UnitedHealthcare Catalyst

Better information. Better decisions. Better health.

Pennsylvania
For Fully Insured Groups
Effective April 1, 2012

Description	Insurance Plan Codes		HMO Plan Codes		Network Pre-Deductible Allowance Benefits[1]							Benefits After Pre-Deductible Allowance[3]										
					Routine Services Pre-Deductible Allowance	Emergency Pre-Deductible Allowance	Copay				Coinsurance	Deductible				Coinsurance		Out-of-Pocket Maximum				IP[2] / OP Surg
	Choice	Choice Plus	Choice	Choice Plus			PCP	SPEC	URG CARE	ER	Ambulance	In		Out		In	Out	In		Out		
	Network Only	Network & Non-Network	Network Only	Network & Non-Network								Single	Family	Single	Family			Single	Family	Single	Family	
3,000/80% 30/0/80%	AJ-B	AJ-N			$350	$1,000	$30	$60	$75	$200	80%	$3,000	$9,000	$7,500	$22,500	80%	60%	$5,500	$11,000	$11,000	$26,000	80% after deductible
5,000/80% 25/0/80%	AJ-K				$450	$1,500	$25	$50	$75	$200	80%	$5,000	$15,000			80%		$7,500	$17,500			80% after deductible
5,000/80% 30/0/80%		AJ-Z			$450	$1,500	$30	$60	$75	$200	80%	$5,000	$15,000	$9,500	$25,000	80%	60%	$7,500	$16,500	$13,000	$30,000	80% after deductible

Pharmacy Plans

RX Plan Code	Deductible		Tier 1	Tier 2	Tier 3	Tier 4	Mail Service Ratio
	Individual	Family					
AU	$250	$750	$10	$35	$70	n/a	2.5x retail
5W	$250	$750	$10	$35	$60	$100	2.5x retail

Please Note: UnitedHealthcare Catalyst plans are only available in states that have implemented the 2007 Certificate of Coverage plans. 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.

· All Plans have an Unlimited Lifetime Maximum
· All Plans cover in network Preventive care at 100%

1 Refer to the Certificate of Coverage and/or Benefits Summary document for complete listing of services included in Pre-Deductible Allowance Benefit. Non-Network services are eligible for Pre-Deductible Allowance and subject to separate coinsurance.
2 Refer to the complete Certificate of Coverage and/or Benefit Summary documents for IP copay type (i.e. per day or per admit).
3 Benefits after Pre-Deductible Allowance has been exhausted and services not eligible for Pre-Deductible Allowance.

Notes for all plan types unless noted otherwise:

- Pre-Deductible Allowance applies to medical services only
- Pre-Deductible Allowance is the amount the plan pays per member before the deductible applies
- Members incur copay or coinsurance cost share during the Pre-Deductible Allowance benefit
- Copay and coinsurance do not accumulate toward Pre-Deductible Allowance or Annual Deductible
- Vision Coverage: 1 Exam every 2 years $30 copay then 100%. Accumulates to the Pre-deductible Allowance
- Out-of-Network Preventive not covered

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