Health Plan Product Offering

UnitedHealthcare offers a wide variety of plan options that allow you to tailor your benefits to your business needs, choosing what you value in a health plan.

UnitedHealthcare

Wisconsin Manufacturers and Commerce
1/1/2026
Package AD154

Plan Code	Coinsurance		Deductible				Out-Of-Pocket Maximum				Copay/Per Occurrence								
	Network	Out of Network	Network		Out of Network		Network		Out of Network		Virtual Visits	PCP	PCP	Spec	Urgent Care	ER	Lab/X-ray	MRI, CT & PET	Inpatient Hospital
			Single	Family	Single	Family	Single	Family	Single	Family		Ages 19+	Ages <19						
Choice Plus Insurance																			
EK-CA	80%	60%	$2,500	$5,000	$5,000	$10,000	$5,000	$10,000	$10,000	$20,000	100%	$30	$0	$60	$100	Ded + 80%	Ded + 80%	Ded + 80%	Ded + 80%
EK-CT	80%	60%	$1,500	$3,000	$3,000	$6,000	$5,000	$10,000	$10,000	$20,000	100%	$30	$0	$60	$100	Ded + 80%	Ded + 100%	Ded + 80%	Ded + 80%
EK-CF	70%	50%	$3,000	$6,000	$6,000	$12,000	$6,350	$12,700	$12,700	$25,400	100%	$30	$0	$60	$100	Ded + 70%	Ded + 70%	Ded + 70%	Ded + 70%
EK-CB	80%	60%	$5,000	$10,000	$10,000	$20,000	$6,350	$12,700	$12,700	$25,400	100%	$30	$0	$60	$100	Ded + 80%	Ded + 80%	Ded + 80%	Ded + 80%

Designated Diagnostic Laboratory and Complex Imaging Provider Requirements Apply.

Plan Code	Coinsurance		Deductible				Out-Of-Pocket Maximum				Copay/Per Occurrence							
	Network	Out of Network	Network		Out of Network		Network		Out of Network		Virtual Visits	PCP	Spec	Urgent Care	ER	Lab/X-ray	MRI, CT & PET	Inpatient Hospital
			Single	Family	Single	Family	Single	Family	Single	Family								
Choice Plus Insurance Non-Embedded H S A																		
EK-E4	100%	80%	$2,000	$4,000	$4,000	$8,000	$3,500	$6,850	$7,000	$14,000	Ded + 100%	Ded + $30	Ded + $60	Ded + $100	Ded + 100%	Ded + 100%	Ded + 100%	Ded + 100%
EK-EY	80%	60%	$2,000	$4,000	$4,000	$8,000	$3,500	$6,850	$7,000	$14,000	Ded + 100%	Ded + $30	Ded + $60	Ded + $100	Ded + 100%	Ded + 80%	Ded + 80%	Ded + 80%
Choice Plus Insurance Consumer																		
EK-DX	100%	80%	$3,500	$7,000	$6,000	$12,000	$6,350	$12,700	$12,700	$25,400	100%	Ded + 100%	Ded + 100%	Ded + 100%	Ded + 100%	Ded + 100%	Ded + 100%	Ded + 100%

Designated Diagnostic Laboratory and Complex Imaging Provider Requirements Apply.

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Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through UnitedHealthcare

Plan Code	Coinsurance		Deductible				Out-Of-Pocket Maximum				Copay/Per Occurrence								
	Network	Out of Network	Network		Out of Network		Network		Out of Network		Virtual Visits	PCP	PCP	Spec	Urgent Care	ER	Lab/X-ray	MRI, CT & PET	Inpatient Hospital
			Single	Family	Single	Family	Single	Family	Single	Family		Ages 19+	Ages <19						
Choice Insurance *																			
EK-CC	80%	N/A	$3,000	$6,000	N/A	N/A	$5,000	$10,000	N/A	N/A	100%	$30	$0	$60	$100	Ded + 80%	Ded + 80%	Ded + 80%	Ded + 80%
EK-CD	80%	N/A	$4,000	$8,000	N/A	N/A	$5,000	$10,000	N/A	N/A	100%	$30	$0	$60	$100	Ded + 80%	Ded + 80%	Ded + 80%	Ded + 80%
EK-CE	80%	N/A	$5,000	$10,000	N/A	N/A	$6,350	$12,700	N/A	N/A	100%	$30	$0	$60	$100	Ded + 80%	Ded + 80%	Ded + 80%	Ded + 80%

Designated Diagnostic Laboratory and Complex Imaging Provider Requirements Apply.

* In-Network Only plans exclude coverage for services provided by Out-of-Network Providers with the exceptions of 1) Services performed in a Network Facility by hospital-based providers; and 2) Services performed under the Emergency Care benefit.

Plan Code	Coinsurance		Deductible				Out-Of-Pocket Maximum				Copay/Per Occurrence							
	Network	Out of Network	Network		Out of Network		Network		Out of Network		Virtual Visits	PCP	Spec	Urgent Care	ER	Lab/X-ray	MRI, CT & PET	Inpatient Hospital
			Single	Family	Single	Family	Single	Family	Single	Family								
Choice Insurance Consumer																		
EK-D3	80%	N/A	$3,500	$7,000	N/A	N/A	$6,350	$12,700	N/A	N/A	100%	Ded + 80%	Ded + 80%	Ded + 80%	Ded + 80%	Ded + 80%	Ded + 80%	Ded + 80%

Designated Diagnostic Laboratory and Complex Imaging Provider Requirements Apply.

* In-Network Only plans exclude coverage for services provided by Out-of-Network Providers with the exceptions of 1) Services performed in a Network Facility by hospital-based providers; and 2) Services performed under the Emergency Care benefit.

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Plan Code	Coinsurance		Deductible				Out-Of-Pocket Maximum				Copay/Per Occurrence								
	Network	Out of Network	Network		Out of Network		Network		Out of Network		Virtual Visits	PCP Ages 19+	PCP Ages <19	Spec	Urgent Care	ER	Lab/X-ray	MRI, CT & PET	Inpatient Hospital
			Single	Family	Single	Family	Single	Family	Single	Family									
Wisconsin Plan Choice Plus																			
EK-C6	100%	80%	$2,000	$4,000	$4,000	$8,000	$3,500	$7,000	$7,000	$14,000	100%	$30	$0	$60	$100	Ded + 100%	Ded + 100%	Ded + 100%	Ded + 100%

Designated Diagnostic Laboratory and Complex Imaging Provider Requirements Apply.

Plan Code	Coinsurance		Deductible				Out-Of-Pocket Maximum				Copay/Per Occurrence								
	Network	Out of Network	Network		Out of Network		Network		Out of Network		Virtual Visits	PCP Ages 19+	PCP Ages <19	Spec	Urgent Care	ER	Lab/X-ray	MRI, CT & PET	Inpatient Hospital
			Single	Family	Single	Family	Single	Family	Single	Family									
Wisconsin Plan Choice*																			
EK-C5	80%	N/A	$7,000	$14,000	N/A	N/A	$7,350	$14,700	N/A	N/A	100%	$45	$0	$90	$50	Ded + 80%	Ded + 80%	Ded + 80%	Ded + 80%

Designated Diagnostic Laboratory and Complex Imaging Provider Requirements Apply.

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Plan Code	Coinsurance		Deductible				Out-Of-Pocket Maximum				Copay/Per Occurrence							
	Network	Out of Network	Network		Out of Network		Network		Out of Network		Virtual Visits	PCP	Spec	Urgent Care	ER	Lab/X-ray	MRI, CT & PET	Inpatient Hospital
			Single	Family	Single	Family	Single	Family	Single	Family								
Choice Plus Insurance H S A																		
EQ-Q8	100%	70%	$3,400	$6,800	$10,000	$20,000	$3,400	$6,800	$20,000	$40,000	Ded + 100%	Ded + 100%	Ded + 100%	Ded + 100%	Ded + 100%	Ded + 100%	Ded + 100%	Ded + 100%
EQ-RD	100%	80%	$3,400	$6,800	$5,000	$10,000	$6,350	$12,700	$12,700	$25,400	Ded + 100%	Ded + $30	Ded + $60	Ded + $100	Ded + 100%	Ded + 100%	Ded + 100%	Ded + 100%
EK-E6	100%	80%	$3,500	$7,000	$7,500	$15,000	$6,350	$12,700	$12,700	$25,400	Ded + 100%	Ded + $30	Ded + $60	Ded + $100	Ded + 100%	Ded + 100%	Ded + 100%	Ded + 100%
EK-E2	80%	60%	$5,000	$10,000	$10,000	$20,000	$6,350	$12,700	$12,700	$25,400	Ded + 100%	Ded + $30	Ded + $60	Ded + $100	Ded + 100%	Ded + 80%	Ded + 80%	Ded + 80%
EK-FO	80%	60%	$6,000	$12,000	$11,000	$22,000	$6,300	$12,600	$13,100	$26,200	Ded + 100%	Ded + 80%	Ded + 80%	Ded + 80%	Ded + 80%	Ded + 80%	Ded + 80%	Ded + 80%
EK-FT	100%	80%	$6,150	$12,300	$13,000	$26,000	$6,400	$12,800	$14,900	$29,800	Ded + 100%	Ded + 100%	Ded + 100%	Ded + 100%	Ded + 100%	Ded + 100%	Ded + 100%	Ded + 100%

Designated Diagnostic Laboratory and Complex Imaging Provider Requirements Apply.

Plan Code	Coinsurance		Deductible				Out-Of-Pocket Maximum				Copay/Per Occurrence							
	Network	Out of Network	Network		Out of Network		Network		Out of Network		Virtual Visits	PCP	Spec	Urgent Care	ER	Lab/X-ray	MRI, CT & PET	Inpatient Hospital
			Single	Family	Single	Family	Single	Family	Single	Family								
Choice Insurance H S A*																		
EK-E7	100%	N/A	$3,500	$7,000	N/A	N/A	$6,350	$12,700	N/A	N/A	Ded + 100%	Ded + $30	Ded + $60	Ded + $100	Ded + 100%	Ded + 100%	Ded + 100%	Ded + 100%
EK-E3	90%	N/A	$3,500	$7,000	N/A	N/A	$6,350	$12,700	N/A	N/A	Ded + 100%	Ded + $30	Ded + $60	Ded + $100	Ded + 100%	Ded + 90%	Ded + 90%	Ded + 90%
EK-E9	80%	N/A	$5,000	$10,000	N/A	N/A	$6,350	$12,700	N/A	N/A	Ded + 100%	Ded + $30	Ded + $60	Ded + $100	Ded + 100%	Ded + 80%	Ded + 80%	Ded + 80%

Designated Diagnostic Laboratory and Complex Imaging Provider Requirements Apply.

* In-Network Only plans exclude coverage for services provided by Out-of-Network Providers with the exceptions of 1) Services performed in a Network Facility by hospital-based providers; and 2) Services performed under the Emergency Care benefit.

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Plan Code	Coinsurance		Deductible				Out-Of-Pocket Maximum				Copay/Per Occurrence								
	Network	Out of Network	Network		Out of Network		Network		Out of Network		Virtual Visits	PCP Ages 19+	PCP Ages <19	Spec	Urgent Care	ER	Lab/X-ray	MRI, CT & PET	Inpatient Hospital
			Single	Family	Single	Family	Single	Family	Single	Family									
Wisconsin Plan Choice Plus Primary Advantage																			
EK-BW	80%	50%	$1,000	$2,000	$5,000	$10,000	$6,500	$13,000	$10,000	$20,000	100%	100%	N/A	$100	$50	Ded + 80%	Ded + 80%	Ded + 80%	Ded + 80%
EK-BX	80%	50%	$2,000	$4,000	$5,000	$10,000	$6,500	$13,000	$10,000	$20,000	100%	100%	N/A	$100	$50	Ded + 80%	Ded + 80%	Ded + 80%	Ded + 80%
EK-BY	80%	50%	$5,000	$10,000	$10,000	$20,000	$6,500	$13,000	$20,000	$40,000	100%	100%	N/A	$100	$50	Ded + 80%	Ded + 80%	Ded + 80%	Ded + 80%

Designated Diagnostic Laboratory and Complex Imaging Provider Requirements Apply.

Plan Code	Coinsurance		Deductible				Out-Of-Pocket Maximum				Copay/Per Occurrence								
	Network	Out of Network	Network		Out of Network		Network		Out of Network		Virtual Visits	PCP Ages 19+	PCP Ages <19	Spec	Urgent Care	ER	Lab/X-ray	MRI, CT & PET	Inpatient Hospital
			Single	Family	Single	Family	Single	Family	Single	Family									
Choice Insurance Primary Advantage*																			
EK-B3	50%	N/A	$2,000	$4,000	N/A	N/A	$7,350	$14,700	N/A	N/A	100%	100%	N/A	$100	$50	Ded + 50%	Ded + 50%	Ded + 50%	Ded + 50%
EK-B4	50%	N/A	$3,000	$6,000	N/A	N/A	$7,350	$14,700	N/A	N/A	100%	100%	N/A	$100	$50	Ded + 50%	Ded + 50%	Ded + 50%	Ded + 50%

Designated Diagnostic Laboratory and Complex Imaging Provider Requirements Apply.

* In-Network Only plans exclude coverage for services provided by Out-of-Network Providers with the exceptions of 1) Services performed in a Network Facility by hospital-based providers; and 2) Services performed under the Emergency Care benefit.

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Plan Code	Coinsurance		Deductible				Out-Of-Pocket Maximum				Copay/Per Occurrence							
	Network	Out of Network	Network		Out of Network		Network		Out of Network		Virtual Visits	PCP	Spec	Urgent Care	ER	Lab/X-ray	MRI, CT & PET	Inpatient Hospital
			Single	Family	Single	Family	Single	Family	Single	Family								
Choice Plus Insurance Flex Free																		
EK-B5	80%	50%	$2,500	$5,000	$5,000	$10,000	$6,850	$13,700	$10,000	$20,000	100%	100%	100%	100%	Ded + 80%	Ded + 80%	+ 80%	$250 + Ded + 80%
EK-B6	80%	50%	$3,500	$7,000	$7,000	$14,000	$6,850	$13,700	$14,000	$24,000	100%	100%	100%	100%	Ded + 80%	Ded + 80%	+ 80%	$250 + Ded + 80%
EK-B7	80%	50%	$5,000	$10,000	$10,000	$20,000	$6,850	$13,700	$20,000	$40,000	100%	100%	100%	100%	Ded + 80%	Ded + 80%	+ 80%	$250 + Ded + 80%

Designated Diagnostic Laboratory and Complex Imaging Provider Requirements Apply.

Plan Code	Coinsurance		Deductible				Out-Of-Pocket Maximum				Copay/Per Occurrence									
	Network	Out of Network	Network		Out of Network		Network		Out of Network		Virtual Visits	PCP Ages 19+	PCP Ages <19	Spec Prem Des	Spec	Urgent Care	ER	Lab/X-ray	MRI, CT, etc.	Inpatient Hospital
			Single	Family	Single	Family	Single	Family	Single	Family										
Choice Plus Insurance Premier																				
EK-GX	80%	50%	$2,000	$4,000	$5,000	$10,000	$7,150	$14,300	$10,000	$20,000	100%	$15	$15	$50	$100	$25	Ded + 80%	Ded + 80%	Ded + 80%	Ded + 80%
EK-GY	80%	50%	$3,000	$6,000	$7,500	$15,000	$7,150	$14,300	$15,000	$30,000	100%	$15	$15	$50	$100	$25	Ded + 80%	Ded + 80%	Ded + 80%	Ded + 80%
EK-GZ	80%	50%	$5,000	$10,000	$10,000	$20,000	$7,150	$14,300	$20,000	$40,000	100%	$15	$15	$50	$100	$25	Ded + 80%	Ded + 80%	Ded + 80%	Ded + 80%

Designated Diagnostic Laboratory and Complex Imaging Provider Requirements Apply.

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Advantage Rx Plans

Rx Plan Code	Deductible Individual	Copays				Combined Med/Rx	Deductible Family	Mail Order
		Tier 1	Tier 2	Tier 3	Tier 4			
454	$250 - T3 & T4	$0	$50	$100	$250	Sep	$500	2.5
455	$250 - T3 & T4	$5	$50	$100	$250	Sep	$500	2.5
2V	N/A	$10	$35	$60	N/A	Sep	N/A	2.5
2V	Same as Medical	$10	$35	$60	N/A	Comb	Same as Medical	2.5
0I	N/A	$10	$35	$70	N/A	Sep	N/A	2.5
0I	Same as Medical	$10	$35	$70	N/A	Comb	Same as Medical	2.5
AU	$250	$10	$35	$70	N/A	Sep	$750	2.5
DS	Same as Medical	$15	$45	$85	$200	Comb	Same as Medical	3.0
DS	N/A	$15	$45	$85	$200	Sep	N/A	3.0
MM*	Same as Medical	No Copay	No Copay	No Copay	N/A	Comb	Same as Medical	No Copay

* Paired with 100% Coinsurance HSA plans with Deductible equal to Out of Pocket Maximum.

Advantage w/SMCS Drugs Rx Plans

Rx Plan Code	Deductible Individual	Copays								Combined Med/Rx	Deductible Family	Mail Order
		Tier 1	Tier 1 Specialty	Tier 2	Tier 2 Specialty	Tier 3	Tier 3 Specialty	Tier 4	Tier 4 Specialty			
0I0S	N/A	$10	$10	$35	$150	$70	$500	N/A	N/A	Sep	N/A	2.5
0I0S	Same as Medical	$10	$10	$35	$150	$70	$500	N/A	N/A	Comb	Same as Medical	2.5

Essential w/SMCS Drugs Rx Plans

Rx Plan Code	Deductible Individual	Copays								Combined Med/Rx	Deductible Family	Mail Order
		Tier 1	Tier 1 Specialty	Tier 2	Tier 2 Specialty	Tier 3	Tier 3 Specialty	Tier 4	Tier 4 Specialty			
G76S	Same as Medical	$5	$5	$40	$40	$105	$105	$250	$500	Comb	Same as Medical	2.5
G76S	N/A	$5	$5	$40	$40	$105	$105	$250	$500	Sep	N/A	2.5
G78S	N/A	$10	$10	$50	$50	$120	$120	$250	$500	Sep	N/A	2.5

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Plan Code	Coinsurance				Deductible				Out-Of-Pocket Maximum				Copay/Per Occurrence							Outpatient Surgery		Inpatient Hospital	
	Network	Out of Network	Physician Professional		Network		Out of Network		Network		Out of Network		PCP			Specialist		Urgent Care	ER				
			Design Network	Network	Single	Family	Single	Family	Single	Family	Single	Family	Virtual Visits	Design Network	Design Network	Network	Design Network			Design Network	Network	Design Network	Network
Nexus Insurance OAP																							
EK-IE	100%	70%	100%	80%	$1,000	$2,000	$5,000	$10,000	$4,000	$8,000	$10,000	$20,000	100%	$10	$40	$40	$100	$50	Ded + 100%	Ded + 100%	$250 + Ded + 80%	Ded + 100%	$500 + Ded + 80%
EK-IF	80%	50%	80%	50%	$2,000	$4,000	$5,000	$10,000	$5,000	$10,000	$10,000	$20,000	100%	$15	$45	$50	$125	$50	Ded + 80%	Ded + 80%	$250 + Ded + 50%	Ded + 80%	$500 + Ded + 50%
EK-IK	100%	70%	100%	70%	$5,000	$10,000	$10,000	$20,000	$7,900	$15,800	$20,000	$40,000	100%	$10	$40	$40	$100	$50	Ded + 100%	Ded + 100%	$250 + Ded + 70%	Ded + 100%	$500 + Ded + 70%

Primary Care Physicians include General Practice, Family Practice, Internal Medicine and Pediatrics

Nexus is not available in all counties

Plan Code	Coinsurance				Deductible				Out-Of-Pocket Maximum				Copay/Per Occurrence							Outpatient Surgery		Inpatient Hospital	
	Network	Out of Network	Physician Professional		Network		Out of Network		Network		Out of Network		PCP			Specialist		Urgent Care	ER				
			Design Network	Network	Single	Family	Single	Family	Single	Family	Single	Family	Virtual Visits	Design Network	Design Network	Network	Design Network			Design Network	Network	Design Network	Network
Nexus Insurance OAP Non-Embedded H S A																							
EK-I2	100%	70%	100%	70%	$2,000	$4,000	$6,000	$12,000	$3,000	$6,000	$12,000	$24,000	Ded + 100%	Ded + 100%	Ded + 70%	Ded + 100%	Ded + 70%	Ded + 100%	Ded + 100%	Ded + 100%	$250 + Ded + 70%	Ded + 100%	$500 + Ded + 70%
EK-I3	100%	70%	100%	70%	$2,800	$5,600	$7,500	$15,000	$6,500	$8,700	$15,000	$30,000	Ded + 100%	Ded + 100%	Ded + 70%	Ded + 100%	Ded + 70%	Ded + 100%	Ded + 100%	Ded + 100%	$250 + Ded + 70%	Ded + 100%	$500 + Ded + 70%
Nexus Insurance OAP H S A																							
EK-I4	100%	70%	100%	80%	$5,000	$10,000	$10,000	$20,000	$6,500	$13,000	$20,000	$40,000	Ded + 100%	Ded + 100%	Ded + 80%	Ded + 100%	Ded + 80%	Ded + 100%	Ded + 100%	Ded + 100%	$250 + Ded + 80%	Ded + 100%	$500 + Ded + 80%

Primary Care Physicians include General Practice, Family Practice, Internal Medicine and Pediatrics

Nexus is not available in all counties

WMC INSURANCE

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Plan Code	Coinsurance				Deductible				Out-Of-Pocket Maximum				Copay/Per Occurrence							Outpatient Surgery		Inpatient Hospital	
	Network	Out of Network	Physician Professional		Network		Out of Network		Network		Out of Network		PCP			Specialist		Urgent Care	ER				
			Design Network	Network	Single	Family	Single	Family	Single	Family	Single	Family	Virtual Visits	Design Network	Design Network	Network	Design Network			Design Network	Network	Design Network	Network
Wisconsin Plan Nexus OA*																							
EK-IQ	80%	N/A	80%	50%	$5,000	$10,000	N/A	N/A	$7,900	$15,800	N/A	N/A	100%	$15	$45	$50	$125	$50	Ded + 80%	Ded + 80%	$250 + Ded + 50%	Ded + 80%	$500 + Ded + 50%
Wisconsin Plan Nexus OA H S A*																							
EK-I7	100%	N/A	100%	80%	$5,000	$10,000	N/A	N/A	$6,500	$13,000	N/A	N/A	Ded + 100%	Ded + 100%	Ded + 80%	Ded + 100%	Ded + 80%	Ded + 100%	Ded + 100%	Ded + 100%	$250 + Ded + 80%	Ded + 100%	$500 + Ded + 80%

* In-Network Only plans exclude coverage for services provided by Out-of-Network Providers with the exceptions of 1) Services performed in a Network Facility by hospital-based providers; and 2) Services performed under the Emergency Care benefit.

Primary Care Physicians include General Practice, Family Practice, Internal Medicine and Pediatrics

Nexus is not available in all counties

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Nexus Advantage Rx Plans

Rx Plan Code	Deductible Individual	Copays				Combined Med/Rx	Deductible Family	Mail Order
		Tier 1	Tier 2	Tier 3	Tier 4			
0I	N/A	$10	$35	$70	N/A	Sep	N/A	2.5
0I	Same as Medical	$10	$35	$70	N/A	Comb	Same as Medical	2.5
AU	$250	$10	$35	$70	N/A	Sep	$750	2.5

Nexus Advantage w/SMCS Drugs Rx Plans

Rx Plan Code	Deductible Individual	Copays								Combined Med/Rx	Deductible Family	Mail Order
		Tier 1	Tier 1 Specialty	Tier 2	Tier 2 Specialty	Tier 3	Tier 3 Specialty	Tier 4	Tier 4 Specialty			
0I0S	N/A	$10	$10	$35	$150	$70	$500	N/A	N/A	Sep	N/A	2.5
0I0S	Same as Medical	$10	$10	$35	$150	$70	$500	N/A	N/A	Comb	Same as Medical	2.5

Nexus Essential w/SMCS Drugs Rx Plans

Rx Plan Code	Deductible Individual	Copays								Combined Med/Rx	Deductible Family	Mail Order
		Tier 1	Tier 1 Specialty	Tier 2	Tier 2 Specialty	Tier 3	Tier 3 Specialty	Tier 4	Tier 4 Specialty			
G76S	Same as Medical	$5	$5	$40	$40	$105	$105	$250	$500	Comb	Same as Medical	2.5
G76S	N/A	$5	$5	$40	$40	$105	$105	$250	$500	Sep	N/A	2.5
G78S	N/A	$10	$10	$50	$50	$120	$120	$250	$500	Sep	N/A	2.5

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Notes

1.Primary Care Physicians include General Practice, Family Practice, Internal Medicine and Pediatrics.

2.Designated Tier applies to UnitedHealth Premium quality and efficiency designated providers. Please visit myuhc.com for details.

3.“Embedded” deductible means once an individual meets their portion of the deductible, services are paid for that person without the entire family deductible being met.

“Non-Embedded” deductible means no covered family member will satisfy an individual deductible until the entire family deductible is met.

4.“FlexFree” plans feature a copay for each covered family member for Office and Urgent Care visits one through three during the calendar year or plan year, depending on plan type selected.

Visits four and over will be subject to plan deductible/coinsurance. This is a separate limit for Physician Office visits and Urgent Care visits. Plans feature one Preventive Care visit per year,

which does not count against the office visit copay limit.

outpatient surgeries, “scopic” procedures, transplants, congenital heart disease, complex imaging, reconstructive procedures and pregnancy-inpatient.

5. Copayments on HSA plans will be required after the deductible has been met and will continue to be required until the annual out-of-pocket maximum is met.

6. In-Network Only plans exclude coverage for services provided by Out-of-Network Providers with the exceptions of 1) Services performed in a Network Facility

by hospital-based providers; and 2) Services performed under the Emergency Care benefit.

Designated Diagnostic Provider (DDP) Requirement

Additional Coinsurance may apply when accessing a Non-DDP provider. See your Benefit Summary for coverage details.

Wisconsin Plans are licensed under United Healthcare of Wisconsin – a Health Maintenance Organization.

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