Medical Plan Offerings– UnitedHealthcare 2025*

*Carrier availability is based on client headquartered location, as well as client selection.

Information shown in this document does not include all plan details or changes. Refer to the Carrier Certificate on TriNet (login.TriNet.com).

PY25 TN III-Q3

Plan Offerings

Plan Highlights	UHC 500 PR	UHC 500 US Territories	UHC Choice+ 1000	UHC Choice+ 1500	UHC Choice+ 1500 Nevada	UHC Choice+ 1500 SC
Network Name	MAPFRE and Differential Options PPO	Options PPO	Choice Plus	Choice Plus	Choice Plus	Choice Plus
Deductible						
Single (In-Network/OON)	$500 / $500	$500 / $500	$1,000 / $2,000	$1,500 / $6,000	$1,500 / $6,000	$1,500 / $6,000
Family (In-Network/OON)	$1,000 / $1,000	$1,000 / $1,000	$2,000 / $4,000	$3,000 / $12,000	$3,000 / $12,000	$3,000 / $12,000
Out-of-Pocket Max						
Single (In-Network/OON)	$3,000 / $3,000	$3,000 / $3,000	$4,000 / $8,000	$5,000 / $12,000	$5,000 / $12,000	$5,000 / $12,000
Family (In-Network/OON)	$6,000 / $6,000	$6,000 / $6,000	$8,000 / $16,000	$10,000 / $24,000	$10,000 / $24,000	$10,000 / $24,000
Coinsurance (In-Network/OON)	20% / 20%	20% / 20%	20% / 40%	30% / 50%	30% / 50%	30% / 50%
Primary / Specialist	20% after ded / 20% after ded	20% after ded / 20% after ded	$30 / $60	$40 / $80	$40 / $80	$40 / $80
Lab & X-Ray	20% after ded	20% after ded	no cost or 20%	no cost or 30%	no cost or 30%	no cost or 30%
Urgent Care Visit	20% after ded	20% after ded	$75	$100	$100	$100
Emergency Room Visit	20% after ded	20% after ded	$350	$500	$500	$500
Hospital Outpatient (Facility / Surgery)	20% after ded / 20% after ded	20% after ded / 20% after ded	20% after ded / 20% after ded	30% after ded / 30% after ded	30% after ded / 30% after ded	30% after ded / 30% after ded
Hospital Inpatient	20% after ded	20% after ded	20% after ded	30% after ded	30% after ded	30% after ded
Rx Deductible (Non-Generic)	N/A	N/A	N/A	N/A	N/A	N/A
Prescriptions (Tier 1 / 2 / 3)	$10 / $35 / $70	$10 / $35 / $70	$10 / $35 / $70	$10 / $35 / $70	$10 / $35 / $70	$10 / $35 / $70

Plan Offerings

Plan Highlights	UHC Choice+ 2500	UHC Choice+ 300	UHC Choice+ 500	UHC Choice+ 500 Nevada	UHC Choice+ 500 SC	UHC Choice+ 7150
Network Name	Choice Plus	Choice Plus	Choice Plus	Choice Plus	Choice Plus	Choice Plus
Deductible						
Single (In-Network/OON)	$2,500 / $5,000	$300 / $500	$500 / $2,000	$500 / $2,000	$500 / $2,000	$7,150 / $10,000
Family (In-Network/OON)	$5,000 / $10,000	$600 / $1,000	$1,000 / $4,000	$1,000 / $4,000	$1,000 / $4,000	$14,300 / $20,000
Out-of-Pocket Max						
Single (In-Network/OON)	$6,000 / $10,000	$1,500 / $3,500	$2,000 / $6,000	$2,000 / $6,000	$2,000 / $6,000	$7,150 / $15,000
Family (In-Network/OON)	$12,000 / $20,000	$3,000 / $7,000	$4,000 / $12,000	$4,000 / $12,000	$4,000 / $12,000	$14,300 / $30,000
Coinsurance (In-Network/OON)	20% / 50%	0% / 30%	10% / 40%	10% / 40%	10% / 40%	0% / 50%
Primary / Specialist	$30 / $60	$10 / $25	$25 / $50	$25 / $50	$25 / $50	$40 / $80
Lab & X-Ray	no cost or 20%	no cost or 0% after ded	no cost or 10%	no cost or 10%	no cost or 10%	no cost
Urgent Care Visit	$75	$35	$75	$75	$75	0% after ded
Emergency Room Visit	$350	$75	$350	$350	$350	0% after ded
Hospital Outpatient (Facility / Surgery)	20% after ded / 20% after ded+$250	0% after ded / 0% after ded	10% after ded / 10% after ded	10% after ded / 10% after ded	10% after ded / 10% after ded	0% after ded / 0% after ded
Hospital Inpatient	20% after ded + $500	$250	10% after ded	10% after ded	10% after ded	0% after ded
Rx Deductible (Non-Generic)	N/A	N/A	N/A	N/A	N/A	N/A
Prescriptions (Tier 1 / 2 / 3)	$10 / $35 / $70	$10 / $35 / $70	$10 / $35 / $70	$10 / $35 / $70	$10 / $35 / $70	$10 / $35 / $70

Plan Offerings

Plan Highlights	UHC Choice+ 7150 Nevada	UHC Choice+ 7150 SC	UHC HDHP 2000	UHC HDHP 3500	UHC HDHP 3500 Nevada	UHC HDHP 3500 SC
Network Name	Choice Plus	Choice Plus	Choice Plus	Choice Plus	Choice Plus	Choice Plus
Deductible						
Single (In-Network/OON)	$7,150 / $10,000	$7,150 / $10,000	$2,000 / $5,000	$3,500 / $7,000	$3,500 / $7,000	$3,500 / $7,000
Family (In-Network/OON)	$14,300 / $20,000	$14,300 / $20,000	$4,000 / $10,000	$7,000 / $14,000	$7,000 / $14,000	$7,000 / $14,000
Out-of-Pocket Max						
Single (In-Network/OON)	$7,150 / $15,000	$7,150 / $15,000	$4,000 / $10,000	$7,000 / $13,000	$7,000 / $13,000	$7,000 / $13,000
Family (In-Network/OON)	$14,300 / $30,000	$14,300 / $30,000	$7,500 / $20,000	$14,000 / $26,000	$14,000 / $26,000	$14,000 / $26,000
Coinsurance (In-Network/OON)	0% / 50%	0% / 50%	10% / 50%	10% / 50%	10% / 50%	10% / 40%
Primary / Specialist	$40 / $80	$40 / $80	10% after ded / 10% after ded	10% after ded / 10% after ded	10% after ded / 10% after ded	10% after ded / 10% after ded
Lab & X-Ray	no cost	no cost	10% after ded	10% after ded	10% after ded	10% after ded
Urgent Care Visit	0% after ded	0% after ded	10% after ded	10% after ded	10% after ded	10% after ded
Emergency Room Visit	0% after ded	0% after ded	10% after ded	10% after ded	10% after ded	10% after ded
Hospital Outpatient (Facility / Surgery)	0% after ded / 0% after ded	0% after ded / 0% after ded	10% after ded / 10% after ded	10% after ded / 10% after ded	10% after ded / 10% after ded	10% after ded / 10% after ded
Hospital Inpatient	0% after ded	0% after ded	10% after ded	10% after ded	10% after ded	10% after ded
Rx Deductible (Non-Generic)	N/A	N/A	Integrated w/med	Integrated w/Med	Integrated w/med	Integrated w/med
Prescriptions (Tier 1 / 2 / 3)	$10 / $35 / $70	$10 / $35 / $70	$10 after ded / $35 after ded / $70 after ded	$10 after ded / $35 after ded / $70 after ded	$10 after ded / $35 after ded / $70 after ded	$10 after ded / $35 after ded / $70 after ded

Plan Offerings

Plan Highlights	UHC HDHP 5500	UHC HDHP 5500 Nevada	UHC HDHP 5500 SC	UHC PPO 100 HI	UHC Primary 1000	UHC Primary 1500
Network Name	Choice Plus	Choice Plus	Choice Plus	Options PPO	Choice Plus	Choice Plus
Deductible						
Single (In-Network/OON)	$5,500 / $15,000	$5,500 / $15,000	$5,500 / $15,000	$100 / $100	$1,000 / $4,000	$1,500 / $6,000
Family (In-Network/OON)	$11,000 / $30,000	$11,000 / $30,000	$11,000 / $30,000	$300 / $300	$2,000 / $8,000	$3,000 / $12,000
Out-of-Pocket Max						
Single (In-Network/OON)	$6,400 / $20,000	$6,400 / $20,000	$6,400 / $20,000	$2,500 / $2,500	$7,150 / $10,000	$7,150 / $12,000
Family (In-Network/OON)	$12,800 / $40,000	$12,800 / $40,000	$12,800 / $40,000	$7,500 / $7,500	$14,300 / $20,000	$14,300 / $24,000
Coinsurance (In-Network/OON)	0% / 30%	0% / 30%	0% / 30%	10% / 30%	20% / 50%	20% / 50%
Primary / Specialist	0% after ded / 0% after ded	0% after ded / 0% after ded	0% after ded / 0% after ded	10% / 10%	$0 / $75	$0 / $75
Lab & X-Ray	0% after ded	0% after ded	0% after ded	10%	no cost or 20%	20% after ded
Urgent Care Visit	0% after ded	0% after ded	0% after ded	10% after ded	$75	$75
Emergency Room Visit	0% after ded	0% after ded	0% after ded	10%	$350	$350
Hospital Outpatient (Facility / Surgery)	0% after ded / 0% after ded	0% after ded / 0% after ded	0% after ded / 0% after ded	10% / 10%	20% after ded / 20% after ded	20% after ded / 20% after ded
Hospital Inpatient	0% after ded	0% after ded	0% after ded	10%	20% after ded	20% after ded
Rx Deductible (Non-Generic)	Integrated w/med	Integrated w/Med	Integrated w/med	N/A	N/A	N/A
Prescriptions (Tier 1 / 2 / 3)	$10 after ded / $35 after ded / $70 after ded	$10 after ded / $35 after ded / $70 after ded	$10 after ded / $35 after ded / $70 after ded	$10 / $35 / $70	$10 / $35 / $70	$10 / $35 / $70

Plan Offerings

Plan Highlights	UHC Primary 2500	UHC Primary 5000
Network Name	Choice Plus	Choice Plus
Deductible		
Single (In-Network/OON)	$2,500 / $10,000	$5,000 / $10,000
Family (In-Network/OON)	$5,000 / $20,000	$10,000 / $20,000
Out-of-Pocket Max		
Single (In-Network/OON)	$7,150 / $20,000	$7,150 / $20,000
Family (In-Network/OON)	$14,300 / $40,000	$14,300 / $40,000
Coinsurance (In-Network/OON)	20% / 50%	20% / 50%
Primary / Specialist	$0 / $75	$0 / $75
Lab & X-Ray	20% after ded	20% after ded
Urgent Care Visit	$75	$75
Emergency Room Visit	$350	$350
Hospital Outpatient (Facility / Surgery)	20% after ded / 20% after ded	20% after ded / 20% after ded
Hospital Inpatient	20% after ded	20% after ded
Rx Deductible (Non-Generic)	N/A	N/A
Prescriptions (Tier 1 / 2 / 3)	$10 / $35 / $70	$10 / $35 / $70