪ Specialty	▪ 20% after deductible	
Rates (per member, per month) [4]		
▪ Adult	▪ $833.56	
▪ Child	▪ $253.57	

***Once enrolled in the Qualified HDHP plan, you cannot switch to the Core Value plan at any time in the future.**

This is a summary of benefits only, for general comparison. Any errors or omissions are purely unintentional. Should any discrepancies be found between this outline and the health plan document, the information in the health plan document shall prevail.

For questions on plan benefits, limitations and exclusions, refer to your health plan's Evidence of Coverage (EOC). You can obtain the EOC by contacting your health plan directly.

[1] A family has to meet the entire family deductible before covered expenses are paid at the plan coinsurance level for any of the family members.
[2] Outpatient Rehab: OT= Occupational Therapy, PT= Physical Therapy, ST= Speech Therapy. Limited to 20 visits per therapy, per calendar year.
[3] Spinal manipulation and acupuncture are limited to 12 combined visits per calendar year. No massage therapy coverage.
[4] Apply the adult rate to the PERS Retiree, Spouse and Dependent Domestic Partner. Apply the Child rate to a dependent child regardless of age. No additional premium (cost) for more than two children.