

Oklahoma PacifiCare SignatureEliteSM Plus Plans

Groups with 2-50 Eligible Employees

Medical Plans

Plan Code	Copay / Per Occurrence						Coinsurance		Deductible				Out-of-Pocket Maximum*			
	PCP	Spec	Urgent Care	ER	OP	IP	Network	Non-Network	Network		Non-Network		Network		Non-Network	
									Single	Family	Single	Family	Single	Family	Single	Family
PacifiCare Plans																
PM-G	\$30	\$50	\$75	\$250	80%	80%	80%	60%	\$1,500	\$3,000	\$4,500	\$9,000	\$4,000	\$8,000	\$12,000	\$24,000
PM-H	\$30	\$50	\$75	\$250	80%	80%	80%	60%	\$2,000	\$4,000	\$6,000	\$12,000	\$5,000	\$10,000	\$15,000	\$30,000
PM-I	\$30	\$50	\$75	\$250	80%	80%	80%	60%	\$2,500	\$5,000	\$7,500	\$15,000	\$6,000	\$12,000	\$18,000	\$36,000
PM-J	\$30	\$50	\$75	\$250	80%	80%	80%	60%	\$3,000	\$6,000	\$9,000	\$18,000	\$7,000	\$14,000	\$21,000	\$42,000
PM-P	\$35	\$60	\$100	\$250	70%	70%	70%	50%	\$1,500	\$3,000	\$4,500	\$9,000	\$6,000	\$12,000	\$18,000	\$36,000
PM-Q	\$35	\$60	\$100	\$250	70%	70%	70%	50%	\$2,000	\$4,000	\$6,000	\$12,000	\$7,000	\$14,000	\$21,000	\$42,000
PM-R	\$35	\$60	\$100	\$250	70%	70%	70%	50%	\$2,500	\$5,000	\$7,500	\$15,000	\$8,000	\$16,000	\$24,000	\$48,000
PM-S	\$35	\$60	\$100	\$250	70%	70%	70%	50%	\$3,000	\$6,000	\$9,000	\$18,000	\$9,000	\$18,000	\$27,000	\$54,000
PM-T	\$35	\$60	\$100	\$250	70%	70%	70%	50%	\$3,500	\$7,000	\$10,500	\$21,000	\$10,000	\$20,000	\$30,000	\$60,000
PM-E	70%	70%	70%	70%	70%	70%	70%	50%	\$5,000	\$10,000	\$15,000	\$30,000	\$10,000	\$20,000	\$30,000	\$60,000

Please note: All plans have a \$2,000,000 combined In-Network and Out-of-Network Lifetime Maximum, a \$500 inpatient hospital per occurrence deductible, and \$250 outpatient surgery per occurrence deductible for Out-of-Network facilities. These are separate from, and in addition to, the annual medical plan deductible and do not apply to the out-of-pocket maximum. Preventive care is subject to member cost share, and is limited to \$400 of plan-paid benefits per year.

*Out-of-pocket maximums listed include the annual plan deductible.

Pharmacy Plans

Plan Code	Deductible		Copay				Mail Order (90-day Supply)
	Single	Family	Tier 1	Tier 2	Tier 3	Tier 4	
2V	N/A	N/A	\$10	\$35	\$60	N/A	2.5x each retail category
5V	\$100	\$300	\$10	\$35	\$60	\$100	2.5x each retail category
0I	N/A	N/A	\$10	\$35	\$70	N/A	2.5x each retail category
G4	\$100	\$300	\$10	\$30	\$50	N/A	2.5x each retail category
H9	N/A	N/A	\$10	\$30	\$50	N/A	2.5x each retail category
S8	\$250	\$750	\$10	\$30	\$50	N/A	2.5x each retail category

Please Note: The information in this grid is provided for informational purposes only & is not intended for use as a contract. For a complete listing of coverage & exclusions please refer to the Certificate of Coverage or talk to your UnitedHealthcare representative for additional details that could impact the benefits.