

California Small Business (1–100) Plan Benefit Changes

For groups renewing January 1, 2020 and after



UnitedHealthcare Select Plus and UnitedHealthcare Core Platinum Plan Mapping

Prior to Jan. 1, 2020

Metallic Level		Plati	num	
Select Plus / Core HDHP Plan	10/	10%	10/	10%
Network ¹	Network	Non-Network	Network	Non-Network
Annual Deductible ² (individual/family)	None	\$1,000/\$2,000	None	\$1,000/\$2,000
Annual Out-of-Pocket Limit ^s (individual/family)	\$3,200/\$6,400	\$6,400/\$12,800	\$3,500/\$7,000	\$7,000/\$14,000
Professional Services				
Office Visits - PCP	\$10	50% after deductible	\$10	50% after deductible
Office Visits - Specialist	\$20	50% after deductible	\$25	50% after deductible
Laboratory ⁴ (standard)	10%	50% after deductible	10%	50% after deductible
Radiology ⁴ (standard)	10%	50% after deductible	10%	50% after deductible
Maternity Care ⁵	\$10	50% after deductible	\$10	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	10%	50% after deductible	10%	50% after deductible
Inpatient Physician Care	10%	50% after deductible	10%	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	10%	50% after deductible	10%	50% after deductible
Emergency Health Coverage				
Emergency Services	10% plus \$150 per- occurrence deductible	Same as Network benefit	10% plus \$150 per- occurrence deductible	Same as Network benefit
Urgent Care Services	\$50	50% after deductible	\$50	50% after deductible
Ambulance Services	10%	Same as Network benefit	10%	Same as Network benefit
Outpatient Services				
Outpatient Surgery ⁴	10%	50% after deductible	10%	50% after deductible
Durable Medical Equipment	10%	50% after deductible	10%	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	10%	50% after deductible	10%	50% after deductible
Infertility Services (Benefits limited to \$2,000 per lifetime)	10%	50% after deductible	10%	50% after deductible
Injections Received in a Physician's Office	\$10	50% after deductible	\$10	50% after deductible
Mental Health & Substance Use Disorder Serv	ices			
Inpatient	10%	50% after deductible	10%	50% after deductible
Outpatient	\$10	50% after deductible	\$10	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	No	one	No	one
Tier 1	\$	10	\$	10
Tier 2	\$	35	\$	35
Tier 3	\$70		\$	70
Tier 4	10% up to \$250		10% up	to \$250
Pediatric Dental & Vision Coverage ⁵				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	10%	50%	10%	50%

¹ Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

³ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁴ The outpatient per-occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.

⁵ No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Select Plus and Core Platinum Plan Mapping

Prior to Jan. 1, 2020

Metallic Level	Platinum				
Select Plus / Core HDHP Plan	15/25	50/20%	15/250/20%		
Network ¹	Network	Non-Network	Network	Non-Network	
Annual Deductible ² (individual/family)	\$250/\$500	\$1,000/\$2,000	\$250/\$500	\$1,000/\$2,000	
Annual Out-of-Pocket Limit ³ (individual/family)	\$3,200/\$6,400	\$6,400/\$12,800	\$3,500/\$7,000	\$7,000/\$14,000	
Professional Services					
Office Visits - PCP	\$15	50% after deductible	\$15	50% after deductible	
Office Visits - Specialist	\$30	50% after deductible	\$30	50% after deductible	
Laboratory ⁴ (standard)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Radiology ⁴ (standard)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Maternity Care ⁵	\$15	50% after deductible	\$15	50% after deductible	
Preventive Care Services	No copayment	No benefit	No copayment	No benefit	
Hospitalization Services					
Inpatient Hospital Benefits	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Inpatient Physician Care	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Emergency Health Coverage					
Emergency Services	20% after deductible, plus \$150 per occurrence deductible	Same as Network benefit	20% after deductible, plus \$150 per occurrence deductible	Same as Network benefit	
Urgent Care Services	\$50	50% after deductible	\$50	50% after deductible	
Ambulance Services	20% after deductible	Same as Network benefit	20% after deductible	Same as Network benefit	
Outpatient Services					
Outpatient Surgery ⁴	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Durable Medical Equipment	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Home Health Services (Up to 100 visits per calendar year)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Infertility Services (Benefits limited to \$2,000 per lifetime)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Injections Received in a Physician's Office	\$15	50% after deductible	\$15	50% after deductible	
Mental Health & Substance Use Disorder Servi	ces				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Outpatient	\$15	50% after deductible	\$15	50% after deductible	
Outpatient Prescription Drug Coverage					
Calendar Year Deductible (individual/family)	N	one	No	one	
Tier 1	\$	310	\$	10	
Tier 2	\$	35	\$	35	
Tier 3	\$70		\$	70	
Tier 4	10% up to \$250		10% ир	to \$250	
Pediatric Dental & Vision Coverage ⁵					
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	50% after deductible	
Vision Exam (routine)	No copayment	50%	No copayment	50%	
Glasses (frames & lenses)	20%	50%	20%	50%	

¹ Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

³ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁴ The outpatient per-occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.

⁵ No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Select Plus and Core Platinum Plan Mapping

Prior to Jan. 1, 2020

Metallic Level		Plati	num	n	
Select Plus / Core HDHP Plan	250	/20%	250/20%		
Network ¹	Network	Non-Network	Network	Non-Network	
Annual Deductible ² (individual/family)	\$250/\$500	\$1,000/\$2,000	\$250/\$500	\$1,000/\$2,000	
Annual Out-of-Pocket Limit ³ (individual/family)	\$3,200/\$6,400	\$6,400/\$12,800	\$3,500/\$7,000	\$7,000/\$14,000	
Professional Services					
Office Visits - PCP	No copayment	50% after deductible	No copayment	50% after deductible	
Office Visits - Specialist	\$75	50% after deductible	\$75	50% after deductible	
Laboratory ⁴ (standard)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Radiology ⁴ (standard)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Maternity Care ⁵	No copayment	50% after deductible	No copayment	50% after deductible	
Preventive Care Services	No copayment	No benefit	No copayment	No benefit	
Hospitalization Services					
Inpatient Hospital Benefits	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Inpatient Physician Care	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Emergency Health Coverage					
Emergency Services	20% after deductible, plus \$150 per occurrence deductible	Same as Network benefit	20% after deductible, plus \$150 per occurrence deductible	Same as Network benefit	
Urgent Care Services	\$50	50% after deductible	\$50	50% after deductible	
Ambulance Services	20% after deductible	Same as Network benefit	20% after deductible	Same as Network benefit	
Outpatient Services					
Outpatient Surgery ⁴	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Durable Medical Equipment	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Home Health Services (Up to 100 visits per calendar year)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Infertility Services (Benefits limited to \$2,000 per lifetime)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Injections Received in a Physician's Office	No copayment	50% after deductible	No copayment	50% after deductible	
Mental Health & Substance Use Disorder Serv	ices				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Outpatient	No copayment	50% after deductible	No copayment	50% after deductible	
Outpatient Prescription Drug Coverage					
Calendar Year Deductible (individual/family)	N	one	No	one	
Tier 1	:	\$5	S	\$5	
Tier 2	\$	35	\$	35	
Tier 3	\$	370	\$	70	
Tier 4	10% up	o to \$250	10% up	to \$250	
Pediatric Dental & Vision Coverage ⁵					
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	50% after deductible	
Vision Exam (routine)	No copayment	50%	No copayment	50%	
Glasses (frames & lenses)	20%	50%	20%	50%	

¹ Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

³ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁴ The outpatient per-occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.

 $^{^{\}mbox{\tiny 5}}$ No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Prior to Jan. 1, 2020

Metallic Level		G	old	
Select Plus / Core HDHP Plan	25,	/20%	25/	30%
Network ¹	Network	Non-Network	Network	Non-Network
Annual Deductible ² (individual/family)	None	\$1,000/\$2,000	None	\$1,000/\$2,000
Annual Out-of-Pocket Limit ³ (individual/family)	\$7,000/\$14,000	\$12,000/\$24,000	\$6,500/\$13,000	\$13,000/\$26,000
Professional Services				
Office Visits - PCP	\$25	50% after deductible	\$25	50% after deductible
Office Visits - Specialist	\$50	50% after deductible	\$50	50% after deductible
Laboratory ⁴ (standard)	20% after \$250 per- occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	30% for independent, non-hospital-affiliated provider; 50% for hospital- affiliated provider	50% after deductible
Radiology ⁴ (standard)	20% after \$250 per- occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	30% for independent, non-hospital-affiliated provider; 50% for hospital- affiliated provider	50% after deductible
Maternity Care ⁵	\$25	50% after deductible	\$25	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	\$0	50% after deductible, plus \$250 per-occurrence deductible	30%	50% after deductible
Inpatient Physician Care	\$0	50% after deductible	30%	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	\$0	50% after deductible	30%	50% after deductible
Emergency Health Coverage				
Emergency Services	20% after \$250 per- occurrence deductible	Same as Network benefit	30% after \$250 per- occurrence deductible	Same as Network benefit
Urgent Care Services	\$75	50% after deductible	\$75	50% after deductible
Ambulance Services	\$0	Same as Network benefit	30%	Same as Network benefit
Outpatient Services				
Outpatient Surgery ⁴	20% after \$250 per- occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	30% after \$250 per- occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Durable Medical Equipment	\$0	50% after deductible	30%	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	\$0	50% after deductible	30%	50% after deductible
Infertility Services (Benefits limited to \$2,000 per lifetime)	\$0	50% after deductible	30%	50% after deductible
Injections Received in a Physician's Office	\$25	50% after deductible	\$25	50% after deductible
Mental Health & Substance Use Disorder Serv	ices			
Inpatient	\$0	50% after deductible	30%	50% after deductible
Outpatient	\$25	50% after deductible	\$25	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	N	one	No	one
Tier 1	\$	815	\$	15
Tier 2	\$	340	\$4	40
Tier 3		880		80
Tier 4	25% up	o to \$250	25% up	to \$250
Pediatric Dental & Vision Coverage ⁵				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	20%	50%	30%	50%

¹ Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

³ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁴ The outpatient per-occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.

 $^{^{\}mbox{\scriptsize 5}}$ No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Prior to Jan. 1, 2020

Metallic Level		Go	old	
Select Plus / Core HDHP Plan	25/25	0/20%	25/50	0/20%
Network ¹	Network	Non-Network	Network	Non-Network
Annual Deductible ² (individual/family)	\$250/\$500	\$1,000/\$2,000	\$500/\$1,000	\$1,000/\$2,000
Annual Out-of-Pocket Limit ³ (individual/family)	\$6,000/\$12,000	\$12,000/\$24,000	\$6,500/\$13,000	\$13,000/\$26,000
Professional Services				
Office Visits - PCP	\$25	50% after deductible	\$25	50% after deductible
Office Visits - Specialist	\$50	50% after deductible	\$50	50% after deductible
Laboratory ⁴ (standard)	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	20% after deductible for independent, non- hospital-affiliated provider; 40% after deductible for hospital-affiliated provider	50% after deductible
Radiology⁴ (standard)	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	20% after deductible for independent, non- hospital-affiliated provider; 40% after deductible for hospital-affiliated provider	50% after deductible
Maternity Care ⁵	\$25	50% after deductible	\$25	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Inpatient Physician Care	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	20% after deductible, plus \$250 per-occurrence deductible	Same as Network benefit	20% after deductible, plus \$250 per-occurrence deductible	Same as Network benefit
Urgent Care Services	\$75	50% after deductible	\$75	50% after deductible
Ambulance Services	20% after deductible	Same as Network benefit	20% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery ⁴	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Durable Medical Equipment	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Infertility Services (Benefits limited to \$2,000 per lifetime)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Injections Received in a Physician's Office	\$25	50% after deductible	\$25	50% after deductible
Mental Health & Substance Use Disorder Serv	vices			
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	\$25	50% after deductible	\$25	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	No	one	\$250/\$500, does	not apply to Tier 1
Tier 1	\$	15	\$	15
Tier 2	\$4	40	\$4	40
Tier 3	\$8	80	\$8	30
Tier 4	25% up	to \$250	25% up	to \$250
Pediatric Dental & Vision Coverage ⁵				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	20%	50%	20%	50%

¹ Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

³ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁴ The outpatient per-occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.

⁵ No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Prior to Jan. 1, 2020

Metallic Level	Gold			
Select Plus / Core HDHP Plan	25/75	0/20%	25/100	00/20%
Network ¹	Network	Non-Network	Network	Non-Network
Annual Deductible ² (individual/family)	\$750/\$1,500	\$1,500/\$3,000	\$1,000/\$2,000	\$2,000/\$4,000
Annual Out-of-Pocket Limit ³ (individual/family)	\$6,000/\$12,000	\$12,000/\$24,000	\$6,500/\$13,000	\$13,000/\$26,000
Professional Services				
Office Visits - PCP	\$25	50% after deductible	\$25	50% after deductible
Office Visits - Specialist	\$50	50% after deductible	\$50	50% after deductible
Laboratory ⁴ (standard)	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	20% after deductible for independent, non- hospital-affiliated provider; 40% after deductible for hospital-affiliated provider	50% after deductible
Radiology ⁴ (standard)	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	20% after deductible for independent, non- hospital-affiliated provider; 40% after deductible for hospital-affiliated provider	50% after deductible
Maternity Care ⁵	\$25	50% after deductible	\$25	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Inpatient Physician Care	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	20% after deductible, plus \$250 per-occurrence deductible	Same as Network benefit	20% after deductible, plus \$250 per-occurrence deductible	Same as Network benefit
Urgent Care Services	\$75	50% after deductible	\$75	50% after deductible
Ambulance Services	20% after deductible	Same as Network benefit	20% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery ⁴	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Durable Medical Equipment	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Infertility Services (Benefits limited to \$2,000 per lifetime)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Injections Received in a Physician's Office	\$25	50% after deductible	\$25	50% after deductible
Mental Health & Substance Use Disorder Serv	vices			
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	\$25	50% after deductible	\$25	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	No	one	\$250/\$500, does	not apply to Tier 1
Tier 1	\$	15	\$	15
Tier 2	\$4	40		40
Tier 3		30		30
Tier 4	25% up	to \$250	25% up	to \$250
Pediatric Dental & Vision Coverage ⁵				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	20%	50%	20%	50%

¹ Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

³ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁴ The outpatient per-occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.

⁵ No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Prior to Jan. 1, 2020

Metallic Level	Gold			
Select Plus / Core HDHP Plan	1250	/30%	1500	/30%
Network ¹	Network	Non-Network	Network	Non-Network
Annual Deductible ² (individual/family)	\$1,250/\$2,500	\$2,500/\$5,000	\$1,500/\$3,000	\$3,000/\$6,000
Annual Out-of-Pocket Limit ³ (individual/family)	\$5,600/\$11,200	\$11,200/\$22,400	\$6,500/\$13,000	\$13,000/\$26,000
Professional Services				
Office Visits - PCP	No copayment	50% after deductible	No copayment	50% after deductible
Office Visits - Specialist	\$75	50% after deductible	\$75	50% after deductible
Laboratory ⁴ (standard)	30% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	30% after deductible for independent, non- hospital-affiliated provider; 50% after deductible for hospital-affiliated provider	50% after deductible
Radiology ⁴ (standard)	30% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	30% after deductible for independent, non- hospital-affiliated provider; 50% after deductible for hospital-affiliated provider	50% after deductible
Maternity Care ⁵	No copayment	50% after deductible	No copayment	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	30% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	30% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Inpatient Physician Care	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	30% after deductible, plus \$250 per-occurrence deductible	Same as Network benefit	30% after deductible, plus \$250 per-occurrence deductible	Same as Network benefit
Urgent Care Services	\$50	50% after deductible	\$50	50% after deductible
Ambulance Services	30% after deductible	Same as Network benefit	30% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery ⁴	30% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	30% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Durable Medical Equipment	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Infertility Services (Benefits limited to \$2,000 per lifetime)	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Injections Received in a Physician's Office	No copayment	50% after deductible	No copayment	50% after deductible
Mental Health & Substance Use Disorder Serv	vices			
Inpatient	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Outpatient	No copayment	50% after deductible	No copayment	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	\$100/\$200, does no	ot apply to Tiers 1 & 2	\$250/\$500, does	not apply to Tier 1
Tier 1		5		5
Tier 2	\$5	50	\$	50
Tier 3	\$1	00	\$1	00
Tier 4	25% up	to \$250	25% up	to \$250
Pediatric Dental & Vision Coverage ⁵				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	30%	50%	30%	50%

¹ Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

³ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁴ The outpatient per-occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.

⁵ No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Prior to Jan. 1, 2020

Metallic Level	Gold					
Select Plus / Core HDHP Plan	25/125	50/20%	25/100	25/1000/20%		
Network ¹	Network	Non-Network	Network	Non-Network		
Annual Deductible ² (individual/family)	\$1,250/\$2,500	\$2,500/\$5,000	\$1,000/\$2,000	\$2,000/\$4,000		
Annual Out-of-Pocket Limit ³ (individual/family)	\$6,000/\$12,000	\$12,000/\$24,000	\$6,500/\$13,000	\$13,000/\$26,000		
Professional Services						
Office Visits - PCP	\$25	50% after deductible	\$25	50% after deductible		
Office Visits - Specialist	\$50	50% after deductible	\$50	50% after deductible		
Laboratory ⁴ (standard)	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	20% after deductible for independent, non- hospital-affiliated provider; 40% after deductible for hospital-affiliated provider	50% after deductible		
Radiology ⁴ (standard)	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	20% after deductible for independent, non- hospital-affiliated provider; 40% after deductible for hospital-affiliated provider	50% after deductible		
Maternity Care ⁵	\$25	50% after deductible	\$25	50% after deductible		
Preventive Care Services	No copayment	No benefit	No copayment	No benefit		
Hospitalization Services						
Inpatient Hospital Benefits	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible		
Inpatient Physician Care	20% after deductible	50% after deductible	20% after deductible	50% after deductible		
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	50% after deductible	20% after deductible	50% after deductible		
Emergency Health Coverage						
Emergency Services	20% after deductible, plus \$250 per-occurrence deductible	Same as Network benefit	20% after deductible, plus \$250 per-occurrence deductible	Same as Network benefit		
Urgent Care Services	\$75	50% after deductible	\$75	50% after deductible		
Ambulance Services	20% after deductible	Same as Network benefit	20% after deductible	Same as Network benefit		
Outpatient Services						
Outpatient Surgery ⁴	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible		
Durable Medical Equipment	20% after deductible	50% after deductible	20% after deductible	50% after deductible		
Home Health Services (Up to 100 visits per calendar year)	20% after deductible	50% after deductible	20% after deductible	50% after deductible		
Infertility Services (Benefits limited to \$2,000 per lifetime)	20% after deductible	50% after deductible	20% after deductible	50% after deductible		
Injections Received in a Physician's Office	\$25	50% after deductible	\$25	50% after deductible		
Mental Health & Substance Use Disorder Serv	rices					
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible		
Outpatient	\$25	50% after deductible	\$25	50% after deductible		
Outpatient Prescription Drug Coverage						
Calendar Year Deductible (individual/family)	No	one	\$250/\$500, does	not apply to Tier 1		
Tier 1	\$	15		15		
Tier 2	\$4	40	\$4	10		
Tier 3	\$8	30	\$8	30		
Tier 4	25% up	to \$250	25% up	to \$250		
Pediatric Dental & Vision Coverage ⁵						
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	50% after deductible		
Vision Exam (routine)	No copayment	50%	No copayment	50%		
Glasses (frames & lenses)	20%	50%	20%	50%		

¹ Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

³ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁴ The outpatient per-occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.

⁵ No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Select Plus and Core Silver Plan Mapping

Prior to Jan. 1, 2020

Metallic Level	Silver			
Select Plus / Core HDHP Plan	40/150	00/30%	50/150	00/40%
Network ¹	Network	Non-Network	Network	Non-Network
Annual Deductible ² (individual/family)	\$1,500/\$3,000	\$3,000/\$6,000	\$1,500/\$3,000	\$3,000/\$6,000
Annual Out-of-Pocket Limit ³ (individual/family)	\$7,900/\$15,800	\$15,800/\$31,600	\$8,150/\$16,300	\$16,300/\$32,600
Professional Services				
Office Visits - PCP	\$40	50% after deductible	\$50	50% after deductible
Office Visits - Specialist	\$70	50% after deductible	\$80	50% after deductible
Laboratory ⁴ (standard)	30% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	40% after deductible for independent, non- hospital-affiliated provider; 50% after deductible for hospital-affiliated provider	50% after deductible
Radiology ⁴ (standard)	30% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	40% after deductible for independent, non- hospital-affiliated provider; 50% after deductible for hospital-affiliated provider	50% after deductible
Maternity Care ⁵	\$40	50% after deductible	\$50	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	30% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	40% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Inpatient Physician Care	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	30% after deductible, plus \$300 per-occurrence deductible	Same as Network benefit	40% after deductible, plus \$300 per-occurrence deductible	Same as Network benefit
Urgent Care Services	\$70	50% after deductible	\$80	50% after deductible
Ambulance Services	30% after deductible	Same as Network benefit	40% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery ⁴	30% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	40% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Durable Medical Equipment	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Infertility Services (Benefits limited to \$2,000 per lifetime)	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Injections Received in a Physician's Office	\$40	50% after deductible	\$50	50% after deductible
Mental Health & Substance Use Disorder Serv	vices			
Inpatient	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient	\$40	50% after deductible	\$50	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	\$250/\$500, does	not apply to Tier 1	\$300/\$600, does	not apply to Tier 1
Tier 1		20		20
Tier 2	\$5	50	\$	50
Tier 3	\$1	00	\$1	00
Tier 4	25% up to \$250 25% up to \$250		to \$250	
Pediatric Dental & Vision Coverage ⁵				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	30%	50%	40%	50%

¹ Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

³ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁴ The outpatient per-occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.

⁵ No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Select Plus and Core Silver Plan Mapping

Prior to Jan. 1, 2020

Metallic Level	Silver			
Select Plus / Core HDHP Plan	45/225	50/40%	50/225	50/40%
Network ¹	Network	Non-Network	Network	Non-Network
Annual Deductible ² (individual/family)	\$2,250/\$4,500	\$4,500/\$9,000	\$2,250/\$4,500	\$4,500/\$9,000
Annual Out-of-Pocket Limit ³ (individual/family)	\$7,900/\$15,800	\$15,800/\$31,600	\$8,150/\$16,300	\$16,300/\$32,600
Professional Services				
Office Visits - PCP	\$45	50% after deductible	\$50	50% after deductible
Office Visits - Specialist	\$80	50% after deductible	\$80	50% after deductible
Laboratory ⁴ (standard)	40% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	40% after deductible for independent, non- hospital-affiliated provider; 50% after deductible for hospital-affiliated provider	50% after deductible
Radiology ⁴ (standard)	40% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	40% after deductible for independent, non- hospital-affiliated provider; 50% after deductible for hospital-affiliated provider	50% after deductible
Maternity Care ⁵	\$45	50% after deductible	\$50	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	40% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	40% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Inpatient Physician Care	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	40% after deductible, plus \$300 per-occurrence deductible	Same as Network benefit	40% after deductible, plus \$300 per-occurrence deductible	Same as Network benefit
Urgent Care Services	\$80	50% after deductible	\$80	50% after deductible
Ambulance Services	40% after deductible	Same as Network benefit	40% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery ⁴	40% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible	40% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Durable Medical Equipment	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Infertility Services (Benefits limited to \$2,000 per lifetime)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Injections Received in a Physician's Office	\$45	50% after deductible	\$50	50% after deductible
Mental Health & Substance Use Disorder Serv	vices			
Inpatient	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient	\$45	50% after deductible	\$50	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	\$250/\$500, does	not apply to Tier 1	\$300/\$600, does	not apply to Tier 1
Tier 1	\$2	20	\$2	20
Tier 2		50		50
Tier 3		00		00
Tier 4	25% up	to \$250	25% up	to \$250
Pediatric Dental & Vision Coverage ⁵				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	40%	50%	40%	50%

¹ Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

³ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁴ The outpatient per-occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.

⁵ No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Select Plus and Core HDHP Silver Plan Mapping

Prior to Jan. 1, 2020

Metallic Level		Silv	er	
Select Plus / Core HDHP Plan	HDHP w/UnitedHealth	ncare Motion® 2300/30%	HDHP w/Mo	tion 2300/30%
Network¹	Network	Non-Network	Network	Non-Network
Annual Deductible ² (individual/family)	\$2,300/\$2,7005	\$4,600/\$5,4005	\$2,300/\$2,8005	\$4,600/\$5,6005
Annual Out-of-Pocket Limit ³ (individual/family)	\$6,650/\$13,300	\$13,300/\$26,600	\$6,650/\$13,300	\$13,300/\$26,600
Professional Services				
Office Visits - PCP	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Office Visits - Specialist	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Laboratory (standard)	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Radiology (standard)	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Maternity Care	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Inpatient Physician Care	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	30% after deductible	Same as Network benefit	30% after deductible	Same as Network benefit
Urgent Care Services	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Ambulance Services	30% after deductible	Same as Network benefit	30% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Durable Medical Equipment	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Infertility Services (Benefits limited to \$2,000 per lifetime)	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Injections Received in a Physician's Office	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Mental Health & Substance Use Disorder Servi	ices			
Inpatient	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Outpatient	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	Annual Ded	luctible applies	Annual Deductible applies	
Tier 1	Ç	\$20	Ç	\$20
Tier 2	Ç	\$50	Ç	\$50
Tier 3	\$	100	\$	100
Tier 4	25% u	p to \$250	25% u	p to \$250
Pediatric Dental & Vision Coverage ⁴				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50% after deductible	No copayment	50% after deductible
Glasses (frames & lenses)	30% after deductible	50% after deductible	30% after deductible	50% after deductible

¹ Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

 $^{^{\}rm 2}$ The Annual Deductible is combined for medical and pharmacy benefits.

³ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit. When a member of a family unit satisfies the individual Out-of-Pocket Limit amount for the calendar year, no further copayments will be required for him or her for that calendar year.

 $^{^{\}rm 4}$ One routine vision exam and one pair of glasses per calendar year for children under age 19.

⁵ The entire Family Deductible must be met before benefits can be paid for each eligible member of a family. One or more eligible members of a family unit may satisfy the Family Deductible.

⁶ When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

Select Plus and Core HDHP Bronze Plan Mapping

Prior to Jan. 1, 2020

Metallic Level	Bronze				
Select Plus / Core HDHP Plan	HDHP w/UnitedHealth	care Motion® 6650/0%	HDHP w/Mo	tion 6900/0%	
Network ¹	Network	Non-Network	Network	Non-Network	
Annual Deductible ² (individual/family)	\$6,650/\$13,3006	\$13,300/\$26,6006	\$6,900/\$13,8006	\$13,800/\$27,6006	
Annual Out-of-Pocket Limit ³ (individual/family)	\$6,650/\$13,300	\$13,300/\$26,600	\$6,900/\$13,800	\$13,800/\$27,600	
Professional Services					
Office Visits - PCP	No copay after deductible	50% after deductible	No copay after deductible	No copay after deductible	
Office Visits - Specialist	No copay after deductible	50% after deductible	No copay after deductible	No copay after deductible	
Laboratory (standard)	No copay after deductible	50% after deductible	No copay after deductible	No copay after deductible	
Radiology (standard)	No copay after deductible	50% after deductible	No copay after deductible	No copay after deductible	
Maternity Care	No copay after deductible	50% after deductible	No copay after deductible	No copay after deductible	
Preventive Care Services	No copayment	No benefit	No copayment	No benefit	
Hospitalization Services					
Inpatient Hospital Benefits	No copay after deductible	50% after deductible	No copay after deductible	No copay after deductible	
Inpatient Physician Care	No copay after deductible	50% after deductible	No copay after deductible	No copay after deductible	
Skilled Nursing Facility Care (100 days per benefit period)	No copay after deductible	50% after deductible	No copay after deductible	No copay after deductible	
Emergency Health Coverage					
Emergency Services	No copay after deductible	Same as Network benefit	No copay after deductible	No copay after deductible	
Urgent Care Services	No copay after deductible	50% after deductible	No copay after deductible	No copay after deductible	
Ambulance Services	No copay after deductible	Same as Network benefit	No copay after deductible	No copay after deductible	
Outpatient Services					
Outpatient Surgery	No copay after deductible	50% after deductible	No copay after deductible	No copay after deductible	
Durable Medical Equipment	No copay after deductible	50% after deductible	No copay after deductible	No copay after deductible	
Home Health Services (Up to 100 visits per calendar year)	No copay after deductible	50% after deductible	No copay after deductible	No copay after deductible	
Infertility Services (Benefits limited to \$2,000 per lifetime)	No copay after deductible	50% after deductible	No copay after deductible	No copay after deductible	
Injections Received in a Physician's Office	No copay after deductible	50% after deductible	No copay after deductible	No copay after deductible	
Mental Health & Substance Use Disorder Serv	vices				
Inpatient	No copay after deductible	50% after deductible	No copay after deductible	No copay after deductible	
Outpatient	No copay after deductible	50% after deductible	No copay after deductible	No copay after deductible	
Outpatient Prescription Drug Coverage					
Calendar Year Deductible (individual/family)	Annual Dedu	ctible applies	Annual Dedu	ictible applies	
Tier 1	No cop	ayment	No cop	payment	
Tier 2	No cop	ayment	No cop	payment	
Tier 3	No cop	ayment	No cop	payment	
Tier 4	No cop	ayment	No cop	payment	
Pediatric Dental & Vision Coverage ⁴					
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	No copay after deductible	
Vision Exam (routine)	No copayment	50% after deductible	No copayment	No copay after deductible	
Glasses (frames & lenses)	No copay after deductible	50% after deductible	No copay after deductible	No copay after deductible	

¹ Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

 $^{^{\}rm 2}$ The Annual Deductible is combined for medical and pharmacy benefits.

³ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit. When a member of a family unit satisfies the individual Out-of-Pocket Limit amount for the calendar year, no further copayments will be required for him or her for that calendar year.

 $^{^{\}rm 4}$ One routine vision exam and one pair of glasses per calendar year for children under age 19.

⁵ The entire Family Deductible must be met before benefits can be paid for each eligible member of a family. One or more eligible members of a family unit may satisfy the Family Deductible.

⁶ When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

Non-Differential PPO Plan Mapping

No Changes

	No Changes
Metallic Level	Silver
Select Plus / Core HDHP Plan	2250/30%
Network ¹	Network & Non-Network
Annual Deductible ² (individual/family)	\$2,250/\$4,500
Annual Out-of-Pocket Limit ³ (individual/family) Professional Services	\$7,350/\$14,700
	000/ -ft
Office Visits - PCP	30% after deductible
Office Visits - Specialist	30% after deductible
Laboratory (standard)	30% after deductible
Radiology (standard)	30% after deductible
Maternity Care	30% after deductible
Preventive Care Services	No copayment
Hospitalization Services	
Inpatient Hospital Benefits	30% after deductible
Inpatient Physician Care	30% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	30% after deductible
Emergency Health Coverage	
Emergency Services	30% after deductible
Urgent Care Services	30% after deductible
Ambulance Services	30% after deductible
Outpatient Services	
Outpatient Surgery	30% after deductible
Durable Medical Equipment	30% after deductible
Home Health Services (Up to 100 visits per calendar year)	30% after deductible
Infertility Services (Benefits limited to \$2,000 per lifetime)	30% after deductible
Injections Received in a Physician's Office	30% after deductible
Mental Health & Substance Use Disorder Serv	rices
Inpatient	30% after deductible
Outpatient	30% after deductible
Outpatient Prescription Drug Coverage	
Calendar Year Deductible (individual/family)	\$200/\$400 does not apply to Tier 1
Tier 1	\$20
Tier 2	\$50
Tier 3	\$100
Tier 4	25% up to \$250
Pediatric Dental & Vision Coverage ⁴	
Dental Exam (preventive/diagnostic)	No copayment
Vision Exam (routine)	No copayment
Glasses (frames & lenses)	30%
	5070

¹ Out-of-area plan available outside of our contracted network service areas. Subject to underwriting guidelines.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

³ Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁴ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Select Plus and Core State Platinum Plan Mapping – All Plans Mapped to Core

Prior to Jan. 1, 2020

	1110110	Dan. 1, 2020		oan. 1, 2020
Metallic Level		Platinu		
Select Plus / Core HDHP Plan		5/10%		5/10%
Network ¹	Network	Non-Network	Network	Non-Network
Annual Deductible ² (individual/family)	None	\$1,000/\$2,000	None	\$1,000/\$2,000
Annual Out-of-Pocket Limit ⁴ (individual/family)	\$3,350/\$6,700	\$8,000/\$16,000	\$4,500/\$9,000	\$9,000/\$18,000
Professional Services				
Office Visits - PCP	\$15	50% after deductible	\$15	50% after deductible
Office Visits - Specialist	\$30	50% after deductible	\$30	50% after deductible
Laboratory (standard)	\$15	50% after deductible	\$15	50% after deductible
Radiology (standard)	\$30	50% after deductible	\$30	50% after deductible
Maternity Care ⁵	\$15	50% after deductible	\$15	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	10%	50% after deductible	10%	50% after deductible
Inpatient Physician Care	10%	50% after deductible	10%	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	10%	50% after deductible	10%	50% after deductible
Emergency Health Coverage				
Emergency Services	\$150	Same as Network benefit	\$150	Same as Network benefi
Urgent Care Services	\$15	50% after deductible	\$15	50% after deductible
Ambulance Services	\$150	Same as Network benefit	\$150	Same as Network benefi
Outpatient Services				
Outpatient Surgery	10%	50% after deductible	10%	50% after deductible
Durable Medical Equipment	10%	50% after deductible	10%	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	10%	50% after deductible	10%	50% after deductible
Infertility Services (Benefits limited to \$2,000 per lifetime)	10%	50% after deductible	10%	50% after deductible
Injections Received in a Physician's Office	\$15	50% after deductible	\$15	50% after deductible
Mental Health & Substance Use Disorder Service	es			
npatient	10%	50% after deductible	10%	50% after deductible
Outpatient	\$15	50% after deductible	\$15	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	١	None	None	
Tier 1		\$5	\$5	
Tier 2		\$15		\$15
Tier 3	\$25			\$25
Tier 4	10% up to \$250		10% (up to \$250
Pediatric Dental & Vision Coverage ⁵				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	No copayment	50%	No copayment	50%

¹ Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

³ The Annual Deductible is combined for medical and pharmacy benefits.

⁴ Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁵ No copayment applies to physician office visits for prenatal care.

 $^{^{\}rm 6}$ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Select Plus and Core State Gold Plan Mapping – All Plans Mapped to Core

Prior to Jan. 1, 2020

Metallic Level		Go	ld	
Select Plus / Core HDHP Plan	3(0/20%	25/2	50/20%
Network¹	Network	Non-Network	Network	Non-Network
Annual Deductible ² (individual/family)	None	\$1,000/\$2,000	\$250/\$500	\$1,000/\$2,000
Annual Out-of-Pocket Limit ⁴ (individual/family)	\$7,200/\$14,400	\$13,500/\$27,000	\$7,800/\$15,600	\$15,600/\$31,200
Professional Services				
Office Visits - PCP	\$30	50% after deductible	\$25	50% after deductible
Office Visits - Specialist	\$55	50% after deductible	\$50	50% after deductible
Laboratory (standard)	\$35	50% after deductible	\$25	50% after deductible
Radiology (standard)	\$55	50% after deductible	\$65	50% after deductible
Maternity Care ⁵	\$30	50% after deductible	\$25	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	20%	50% after deductible	20% after deductible	50% after deductible
Inpatient Physician Care	20%	50% after deductible	20% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20%	50% after deductible	20% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	\$325	Same as Network benefit	\$250 after deductible	Same as Network benefit
Urgent Care Services	\$30	50% after deductible	\$25	50% after deductible
Ambulance Services	\$250	Same as Network benefit	\$250 after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery	20%	50% after deductible	20%	50% after deductible
Durable Medical Equipment	20%	50% after deductible	20%	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	20%	50% after deductible	20%	50% after deductible
Infertility Services (Benefits limited to \$2,000 per lifetime)	20%	50% after deductible	20%	50% after deductible
Injections Received in a Physician's Office	\$30	50% after deductible	\$25	50% after deductible
Mental Health & Substance Use Disorder Servi	ces			
Inpatient	20%	50% after deductible	20% after deductible	50% after deductible
Outpatient	\$30	50% after deductible	\$25	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	1	None	N	one
Tier 1		\$15	9	\$15
Tier 2	\$55		9	\$50
Tier 3	\$75		9	880
Tier 4	20% up to \$250		20% սլ	o to \$250
Pediatric Dental & Vision Coverage ⁵				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	No copayment	50%	No copayment	50%

¹ Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

³ The Annual Deductible is combined for medical and pharmacy benefits.

⁴ Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁵ No copayment applies to physician office visits for prenatal care.

 $^{^{\}rm 6}$ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Select Plus and Core State Silver Plan Mapping – All Plans Mapped to Core

Prior to Jan. 1, 2020

Metallic Level	Silver				
Select Plus / Core HDHP Plan	45/20	00/20%	50/2250/20%		
Network ¹	Network	Non-Network	Network	Non-Network	
Annual Deductible ² (individual/family)	\$2,000/\$4,000	\$4,000/\$8,000	\$2,250/\$4,500	\$4,500/\$9,000	
Annual Out-of-Pocket Limit ⁴ (individual/family)	\$7,550/\$15,100	\$14,000/\$28,000	\$7,800/\$15,600	\$15,600/\$31,200	
Professional Services					
Office Visits - PCP	\$45	50% after deductible	\$50	50% after deductible	
Office Visits - Specialist	\$80	50% after deductible	\$85	50% after deductible	
Laboratory (standard)	\$40	50% after deductible	\$40	50% after deductible	
Radiology (standard)	\$75	50% after deductible	\$85	50% after deductible	
Maternity Care ⁵	\$45	50% after deductible	\$50	50% after deductible	
Preventive Care Services	No copayment	No benefit	No copayment	No benefit	
Hospitalization Services					
Inpatient Hospital Benefits	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Inpatient Physician Care	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Emergency Health Coverage					
Emergency Services	\$350	Same as Network benefit	\$400 after deductible	Same as Network benefit	
Urgent Care Services	\$45	50% after deductible	\$50	50% after deductible	
Ambulance Services	\$250 after deductible	Same as Network benefit	\$250 after deductible	Same as Network benefit	
Outpatient Services					
Outpatient Surgery	20%	50% after deductible	20%	50% after deductible	
Durable Medical Equipment	20%	50% after deductible	20%	50% after deductible	
Home Health Services (Up to 100 visits per calendar year)	20%	50% after deductible	20%	50% after deductible	
Infertility Services (Benefits limited to \$2,000 per lifetime)	20%	50% after deductible	20%	50% after deductible	
Injections Received in a Physician's Office	\$45	50% after deductible	\$50	50% after deductible	
Mental Health & Substance Use Disorder Servi	ices				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible	
Outpatient	\$45	50% after deductible	\$50	50% after deductible	
Outpatient Prescription Drug Coverage					
Calendar Year Deductible (individual/family)	\$200	0/\$400	\$300/\$600		
Tier 1	\$	\$15	\$17		
Tier 2	\$55		\$	665	
Tier 3	\$85		\$	90	
Tier 4	20% up to \$250		20% սլ	o to \$250	
Pediatric Dental & Vision Coverage ⁵					
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	50% after deductible	
Vision Exam (routine)	No copayment	50%	No copayment	50%	
Glasses (frames & lenses)	No copayment	50%	No copayment	50%	

¹ Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

³ The Annual Deductible is combined for medical and pharmacy benefits.

⁴ Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁵ No copayment applies to physician office visits for prenatal care.

 $^{^{\}rm 6}$ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Select Plus and Core State Bronze Plan Mapping – All Plans Mapped to Core

Prior to Jan. 1, 2020

Metallic Level	Bronze				
Select Plus / Core HDHP Plan	75/6300/100%		65/6300/40%		
Network ¹	Network	Non-Network	Network	Non-Network	
Annual Deductible ² (individual/family)	\$6,300/\$12,600	\$12,600/\$25,200	\$6,300/\$12,600	\$12,600/\$25,200	
Annual Out-of-Pocket Limit ⁴ (individual/family)	\$7,550/\$15,100	\$14,000/\$28,000	\$7,800/\$15,600	\$15,600/\$31,200	
Professional Services					
Office Visits - PCP	\$75 for first 3 visits, then deductible applies	50% after deductible	\$65 for first 3 visits, then deductible applies	50% after deductible	
Office Visits - Specialist	\$105 for first 3 visits, then deductible applies	50% after deductible	\$95 for first 3 visits, then deductible applies	50% after deductible	
Laboratory (standard)	\$40	50% after deductible	\$40	50% after deductible	
Radiology (standard)	100% after deductible	50% after deductible	40% after deductible	50% after deductible	
Maternity Care ⁵	\$75	50% after deductible	\$65	50% after deductible	
Preventive Care Services	No copayment	No benefit	No copayment	No benefit	
Hospitalization Services					
Inpatient Hospital Benefits	100% after deductible	50% after deductible	40% after deductible	50% after deductible	
Inpatient Physician Care	100% after deductible	50% after deductible	40% after deductible	50% after deductible	
Skilled Nursing Facility Care (100 days per benefit period)	100% after deductible	50% after deductible	40% after deductible	50% after deductible	
Emergency Health Coverage					
Emergency Services	100% after deductible	Same as Network benefit	40% after deductible	Same as Network benef	
Urgent Care Services	\$75 for first 3 visits, then deductible applies	50% after deductible	\$65 for first 3 visits, then deductible applies	50% after deductible	
Ambulance Services	100% after deductible	Same as Network benefit	40% after deductible	Same as Network benef	
Outpatient Services					
Outpatient Surgery	100% after deductible	50% after deductible	40% after deductible	50% after deductible	
Durable Medical Equipment	100% after deductible	50% after deductible	40% after deductible	50% after deductible	
Home Health Services (Up to 100 visits per calendar year)	100% after deductible	50% after deductible	40% after deductible	50% after deductible	
Infertility Services (Benefits limited to \$2,000 per lifetime)	100% after deductible	50% after deductible	40% after deductible	50% after deductible	
Injections Received in a Physician's Office	\$75	50% after deductible	\$65	50% after deductible	
Mental Health & Substance Use Disorder Serv	rices				
npatient	100% after deductible	50% after deductible	40% after deductible	50% after deductible	
Outpatient	No copayment	50% after deductible	No copayment	50% after deductible	
Outpatient Prescription Drug Coverage					
Calendar Year Deductible (individual/family)	\$500/	\$1,000	\$500/	\$1,000	
Tier 1	100% up	to \$500	\$	18	
Tier 2	100% up	100% up to \$500		40% up to \$500	
Tier 3	100% up to \$500		40% up	to \$500	
Tier 4	100% up to \$500		40% up	to \$500	
Pediatric Dental & Vision Coverage ⁵					
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	50% after deductible	
Vision Exam (routine)	No copayment	50%	No copayment	50%	
Glasses (frames & lenses)	No copayment	50%	40%	50%	

¹ Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

³ The Annual Deductible is combined for medical and pharmacy benefits.

⁴ Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁵ No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Select Plus and Core State Bronze Plan Mapping – All Plans Mapped to Core

Prior to Jan. 1, 2020

Metallic Level	Bronze			
Select Plus / Core HDHP Plan	HDHP (6000/40%	65/63	00/40%
Network¹	Network	Non-Network	Network	Non-Network
Annual Deductible ² (individual/family)	\$6,000/\$12,000 ³	\$9,600/\$19,200 ³	\$6,300/\$12,600	\$12,600/\$25,200
Annual Out-of-Pocket Limit ⁴ (individual/family)	\$6,650/\$13,300	\$13,100/\$26,200	\$7,800/\$15,600	\$15,600/\$31,200
Professional Services				
Office Visits - PCP	40% after deductible	50% after deductible	\$65 for first 3 visits, then deductible applies	50% after deductible
Office Visits - Specialist	40% after deductible	50% after deductible	\$95 for first 3 visits, then deductible applies	50% after deductible
Laboratory (standard)	40% after deductible	50% after deductible	\$40	50% after deductible
Radiology (standard)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Maternity Care ⁵	40% after deductible	50% after deductible	\$65	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Inpatient Physician Care	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	40% after deductible	Same as Network benefit	40% after deductible	Same as Network benefit
Urgent Care Services	40% after deductible	50% after deductible	\$65 for first 3 visits, then deductible applies	50% after deductible
Ambulance Services	40% after deductible	Same as Network benefit	40% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Durable Medical Equipment	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Infertility Services (Benefits limited to \$2,000 per lifetime)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Injections Received in a Physician's Office	40% after deductible	50% after deductible	\$65	50% after deductible
Mental Health & Substance Use Disorder Servi	ces			
Inpatient	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient	40% after deductible	50% after deductible	No copayment	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	Annual Ded	uctible applies	\$500/	\$1,000
Tier 1	40% u _l	o to \$500	\$18	
Tier 2	40% up to \$500		40% up	to \$500
Tier 3	40% up to \$500		40% up	to \$500
Tier 4	40% up to \$500		40% up	to \$500
Pediatric Dental & Vision Coverage ⁵				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50% after deductible	No copayment	50%
Glasses (frames & lenses)	No copayment	50% after deductible	40%	50%

¹ Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

³ The Annual Deductible is combined for medical and pharmacy benefits.

⁴ Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁵ No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

UnitedHealthcare SignatureValue® Advantage, Alliance, UnitedHealthcare SignatureValue® Harmony Focus and Harmony Platinum Plan Mapping

	Prior to Jan. 1, 2020	Effective Jan. 1, 2020	Prior to Jan. 1, 2020	Effective Jan. 1, 2020
Metallic Level	Plat	inum	Plat	inum
HMO Plan	20-40/500d	20-40/500d	20-40/20%	20-40/20%
Annual Deductible ¹ (individual/family)	None	None	None	None
Annual Out-of-Pocket Limit ² (individual/family)	\$2,500/\$5,000	\$3,000/\$6,000	\$3,000/\$6,000	\$3,500/\$7,000
Professional Services				
Office Visits - PCP	\$20	\$20	\$20	\$20
Office Visits - Specialist	\$40	\$40	\$40	\$40
Laboratory (standard)	\$15	\$15	\$25	\$25
Radiology (standard)	\$15	\$15	\$25	\$25
Maternity Care	No charge	No charge	No charge	No charge
Preventive Care Services	No charge	No charge	No charge	No charge
Hospitalization Services				
Inpatient Hospital Benefits	\$500/day, max 4 days per stay	\$500/day, max 4 days per stay	20%	20%
Inpatient Physician Care	No charge	No charge	No charge	No charge
Skilled Nursing Facility Care (100 days per benefit period)	\$300/day, max 4 days per stay	\$300/day, max 4 days per stay	20%	20%
Emergency Health Coverage				
Emergency Services	\$400	\$400	20%	20%
Urgently Needed Services - within physician service area	\$20	\$20	\$20	\$20
outside physician service area	\$50	\$50	\$50	\$50
Ambulance Services	\$100	\$100	\$100	\$100
Outpatient Services				
Outpatient Surgery	\$250	\$250	20%	20%
Durable Medical Equipment	\$50	\$50	\$50	\$50
Home Health Services (Up to 100 visits per calendar year)	\$20	\$20	\$20	\$20
nfertility Services	Not covered	Not covered	Not covered	Not covered
njectable Drugs	\$150	\$150	\$150	\$150
Mental Health & Substance Use Disorder Servi	ices			
Inpatient	\$500/day, max 4 days per stay	\$500/day, max 4 days per stay	20%	20%
Outpatient	\$20	\$20	\$20	\$20
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	None	None	None	None
Tier 1	\$15	\$15	\$15	\$15
Tier 2	\$35	\$35	\$35	\$35
Tier 3	\$70	\$70	\$70	\$70
Tier 4	25% up to \$250	25% up to \$250	25% up to \$250	25% up to \$250
Pediatric Dental & Vision Coverage ³				
Dental Exam (preventive/diagnostic)	No charge	No charge	No charge	No charge
Vision Exam (routine)	No charge	No charge	No charge	No charge
Glasses (frames & lenses)	10%	10%	20%	20%
Optional Group Coverage - Infertility Services	50%	50%	50%	50%

¹ When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

 $^{^2\ \}text{Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.}\\$

³ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Advantage, Alliance, Focus and UnitedHealthcare SignatureValue® Harmony Platinum Plan Mapping

Prior to Jan. 1, 2020

Metallic Level	Platinum		
HMO Plan	0-80/20%	0-80/20%	
Annual Deductible ¹ (individual/family)	None	None	
Annual Out-of-Pocket Limit ² (individual/family)	\$3,500/\$7,000	\$4,000/\$8,000	
Professional Services			
Office Visits - PCP	No charge	No charge	
Office Visits - Specialist	\$80	\$80	
Laboratory (standard)	\$25	\$25	
Radiology (standard)	\$25	\$25	
Maternity Care	No charge	No charge	
Preventive Care Services	No charge	No charge	
Hospitalization Services			
Inpatient Hospital Benefits	20%	20%	
Inpatient Physician Care	No charge	No charge	
Skilled Nursing Facility Care (100 days per benefit period)	20%	20%	
Emergency Health Coverage			
Emergency Services	20%	20%	
Urgently Needed Services – within physician service area	No charge	No charge	
- outside physician service area	\$50	\$50	
Ambulance Services	\$100	\$100	
Outpatient Services			
Outpatient Surgery	20%	20%	
Durable Medical Equipment	\$50	\$50	
Home Health Services (Up to 100 visits per calendar year)	No charge	No charge	
Infertility Services	Not covered	Not covered	
Injectable Drugs	\$150	\$150	
Mental Health & Substance Use Disorder Servi	ices		
Inpatient	20%	20%	
Outpatient	No charge	No charge	
Outpatient Prescription Drug Coverage			
Calendar Year Deductible (individual/family)	None	None	
Tier 1	\$5	\$5	
Tier 2	\$35	\$35	
Tier 3	\$70	\$70	
Tier 4	25% up to \$250	25% up to \$250	
Pediatric Dental & Vision Coverage ³			
Dental Exam (preventive/diagnostic)	No charge	No charge	
Vision Exam (routine)	No charge	No charge	
Glasses (frames & lenses)	20%	20%	
Optional Group Coverage - Infertility Services	50%	50%	

¹ When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

 $^{^2\ \}text{Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.}\\$

 $^{^{\}rm 3}$ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Advantage, Alliance, Focus and UnitedHealthcare SignatureValue® Harmony Gold Plan Mapping

	Prior to Jan. 1, 2020	Effective Jan. 1, 2020	Prior to Jan. 1, 2020	Effective Jan. 1, 2020
Metallic Level	G		Go	
HMO Plan	30-60/1000d	30-60/1000d	30-60/20%/250ded	30-60/20%/500ded
Annual Deductible ¹ (individual/family)	None	None	\$250/\$500	\$500/\$1,000
Annual Out-of-Pocket Limit ² (individual/family)	\$6,000/\$12,000	\$6,000/\$12,000	\$6,000/\$12,000	\$6,500/\$13,000
Professional Services				
Office Visits - PCP	\$30	\$30	\$30	\$30
Office Visits - Specialist	\$60	\$60	\$60	\$60
Laboratory (standard)	\$30	\$30	\$30	\$30
Radiology (standard)	\$30	\$30	\$30	\$30
Maternity Care	No charge	No charge	No charge	No charge
Preventive Care Services	No charge	No charge	No charge	No charge
Hospitalization Services				
Inpatient Hospital Benefits	\$1,000/day, max 4 days per stay	\$1,000/day, max 4 days per stay	20% after deductible	20% after deductible
Inpatient Physician Care	No charge	No charge	20%	20%
Skilled Nursing Facility Care (100 days per benefit period)	\$300/day, max 4 days per stay	\$300/day, max 4 days per stay	20% after deductible	20% after deductible
Emergency Health Coverage				
Emergency Services	\$500	\$500	\$500 after deductible	\$500 after deductible
Urgently Needed Services – within physician service area	\$30	\$30	\$30	\$30
- outside physician service area	\$75	\$75	\$75	\$75
Ambulance Services	\$100	\$100	\$100	\$100
Outpatient Services				
Outpatient Surgery	\$500	\$500	20% after deductible	20% after deductible
Durable Medical Equipment	\$50	\$50	\$50	\$50
Home Health Services (Up to 100 visits per calendar year)	\$30	\$30	\$30	\$30
Infertility Services	Not covered	Not covered	Not covered	Not covered
Injectable Drugs	\$150	\$150	\$150	\$150
Mental Health & Substance Use Disorder Serv	rices			
Inpatient	\$600/day, max 4 days per stay	\$600/day, max 4 days per stay	20% after deductible	20% after deductible
Outpatient	\$30	\$30	\$30	\$30
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	\$100/\$200 (does not apply to Tier 1)	\$100/\$200 (does not apply to Tier 1)	\$250/\$500 (does not apply to Tier 1)	\$250/\$500 (does not apply to Tier 1)
Tier 1	\$15	\$15	\$15	\$15
Tier 2	\$40	\$40	\$40	\$40
Tier 3	\$80	\$80	\$80	\$80
Tier 4	25% up to \$250			
Pediatric Dental & Vision Coverage ³				
Dental Exam (preventive/diagnostic)	No charge	No charge	No charge	No charge
Vision Exam (routine)	No charge	No charge	No charge	No charge
Glasses (frames & lenses)	10%	10%	20%	20%
Optional Group Coverage - Infertility Services	50%	50%	50%	50%

¹ When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

² Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

³ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Advantage, Alliance, Focus and UnitedHealthcare SignatureValue® Harmony Gold Plan Mapping

	Prior to Jan. 1, 2020	Effective Jan. 1, 2020	Prior to Jan. 1, 2020	Effective Jan. 1, 2020
Metallic Level	Go	old	Go	old
HMO Plan	30-60/30%/1000ded	30-60/30%/1250ded	0-80/30%/1250ded	0-80/30%/1500ded
Annual Deductible ¹ (individual/family)	\$1,000/\$2,000	\$1,250/\$2,500	\$1,250/\$2,500	\$1,500/\$3,000
Annual Out-of-Pocket Limit ² (individual/family)	\$6,000/\$12,000	\$6,500/\$13,000	\$7,000/\$14,000	\$7,500/\$15,000
Professional Services				
Office Visits - PCP	\$30	\$30	No charge	No charge
Office Visits - Specialist	\$60	\$60	\$80	\$80
Laboratory (standard)	\$30	\$30	\$30	\$30
Radiology (standard)	\$30	\$30	\$30	\$30
Maternity Care	No charge	No charge	No charge	No charge
Preventive Care Services	No charge	No charge	No charge	No charge
Hospitalization Services				
Inpatient Hospital Benefits	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Inpatient Physician Care	30%	30%	30%	30%
Skilled Nursing Facility Care (100 days per benefit period)	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Emergency Health Coverage				
Emergency Services	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Urgently Needed Services – within physician service area	\$30	\$30	No charge	No charge
- outside physician service area	\$75	\$75	\$75	\$75
Ambulance Services	\$100	\$100	\$100	\$100
Outpatient Services				
Outpatient Surgery	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Durable Medical Equipment	\$50	\$50	\$50	\$50
Home Health Services (Up to 100 visits per calendar year)	\$30	\$30	No charge	No charge
Infertility Services	Not covered	Not covered	Not covered	Not covered
Injectable Drugs	\$150	\$150	\$150	\$150
Mental Health & Substance Use Disorder Serv	vices			
Inpatient	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Outpatient	\$30	\$30	No charge	No charge
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	\$250/\$500 (does not apply to Tier 1)			
Tier 1	\$15	\$15	\$5	\$5
Tier 2	\$40	\$40	\$50	\$50
Tier 3	\$80	\$80	\$100	\$100
Tier 4	25% up to \$250			
Pediatric Dental & Vision Coverage ³				
Dental Exam (preventive/diagnostic)	No charge	No charge	No charge	No charge
Vision Exam (routine)	No charge	No charge	No charge	No charge
Glasses (frames & lenses)	30%	30%	30%	30%
Optional Group Coverage - Infertility Services	50%	50%	50%	50%

¹ When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

 $^{^{2}}$ Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

³ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Advantage, Alliance, Focus and UnitedHealthcare SignatureValue® Harmony Silver Plan Mapping

	Prior to Jan. 1, 2020	Effective Jan. 1, 2020	Prior to Jan. 1, 2020	Effective Jan. 1, 2020
Metallic Level	Sil	lver	Sil	lver
HMO Plan	50-75/40%/2250ded	55-80/40%/2250ded	30%/2200ded (Alliance only)	30%/2250ded (Alliance & Harmony only)
Annual Deductible ¹ (individual/family)	\$2,250/\$4,500	\$2,250/\$4,500	\$2,200/\$4400	\$2,250/\$4,500
Annual Out-of-Pocket Limit ² (individual/family)	\$7,900/\$15,800	\$8,150/\$16,300	\$7,900/\$15,800	\$8,150/\$16,300
Professional Services				
Office Visits - PCP	\$50	\$55	30% after deductible	30% after deductible
Office Visits - Specialist	\$75	\$80	30% after deductible	30% after deductible
Laboratory (standard)	\$40	\$45	30% after deductible	30% after deductible
Radiology (standard)	\$40	\$45	30% after deductible	30% after deductible
Maternity Care	No charge	No charge	30% after deductible	30% after deductible
Preventive Care Services	No charge	No charge	No charge	No charge
Hospitalization Services				
Inpatient Hospital Benefits	40% after deductible	40% after deductible	30% after deductible	30% after deductible
Inpatient Physician Care	40%	40%	30% after deductible	30% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	40% after deductible	40% after deductible	30% after deductible	30% after deductible
Emergency Health Coverage				
Emergency Services	40% after deductible	40% after deductible	30% after deductible	30% after deductible
Urgently Needed Services – within physician service area	\$50	\$55	30% after deductible	30% after deductible
- outside physician service area	\$100	\$100	30% after deductible	30% after deductible
Ambulance Services	\$100	\$100	30% after deductible	30% after deductible
Outpatient Services				
Outpatient Surgery	40% after deductible	40% after deductible	30% after deductible	30% after deductible
Durable Medical Equipment	\$50	\$50	30% after deductible	30% after deductible
Home Health Services (Up to 100 visits per calendar year)	\$50	\$55	30% after deductible	30% after deductible
Infertility Services	Not covered	Not covered	Not covered	Not covered
Injectable Drugs	\$150	\$150	30% after deductible	30% after deductible
Mental Health & Substance Use Disorder Serv	vices			
Inpatient	40% after deductible	40% after deductible	30% after deductible	30% after deductible
Outpatient	\$50	\$55	30% after deductible	30% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	\$250/\$500 (does not apply to Tier 1)	\$300/\$600 (does not apply to Tier 1)	\$250/\$500 (does not apply to Tier 1)	\$300/\$600 (does not apply to Tier 1)
Tier 1	\$20	\$20	\$20	\$20
Tier 2	\$50	\$50	\$50	\$50
Tier 3	\$100	\$100	\$100	\$100
Tier 4	25% up to \$250			
Pediatric Dental & Vision Coverage ³				
Dental Exam (preventive/diagnostic)	No charge	No charge	No charge	No charge
Vision Exam (routine)	No charge	No charge	No charge	No charge
Glasses (frames & lenses)	40%	40%	30%	30%
Optional Group Coverage - Infertility Services	50%	50%	50% after deductible	50% after deductible

¹ When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

 $^{^{2}}$ Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

³ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Advantage, Alliance, Focus and UnitedHealthcare SignatureValue® Harmony HDHP Bronze Plan Mapping

	Prior to Jan. 1, 2020	Effective Jan. 1, 2020	Prior to Jan. 1, 2020	Effective Jan. 1, 2020
Metallic Level	Bronze (Alliance Only)		Bronze (Harmony Only)	
HMO Plan	HDHP 0%/6500ded	HDHP 0%/6900ded	HDHP w/UnitedHealthcare Motion® 0%/6500ded	HDHP w/Motion 0%/6900ded
Annual Deductible ¹ (individual/family)	\$6,500/\$13,000	\$6,900/\$13,800	\$6,500/\$13,000	\$6,900/\$13,800
Annual Out-of-Pocket Limit ² (individual/family)	\$6,500/\$13,000	\$6,900/\$13,800	\$6,500/\$13,000	\$6,900/\$13,800
Professional Services				
Office Visits - PCP	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Office Visits - Specialist	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Laboratory (standard)	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Radiology (standard)	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Maternity Care	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Preventive Care Services	No charge	No charge	No charge	No charge
Hospitalization Services				
Inpatient Hospital Benefits	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Inpatient Physician Care	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Skilled Nursing Facility Care (100 days per benefit period)	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Emergency Health Coverage				
Emergency Services	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Urgently Needed Services – within physician service area	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
- outside physician service area	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Ambulance Services	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient Services				
Outpatient Surgery	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient Surgery Physician Care	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Durable Medical Equipment	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Home Health Services (Up to 100 visits per calendar year)	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Infertility Services	Not covered	Not covered	Not covered	Not covered
Injectable Drugs	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Mental Health & Substance Use Disorder Serv	vices			
Inpatient	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	Annual Deductible applies	Annual Deductible applies	Annual Deductible applies	Annual Deductible applies
Tier 1	No charge	No charge	No charge	No charge
Tier 2	No charge	No charge	No charge	No charge
Tier 3	No charge	No charge	No charge	No charge
Tier 4	No charge	No charge	No charge	No charge
Pediatric Dental & Vision Coverage ³				
Dental Exam (preventive/diagnostic)	No charge	No charge	No charge	No charge
Vision Exam (routine)	No charge	No charge	No charge	No charge
Glasses (frames & lenses)	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Optional Group Coverage - Infertility Services	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible

¹ The Annual Deductible is combined for medical and pharmacy benefits. When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

² Annual deductible applies to the Out-of-Pocket Limit.

 $^{^{\}rm 3}$ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Advantage, Alliance and Focus Platinum State Plan Mapping – All Plans Mapped to Alliance

Prior to Jan. 1, 2020

		,,,
Metallic Level		Platinum
HMO Plan	Platinum 90 HMO 0/15	Platinum 90 HMO 0/15
Annual Deductible ¹ (individual/family)	None	None
Annual Out-of-Pocket Limit ³ (individual/family)	\$3,350/\$6,700	\$4,500/\$9,000
Professional Services		
Office Visits - PCP	\$15	\$15
Office Visits - Specialist	\$30	\$30
Laboratory (standard)	\$15	\$15
Radiology (standard)	\$30	\$30
Maternity Care	No charge	No charge
Preventive Care Services	No charge	No charge
Hospitalization Services		
Inpatient Hospital Benefits	10%	10%
Inpatient Physician Care	10%	10%
Skilled Nursing Facility Care (100 days per benefit period)	10%	10%
Emergency Health Coverage		
Emergency Services	\$150	\$150
Urgently Needed Services – within physician service area	\$15	\$15
- outside physician service area	\$15	\$15
Ambulance Services	\$150	\$150
Outpatient Services		
Outpatient Surgery	10%	10%
Durable Medical Equipment	10%	10%
Home Health Services (Up to 100 visits per calendar year)	10%	10%
Infertility Services	Not covered	Not covered
Injectable Drugs	10%	10%
Mental Health & Substance Use Disorder Services		
Inpatient	10%	10%
Outpatient	\$15	\$15
Outpatient Prescription Drug Coverage		
Calendar Year Deductible (individual/family)	None	None
Tier 1	\$5	\$5
Tier 2	\$15	\$15
Tier 3	\$25	\$25
Tier 4	10% up to \$250	10% up to \$250
Pediatric Dental & Vision Coverage ⁴		
Dental Exam (preventive/diagnostic)	No charge	No charge
Vision Exam (routine)	No charge	No charge
Glasses (frames & lenses)	No charge	No charge
Optional Group Coverage - Infertility Services	50%	50%

¹ When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

² The Annual Deductible is combined for medical and pharmacy benefits.

 $^{^{3}}$ Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁴ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Advantage, Alliance and Focus Gold State Plan Mapping – All Plans Mapped to Alliance

Prior to Jan. 1, 2020

	Filor to dail. 1, 2020	Lifective dall. 1, 2020
Metallic Level	G	old
HMO Plan	Gold 80 HMO 0/30	Gold 80 HMO 250/25
Annual Deductible ¹ (individual/family)	None	\$250/\$500
Annual Out-of-Pocket Limit ³ (individual/family)	\$7,200/\$14,400	\$7,800/\$15,600
Professional Services		
Office Visits - PCP	\$30	\$25
Office Visits - Specialist	\$55	\$50
Laboratory (standard)	\$35	\$25
Radiology (standard)	\$55	\$65
Maternity Care	No charge	No charge
Preventive Care Services	No charge	No charge
Hospitalization Services		
Inpatient Hospital Benefits	20%	20% after deductible
Inpatient Physician Care	20%	20% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20%	20% after deductible
Emergency Health Coverage		
Emergency Services	\$325	\$250 after deductible
Urgently Needed Services – within physician service area	\$30	\$25
- outside physician service area	\$30	\$25
Ambulance Services	\$250	\$250 after deductible
Outpatient Services		
Outpatient Surgery	20%	20%
Durable Medical Equipment	20%	20%
Home Health Services (Up to 100 visits per calendar year)	20%	\$30
Infertility Services	Not covered	Not covered
Injectable Drugs	20%	20%
Mental Health & Substance Use Disorder Services		
Inpatient	20%	20% after deductible
Outpatient	\$30	\$25
Outpatient Prescription Drug Coverage		
Calendar Year Deductible (individual/family)	None	None
Tier 1	\$15	\$15
Tier 2	\$55	\$50
Tier 3	\$75	\$80
Tier 4	20% up to \$250	20% up to \$250
Pediatric Dental & Vision Coverage ⁴		
Dental Exam (preventive/diagnostic)	No charge	No charge
Vision Exam (routine)	No charge	No charge
Glasses (frames & lenses)	No charge	No charge
Optional Group Coverage - Infertility Services	50%	50%

¹ When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

² The Annual Deductible is combined for medical and pharmacy benefits.

³ Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁴ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Advantage, Alliance and Focus Silver State Plan Mapping – All Plans Mapped to Alliance

Prior to Jan. 1, 2020

HMO Plan Sliver 70 HMO 2000/45 Sliver 70 HMO 2250/50 Annual Deut-dicible (Individual/Iranity) \$2,000/\$4,000 \$2,250/\$4,500 Annual Deut-Grobet Limit* (Individual/Iranity) \$7,550/\$15,100 \$7,800/\$15,600 Professional Services ***Professional Services Office Valits - Specialist \$85 \$50 Elaboratory Identified \$40 \$40 Radiology (standard) \$75 \$85 Materinty Care No change No change Preventive Care No change No change Preventive Care Services No change No change Propatent Hospital Benefits 20% after deductible 20% after deductible Impatent Physical Benefits 20% after deductible 20% after deductible Impatent Physical Benefits 20% after deductible 20% after deductible Emergency Servines \$550 \$40 after deductible Emergency Servines \$550 \$40 after deductible Emergency Servines \$45 \$50 Cold day pare family particle	Metallic Level	Silver		
Annual Out-of-Pocket Limit* (individual/manit*) \$7,550/\$15,000 \$7,800/\$15,600 Potessional Services ************************************	HMO Plan	Silver 70 HMO 2000/45	Silver 70 HMO 2250/50	
(includin/Jamily) \$7,850/y \$15,00 Professional Sarviess Office Visits - PCP \$45 \$50 Office Visits - Specialist \$80 \$85 Laboratory (standard) \$40 \$40 Eaddoclogy (standard) \$75 \$85 Maternity Care No charge No charge Preventbe Care Services No charge No charge Inpatient Hospital Benefits 20% after deductible 20% after deductible Inpatient Hospital Benefits 20% after deductible 20% after deductible Inpatient Physician Care 20% after deductible 20% after deductible Inpatient Physician Care 20% after deductible 20% after deductible Inpatient Rowing 20% after deductible 20% after deductible Inpatient Rowing \$50 \$400 after deductible Emergency Services \$50 \$400 after deductible Urgently Needed Services \$45 \$50 Under Services \$50 \$400 after deductible Urgently Needed Services \$20 \$50 Urgently Needed Services <td>Annual Deductible¹ (individual/family)</td> <td>\$2,000/\$4,000</td> <td>\$2,250/\$4,500</td>	Annual Deductible ¹ (individual/family)	\$2,000/\$4,000	\$2,250/\$4,500	
Portessional Services \$45 \$50 Office Valles - PCP \$45 \$50 Chillow Valles - Specialist \$80 \$85 Laboratory (standard) \$40 \$40 Radiciogy (standard) \$75 \$85 Maternity Care No charge No charge Preventive Care Services No charge No charge Preventive Care Services No charge No charge Preventive Care Services No charge 20% after deductible Hopstratify Nacidal Benefits 20% after deductible 20% after deductible Inpatient Playsicial Benefits 20% after deductible 20% after deductible Valled Nucring Facility Care 20% after deductible 20% after deductible Valled Nucring Facility Care 20% after deductible 20% after deductible Emergency Services \$350 \$400 after deductible Emergency Services \$350 \$400 after deductible Departly Needed Services \$45 \$50 Outpatient Services \$250 after deductible \$200 after deductible Duratient Services		\$7,550/\$15,100	\$7,800/\$15,600	
Office Visits - Specialist \$80 \$85 Laboratory (standard) \$40 \$40 Radiclogy (standard) \$75 \$85 Maternity Care No charge No charge Preventive Care Services No charge No charge Hospitalization Services Inpation I Hyspician Care 20% after deductible 20% after deductible Skilled Nursing Facility Care 20% after deductible 20% after deductible Skilled Nursing Facility Care 20% after deductible 20% after deductible Skilled Nursing Facility Care 20% after deductible 20% after deductible Skilled Nursing Facility Care 20% after deductible 20% after deductible Emergency Services \$350 \$400 after deductible Urgenty Needed Services \$45 \$50 Outside physician service area \$45 \$50 <td col<="" td=""><td></td><td></td><td></td></td>	<td></td> <td></td> <td></td>			
Laboratory (standard) \$40 \$40 Radiology (standard) \$75 \$85 Maternity Care No charge No charge Preventhe Care Services No charge No charge Preventhe Care Services No charge No charge Preventhe Care Services No charge No charge Hospitalization Services 20% after deductible 20% after deductible Inpatient Physician Care 20% after deductible 20% after deductible Silled Nursing Facility Care (100 days per benefit period) 20% after deductible 20% after deductible Emergency Services \$350 \$400 after deductible Emergency Services \$350 \$400 after deductible Urgantly Naeded Services (100 days per benefit period) \$45 \$50 Urgantly Naeded Services (20% after deductible (20% after ded	Office Visits - PCP	\$45	\$50	
Radiology (standard) \$75 \$85 Maternity Care No charge No charge Preventive Care Services No charge No charge Preventive Care Services No charge No charge Mosphaltzation Services Preventive Care Services Very Service Care Services Impatient Physician Care 20% after deductible 20% after deductible Skilled Nursing Facility Care 20% after deductible 20% after deductible Uniformative Read Services \$350 \$400 after deductible Emergency Services \$355 \$50 - within physician service area \$45 \$50 - within physician service area \$45 \$50 Annulaince Services \$200 after deductible \$250 after deductible Dusplaint Survices \$20% \$20% Durable Medical Equipment 20% 20% Ups time I Survices Not covered Not covered Not covered Not published Services Not covered Not covered Not covered Impatient Description Drug Coverage \$45 \$50 \$	Office Visits - Specialist	\$80	\$85	
Maternity Care No charge No charge Preventive Care Services No charge No charge Hospitalization Services No charge No charge Inpatient Hospital Benefits 20% after deductible 20% after deductible Skilled Nursing Facility Care 20% after deductible 20% after deductible Skilled Nursing Facility Care 20% after deductible 20% after deductible Skilled Nursing Facility Care 20% after deductible 20% after deductible Skilled Nursing Facility Care 20% after deductible 20% after deductible Skilled Nursing Facility Care 20% after deductible 20% after deductible Emergency Services \$350 \$400 after deductible Urgently Needed Services \$45 \$50 Ambulance Services \$45 \$50 Ambulance Services \$20 after deductible \$20% Outpatient Surgery 20% 20% Usuable Medical Equipment 20% 20% Home Health Services Not covered Not covered Injectable Drugs 20% after deductible 20% after deductibl	Laboratory (standard)	\$40	\$40	
Preventive Care Services No charge No charge Hospitalization Services Compation of Lospital Benefits 20% after deductible 20% after deductible Inpatient Hospital Benefits 20% after deductible 20% after deductible Skilled Nursing Facility Care (100 days per benefit period) 20% after deductible 20% after deductible Emergency Benefit period) Emergency Services \$350 \$400 after deductible Emergency Services \$350 \$400 after deductible Urgently Needed Services \$50 \$50 - outside physician service area \$45 \$50 - outside physician service area \$45 \$50 Armonic Services \$250 after deductible \$250 after deductible Uupstile Surgery 20% 20% Durable Medical Equipment 20% 20% Home Health Services Not cowered Not cowered Upstile Drugs 20% 20% Home Health & Substance Use Disorder Services \$20 \$50 Outpatient	Radiology (standard)	\$75	\$85	
Propertical Exercises 20% after deductible 20% after deductibl	Maternity Care	No charge	No charge	
Inpatient Hospital Benefits 20% after deductible 20% after deductible Inpatient Physician Care 20% after deductible 20% after deductible Skilled Nursing Facility Care (100 days per benefit period) 20% after deductible Emergency Health Coverage ************************************	Preventive Care Services	No charge	No charge	
Inpatient Physician Care 20% after deductible 20% after deductible Skilled Nursing Facility Care (100 days per benefit period) 20% after deductible Emergency Health Coverage \$350 \$400 after deductible Urgently Needed Services \$350 \$50 - outside physician service area \$45 \$50 - outside physician service area \$45 \$50 Ambulance Services \$20 after deductible \$250 after deductible Outpatient Services \$20% \$20% Outpatient Survices 20% 20% Durable Medical Equipment 20% 20% Home Health Services Not covered Not covered Infertility Services Not covered Not covered Injectable Drugs 20% after deductible 20% after deductible Mental Health & Substance Use Disorder Services Not covered Not covered Injectable Drugs 20% after deductible 20% after deductible Outpatient Frescription Drug Coverage \$50 \$50 Calendar Year Deductible (individual/lamliy) \$200/\$400 \$300/\$800	Hospitalization Services			
Skilled Nursing Facility Care (100 days per benefit period) 20% after deductible Emergency Services \$350 \$400 after deductible Urgently Needed Services - within physician service area \$45 \$50 Outside physician service area \$45 \$50 Ambulance Services \$250 after deductible \$250 after deductible Outside physician service area \$45 \$50 Ambulance Services \$250 after deductible \$250 after deductible Outside physician service area \$45 \$50 Ambulance Services \$250 after deductible \$250 after deductible Outside Projection \$20% \$20% Durable Medical Equipment \$20% \$20% Lower Health Services Not covered Not covered Not covered Up to 100 visits per calendar year) \$20% 20% 20% Infertility Services Not covered Not covered Not covered Not covered Up to 100 visits per calendar year) \$200% 20% 20% 20% Infertility Services \$45 \$50 \$50	Inpatient Hospital Benefits	20% after deductible	20% after deductible	
(100 days per benefit period) 20% after deductible Emergency Health Coverage \$350 \$400 after deductible Urgently Needed Services - within physician service area \$45 \$50 - outside physician services area \$250 after deductible \$50 Ambulance Services \$250 after deductible \$250 after deductible Outpatient Services Outpatient Surgery 20% 20% Durable Medical Equipment 20% 20% Home Health Services Not covered Not covered Infectility Services Not covered Not covered Injectable Drugs 20% after deductible 20% after deductible Mental Health & Substance Use Disorder Services Injectable Drugs 20% after deductible 20% after deductible Outpatient \$45 \$50 Outpatient Prescription Drug Coverage Calendar Year Deductible (individual/tamly) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$9	Inpatient Physician Care	20% after deductible	20% after deductible	
Emergency Services \$350 \$400 after deductible Urgently Needed Services - within physician service area \$45 \$50 - outside physician service area \$45 \$50 Ambulance Services \$250 after deductible \$250 after deductible Outpatient Services Outpatient Surgery 20% 20% Durable Medical Equipment 20% 20% Home Health Services 20% 20% Uly to 100 visits per calendar year) 20% 20% Infertility Services Not covered Not covered Injectable Drugs 20% 20% Injectable Drugs 20% 20% Injectable Drugs 20% after deductible 20% after deductible Outpatient \$45 \$50 Mental Health & Substance Use Disorder Services Injectable Drugs 20% after deductible 20% after deductible Outpatient \$45 \$50 Duty after deductible 20% after deductible Outpatient Prescription Drug Coverage \$17 \$17 <		20% after deductible	20% after deductible	
Urgently Needed Services - within physician service area \$45 \$50 - outside physician service area \$45 \$50 Ambulance Services \$250 after deductible \$250 after deductible Outpatient Services Outpatient Surgery 20% 20% Durable Medical Equipment 20% 20% Home Health Services 20% 20% Urge to 100 visits per calendar year) 20% 20% Infertility Services Not covered Not covered Injectable Drugs 20% 20% Injectable Drugs 20% 20% Injectable Drugs 20% after deductible 80 Injectable Drugs 20% after deductible 20% after deductible Outpatient Prescription Drug Coverage \$50 \$50 Outpatient Prescription Drug Coverage \$200 yield after deductible \$300 yield after deductible Calendar Year Deductible (Individual/family) \$200 yield after deductible \$300 yield after deductible Calendar Year Deductible (Individual/family) \$200 yield yield after deductible \$300 yield after deductible	Emergency Health Coverage			
-within physician service area \$45 \$50 - outside physician service area \$45 \$50 Ambulance Services \$250 after deductible \$250 after deductible Outpatient Services Outpatient Surgery 20% 20% Durable Medical Equipment 20% 20% Home Health Services (Up to 100 visits per calendar year) 20% Not covered Infertilly Services Not covered Not covered Injectable Drugs 20% 20% Mental Health & Substance Use Disorder Services Injectable Drugs 20% after deductible 20% after deductible Outpatient \$45 \$50 Outpatient Prescription Drug Coverage Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage* Dental Exam (preventive/diagnostic) No	Emergency Services	\$350	\$400 after deductible	
Ambulance Services \$250 after deductible \$250 after deductible Outpatient Services 20% 20% Durable Medical Equipment 20% 20% Home Health Services (Up to 100 visits per calendar year) 20% 20% Injectable Drugs 20% 20% Injectable Drugs 20% 20% Mental Health & Substance Use Disorder Services Not covered Not covered Inpatient 20% after deductible 20% after deductible Outpatient Prescription Drug Coverage \$50 \$50 Outpatient Prescription Drug Coverage \$15 \$17 Calendar Year Deductible (individual/family) \$200,\$400 \$300,\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage* Dental Exam (preventive/diagnostic) No charge No charge Vision Exam (routine) No charge No charge		\$45	\$50	
Outpatient Services Outpatient Surgery 20% 20% Durable Medical Equipment 20% 20% Home Health Services (Up to 100 visits per calendar year) 20% 20% Infertility Services Not covered Not covered Injectable Drugs 20% 20% Mental Health & Substance Use Disorder Services 80 20% Inpatient 20% after deductible 20% after deductible Outpatient Prescription Drug Coverage \$50 \$50 Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage* Dental Exam (preventive/diagnostic) No charge No charge Vision Exam (routine) No charge No charge Glasses (frames & lenses) No charge No charge	- outside physician service area	\$45	\$50	
Outpatient Surgery 20% 20% Durable Medical Equipment 20% 20% Home Health Services (Up to 100 visits per calendar year) 20% 20% Infectility Services Not covered Not covered Injectable Drugs 20% 20% Mental Health & Substance Use Disorder Services Inpatient 20% after deductible 20% after deductible Outpatient \$45 \$50 Outpatient Prescription Drug Coverage Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage* Dental Exam (preventive/diagnostic) No charge No charge Vision Exam (routine) No charge No charge Glasses (frames & lenses) No charge No charge	Ambulance Services	\$250 after deductible	\$250 after deductible	
Durable Medical Equipment 20% 20% Home Health Services (Up to 100 visits per calendar year) 20% 20% Infertility Services Not covered Not covered Injectable Drugs 20% 20% Mental Health & Substance Use Disorder Services Inpatient 20% after deductible 20% after deductible Outpatient Prescription Drug Coverage \$50 \$50 Outpatient Prescription Drug Coverage Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage ⁴ Dental Exam (preventive/diagnostic) No charge No charge Vision Exam (routine) No charge No charge Glasses (frames & lenses) No charge No charge	Outpatient Services			
Home Health Services (Up to 100 visits per calendar year) 20% 20% Infertility Services Not covered Not covered Injectable Drugs 20% 20% Mental Health & Substance Use Disorder Services Inpatient 20% after deductible 20% after deductible Outpatient \$45 \$50 Outpatient Prescription Drug Coverage Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage* Dental Exam (preventive/diagnostic) No charge No charge Vision Exam (routine) No charge No charge Glasses (frames & lenses) No charge No charge	Outpatient Surgery	20%	20%	
(Up to 100 visits per calendar year) 20% Infertility Services Not covered Not covered Injectable Drugs 20% 20% Mental Health & Substance Use Disorder Services Inpatient 20% after deductible 20% after deductible Outpatient Prescription Drug Coverage 550 \$50 Outpatient Prescription Drug Coverage \$300/\$600 \$17 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage* Dental Exam (preventive/diagnostic) No charge No charge Vision Exam (routine) No charge No charge Glasses (frames & lenses) No charge No charge	Durable Medical Equipment	20%	20%	
Injectable Drugs 20% Mental Health & Substance Use Disorder Services Inpatient 20% after deductible 20% after deductible Outpatient \$45 \$50 Outpatient Prescription Drug Coverage Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage* Dental Exam (preventive/diagnostic) No charge No charge Vision Exam (routine) No charge No charge Glasses (frames & lenses) No charge No charge		20%	20%	
Mental Health & Substance Use Disorder Services Inpatient 20% after deductible 20% after deductible Outpatient \$45 \$50 Outpatient Prescription Drug Coverage Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage¹ Dental Exam (preventive/diagnostic) No charge No charge Vision Exam (routine) No charge No charge Glasses (frames & lenses) No charge No charge	Infertility Services	Not covered	Not covered	
Inpatient 20% after deductible 20% after deductible Outpatient \$45 \$50 Outpatient Prescription Drug Coverage Stock Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage ⁴ Dental Exam (preventive/diagnostic) No charge No charge Vision Exam (routine) No charge No charge Glasses (frames & lenses) No charge No charge	Injectable Drugs	20%	20%	
Outpatient \$45 \$50 Outpatient Prescription Drug Coverage Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage ⁴ Dental Exam (preventive/diagnostic) No charge No charge Vision Exam (routine) No charge No charge Glasses (frames & lenses) No charge No charge	Mental Health & Substance Use Disorder Services			
Outpatient Prescription Drug Coverage Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage ⁴ Dental Exam (preventive/diagnostic) No charge No charge Vision Exam (routine) No charge No charge Glasses (frames & lenses) No charge No charge	Inpatient	20% after deductible	20% after deductible	
Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage ⁴ Dental Exam (preventive/diagnostic) No charge No charge Vision Exam (routine) No charge No charge Glasses (frames & lenses) No charge No charge	Outpatient	\$45	\$50	
Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage ⁴ Dental Exam (preventive/diagnostic) No charge No charge Vision Exam (routine) No charge No charge Glasses (frames & lenses) No charge No charge	Outpatient Prescription Drug Coverage			
Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage ⁴ Dental Exam (preventive/diagnostic) No charge No charge Vision Exam (routine) No charge No charge Glasses (frames & lenses) No charge No charge	Calendar Year Deductible (individual/family)	\$200/\$400	\$300/\$600	
Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage ⁴ Dental Exam (preventive/diagnostic) No charge No charge Vision Exam (routine) No charge No charge Glasses (frames & lenses) No charge No charge	Tier 1	\$15	\$17	
Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage4 Dental Exam (preventive/diagnostic) No charge No charge Vision Exam (routine) No charge No charge Glasses (frames & lenses) No charge	Tier 2	\$55	\$65	
Pediatric Dental & Vision Coverage ⁴ Dental Exam (preventive/diagnostic) No charge No charge No charge No charge Ro charge No charge No charge No charge No charge	Tier 3	\$85	\$90	
Dental Exam (preventive/diagnostic) No charge	Tier 4	20% up to \$250	20% up to \$250	
Vision Exam (routine) No charge No charge Glasses (frames & lenses) No charge No charge	Pediatric Dental & Vision Coverage ⁴			
Glasses (frames & lenses) No charge No charge	Dental Exam (preventive/diagnostic)	No charge	No charge	
	Vision Exam (routine)	No charge	No charge	
Optional Group Coverage - Infertility Services 50% 50%	Glasses (frames & lenses)	No charge	No charge	
	Optional Group Coverage - Infertility Services	50%	50%	

¹ When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

² The Annual Deductible is combined for medical and pharmacy benefits.

³ Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁴ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Advantage, Alliance and Focus Bronze State Plan Mapping – All Plans Mapped to Alliance

Prior to Jan. 1, 2020

Metallic Level	Bronze		
HMO Plan	Bronze 60 HMO HDHP 6000/40% (Alliance only)	Bronze 60 HMO HDHP 6900/0%	
Annual Deductible ¹ (individual/family)	\$6,000/\$12,000 ²	\$6,900/\$13,800 ²	
Annual Out-of-Pocket Limit ² (individual/family)	\$6,650/\$13,300	\$6,900/\$13,800	
Professional Services			
Office Visits - PCP	40% after deductible	No charge after deductible	
Office Visits - Specialist	40% after deductible	No charge after deductible	
Laboratory (standard)	40% after deductible	No charge after deductible	
Radiology (standard)	40% after deductible	No charge after deductible	
Maternity Care	40% after deductible	No charge after deductible	
Preventive Care Services	No charge	No charge	
Hospitalization Services			
Inpatient Hospital Benefits	40% after deductible	No charge after deductible	
Inpatient Physician Care	40% after deductible	No charge after deductible	
Skilled Nursing Facility Care (100 days per benefit period)	40% after deductible	No charge after deductible	
Emergency Health Coverage			
Emergency Services	40% after deductible	No charge after deductible	
Urgently Needed Services – within physician service area	40% after deductible	No charge after deductible	
- outside physician service area	40% after deductible	No charge after deductible	
Ambulance Services	40% after deductible	No charge after deductible	
Outpatient Services			
Outpatient Surgery	40% after deductible	No charge after deductible	
Durable Medical Equipment	40% after deductible	No charge after deductible	
Home Health Services (Up to 100 visits per calendar year)	40% after deductible	No charge after deductible	
Infertility Services	Not covered	Not covered	
Injectable Drugs	40% after deductible	No charge after deductible	
Mental Health & Substance Use Disorder Services			
Inpatient	40% after deductible	No charge after deductible	
Outpatient	40% after deductible	No charge after deductible	
Outpatient Prescription Drug Coverage			
Calendar Year Deductible (individual/family)	Annual Deductible applies	Annual Deductible applies	
Tier 1	40% up to \$500	No charge	
Tier 2	40% up to \$500	No charge	
Tier 3	40% up to \$500	No charge	
Tier 4	40% up to \$500	No charge	
Pediatric Dental & Vision Coverage ⁴			
Dental Exam (preventive/diagnostic)	No charge	No charge	
Vision Exam (routine)	No charge	No charge	
Glasses (frames & lenses)	No charge	No charge	
Optional Group Coverage - Infertility Services	50% after deductible	50% after deductible	

¹ When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

 $^{^{\}rm 2}$ The Annual Deductible is combined for medical and pharmacy benefits.

³ Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

 $^{^{4}}$ One routine vision exam and one pair of glasses per calendar year for children under age 19.

UnitedHealthcare Navigate® Platinum Plan Mapping – All Plans Mapped to Core

Prior to Jan. 1, 2020

Metallic Level	Platinum		
Navigate Plan	10/10%	10/1	0%
Network¹	Network	Network	Non-Network
Annual Deductible ² (individual/family)	None	None	\$1,000/\$2,000
Annual Out-of-Pocket Limit ³ individual/family)	\$3,200/\$6,400	\$3,500/\$7,000	\$7,000/\$14,000
Professional Services			
Office Visits - PCP	\$10	\$10	50% after deductible
Office Visits - Specialist	\$20	\$25	50% after deductible
aboratory ⁴ (standard)	10%	10%	50% after deductible
Radiology ⁴ (standard)	10%	10%	50% after deductible
Maternity Care ⁵	\$10	\$10	50% after deductible
Preventive Care Services	No copayment	No copayment	No benefit
lospitalization Services			
npatient Hospital Benefits	10%	10%	50% after deductible
npatient Physician Care	10%	10%	50% after deductible
Skilled Nursing Facility Care 100 days per benefit period)	10%	10%	50% after deductible
mergency Health Coverage			
mergency Services	10% plus \$150 per-occurrence deductible	10% plus \$150 per-occurrence deductible	Same as Network benefit
Irgent Care Services	\$50	\$50	50% after deductible
Ambulance Services	10%	10%	Same as Network benefit
Outpatient Services			
Outpatient Surgery ⁴	10%	10%	50% after deductible
Ourable Medical Equipment	10%	10%	50% after deductible
Home Health Services Up to 100 visits per calendar year)	10%	10%	50% after deductible
nfertility Services Benefits limited to \$2,000 per lifetime)	10%	10%	50% after deductible
njections Received in a Physician's Office	\$10	\$10	50% after deductible
Mental Health & Substance Use Disorder Servi	ces		
npatient	10%	10%	50% after deductible
Dutpatient	\$10	\$10	50% after deductible
Outpatient Prescription Drug Coverage			
Calendar Year Deductible (individual/family)	None	Nor	ne
ier 1	\$10	\$10	0
ier 2	\$35	\$3	5
ier3	\$70	\$70	0
ier 4	10% up to \$250	10% up t	o \$250
ediatric Dental & Vision Coverage ⁶			
Dental Exam (preventive/diagnostic)	No copayment	No copayment	50% after deductible
/ision Exam (routine)	No copayment	No copayment	50%
Glasses (frames & lenses)	10%	10%	50%

¹ No benefits for Non-Network services, except for emergency health and urgent care services. Members must obtain an electronic referral from their primary care physician before seeing another network physician.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

³ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

When the cost share, including onice visits, annual deductible, per-occurrence deductible, consulance and pharmacy, apply to the out-of-rocket cir.
 The outpatient per-occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.

No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Prior to Jan. 1, 2020

Metallic Level		Platinum	
Navigate Plan	15/250/20%	15/250/	/20%
Network ¹	Network	Network	Non-Network
Annual Deductible ² (individual/family)	\$250/\$500	\$250/\$500	\$1,000/\$2,000
Annual Out-of-Pocket Limit ³ (individual/family)	\$3,200/\$6,400	\$3,500/\$7,000	\$7,000/\$14,000
Professional Services			
Office Visits - PCP	\$15	\$15	50% after deductible
Office Visits - Specialist	\$30	\$30	50% after deductible
_aboratory ⁴ (standard)	20% after deductible	20% after deductible	50% after deductible
Radiology ⁴ (standard)	20% after deductible	20% after deductible	50% after deductible
Maternity Care ⁵	\$15	\$15	50% after deductible
Preventive Care Services	No copayment	No copayment	No benefit
Hospitalization Services			
npatient Hospital Benefits	20% after deductible	20% after deductible	50% after deductible
npatient Physician Care	20% after deductible	20% after deductible	50% after deductible
Skilled Nursing Facility Care 100 days per benefit period)	20% after deductible	20% after deductible	50% after deductible
mergency Health Coverage			
Emergency Services	20% after deductible, plus \$150 per- occurrence deductible	20% after deductible, plus \$150 per- occurrence deductible	Same as Network benefit
Jrgent Care Services	\$50	\$50	50% after deductible
Ambulance Services	20% after deductible	20% after deductible	Same as Network benefit
Outpatient Services			
Dutpatient Surgery ⁴	20% after deductible	20% after deductible	50% after deductible
Durable Medical Equipment	20% after deductible	20% after deductible	50% after deductible
Home Health Services Up to 100 visits per calendar year)	20% after deductible	20% after deductible	50% after deductible
nfertility Services Benefits limited to \$2,000 per lifetime)	20% after deductible	20% after deductible	50% after deductible
njections Received in a Physician's Office	\$15	\$15	50% after deductible
Mental Health & Substance Use Disorder Serv	vices		
npatient	20% after deductible	20% after deductible	50% after deductible
Dutpatient	\$15	\$15	50% after deductible
Outpatient Prescription Drug Coverage			
Calendar Year Deductible (individual/family)	None	Non	е
ier 1	\$10	\$10)
-ier 2	\$35	\$35	5
-ier3	\$70	\$70)
-ier 4	10% up to \$250	10% up to	\$250
Pediatric Dental & Vision Coverage ⁵			
Dental Exam (preventive/diagnostic)	No copayment	No copayment	50% after deductible
Vision Exam (routine)	No copayment	No copayment	50%
Glasses (frames & lenses)	20%	20%	50%

¹ No benefits for Non-Network services, except for emergency health and urgent care services. Members must obtain an electronic referral from their primary care physician before seeing another network physician.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

³ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁴ The outpatient per-occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.

No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Prior to Jan. 1, 2020

Metallic Level	Gold		
Navigate Plan	25/250/20%	25/250/20% 25/500/20%	
Network ¹	Network	Network	Non-Network
Annual Deductible ² (individual/family)	\$250/\$500	\$500/\$1,000	\$1,000/\$2,000
Annual Out-of-Pocket Limit ³ (individual/family)	\$6,000/\$12,000	\$6,500/\$13,000	\$13,000/\$26,000
Professional Services			
Office Visits - PCP	\$25	\$25	50% after deductible
Office Visits - Specialist	\$50	\$50	50% after deductible
Laboratory ⁴ (standard)	20% after deductible, plus \$250 per-occurrence deductible	20% after deductible for independent, non-hospital-affiliated provider; 40% after deductible for hospital-affiliated provider	50% after deductible
Radiology ⁴ (standard)	20% after deductible, plus \$250 per-occurrence deductible	20% after deductible for independent, non-hospital-affiliated provider; 40% after deductible for hospital-affiliated provider	50% after deductible
Maternity Care ⁵	\$25	\$25	50% after deductible
Preventive Care Services	No copayment	No copayment	No benefit
Hospitalization Services			
Inpatient Hospital Benefits	20% after deductible, plus \$250 per-occurrence deductible	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Inpatient Physician Care	20% after deductible	20% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	20% after deductible	50% after deductible
Emergency Health Coverage			
Emergency Services	20% after deductible, plus \$250 per-occurrence deductible	20% after deductible, plus \$250 per-occurrence deductible	Same as Network benefit
Urgent Care Services	\$75	\$75	50% after deductible
Ambulance Services	20% after deductible	20% after deductible	Same as Network benefit
Outpatient Services			
Outpatient Surgery ⁴	20% after deductible, plus \$250 per-occurrence deductible	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Durable Medical Equipment	20% after deductible	20% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	20% after deductible	20% after deductible	50% after deductible
Infertility Services (Benefits limited to \$2,000 per lifetime)	20% after deductible	20% after deductible	50% after deductible
Injections Received in a Physician's Office	\$25	\$25	50% after deductible
Mental Health & Substance Use Disorder Serv	ices		
Inpatient	20% after deductible	20% after deductible	50% after deductible
Outpatient	\$25	\$25	50% after deductible
Outpatient Prescription Drug Coverage			
Calendar Year Deductible (individual/family)	None	\$250, does not ap	/\$500 ply to Tier 1
Tier 1	\$15	\$1	15
Tier 2	\$40	\$4	40
Tier 3	\$80	\$8	30
Tier 4	25% up to \$250	25% up	to \$250
Pediatric Dental & Vision Coverage ⁵			
Dental Exam (preventive/diagnostic)	No copayment	No copayment	50% after deductible
Vision Exam (routine)	No copayment	No copayment	50%
Glasses (frames & lenses)	20%	20%	50%
(- 7-	- / -	

¹ No benefits for Non-Network services, except for emergency health and urgent care services. Members must obtain an electronic referral from their primary care physician before seeing another network physician.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

³ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁴ The outpatient per-occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.

⁵ No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Prior to Jan. 1, 2020

Metallic Level	Gold		
Navigate Plan	25/750/20%	25/100	0/20%
Network ¹	Network	Network	Non-Network
Annual Deductible ² (individual/family)	\$750/\$1,500	\$1,000/\$2,000	\$2,000/\$4,000
Annual Out-of-Pocket Limit ³ (individual/family)	\$6,000/\$12,000	\$6,500/\$13,000	\$13,000/\$26,000
Professional Services			
Office Visits - PCP	\$25	\$25	50% after deductible
Office Visits - Specialist	\$50	\$50	50% after deductible
Laboratory ⁴ (standard)	20% after deductible, plus \$250 per-occurrence deductible	20% after deductible for independent, non-hospital-affiliated provider; 40% after deductible for hospital-affiliated provider	50% after deductible
Radiology ⁴ (standard)	20% after deductible, plus \$250 per-occurrence deductible	20% after deductible for independent, non-hospital-affiliated provider; 40% after deductible for hospital-affiliated provider	50% after deductible
Maternity Care ⁵	\$25	\$25	50% after deductible
Preventive Care Services	No copayment	No copayment	No benefit
Hospitalization Services			
Inpatient Hospital Benefits	20% after deductible, plus \$250 per-occurrence deductible	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Inpatient Physician Care	20% after deductible	20% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	20% after deductible	50% after deductible
Emergency Health Coverage			
Emergency Services	20% after deductible, plus \$250 per-occurrence deductible	20% after deductible, plus \$250 per-occurrence deductible	Same as Network benefit
Urgent Care Services	\$75	\$75	50% after deductible
Ambulance Services	20% after deductible	20% after deductible	Same as Network benefit
Outpatient Services			
Outpatient Surgery ⁴	20% after deductible, plus \$250 per-occurrence deductible	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Durable Medical Equipment	20% after deductible	20% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	20% after deductible	20% after deductible	50% after deductible
Infertility Services (Benefits limited to \$2,000 per lifetime)	20% after deductible	20% after deductible	50% after deductible
Injections Received in a Physician's Office	\$25	\$25	50% after deductible
Mental Health & Substance Use Disorder Serv	ices		
Inpatient	20% after deductible	20% after deductible	50% after deductible
Outpatient	\$25	\$25	50% after deductible
Outpatient Prescription Drug Coverage			
Calendar Year Deductible (individual/family)	None	\$250, does not ap	/\$500 ply to Tier 1
Tier 1	\$15	\$1	5
Tier 2	\$40	\$4	10
Tier 3	\$80	\$8	30
Tier 4	25% up to \$250	25% up	to \$250
Pediatric Dental & Vision Coverage ⁵			
Dental Exam (preventive/diagnostic)	No copayment	No copayment	50% after deductible
Vision Exam (routine)	No copayment	No copayment	50%
Glasses (frames & lenses)	20%	20%	50%
	- /-	- / -	

¹ No benefits for Non-Network services, except for emergency health and urgent care services. Members must obtain an electronic referral from their primary care physician before seeing another network physician.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

³ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁴ The outpatient per-occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.

⁵ No copayment applies to physician office visits for prenatal care.

 $^{^{\}rm 6}$ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Prior to Jan. 1, 2020

Metallic Level	Gold		
Navigate Plan	25/1250/20%	25/1250/20% 25/1000/20%	
Network ¹	Network	Network	Non-Network
Annual Deductible ² (individual/family)	\$1,250/\$2,500	\$1,000/\$2,000	\$2,000/\$4,000
Annual Out-of-Pocket Limit ³ (individual/family)	\$6,000/\$12,000	\$6,500/\$13,000	\$13,000/\$26,000
Professional Services			
Office Visits - PCP	\$25	\$25	50% after deductible
Office Visits - Specialist	\$50	\$50	50% after deductible
Laboratory ⁴ (standard)	20% after deductible, plus \$250 per-occurrence deductible	20% after deductible for independent, non-hospital-affiliated provider; 40% after deductible for hospital-affiliated provider	50% after deductible
Radiology ⁴ (standard)	20% after deductible, plus \$250 per-occurrence deductible	20% after deductible for independent, non-hospital-affiliated provider; 40% after deductible for hospital-affiliated provider	50% after deductible
Maternity Care ⁵	\$25	\$25	50% after deductible
Preventive Care Services	No copayment	No copayment	No benefit
Hospitalization Services			
Inpatient Hospital Benefits	20% after deductible, plus \$250 per-occurrence deductible	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Inpatient Physician Care	20% after deductible	20% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	20% after deductible	50% after deductible
Emergency Health Coverage			
Emergency Services	20% after deductible, plus \$250 per-occurrence deductible	20% after deductible, plus \$250 per-occurrence deductible	Same as Network benefit
Urgent Care Services	\$75	\$75	50% after deductible
Ambulance Services	20% after deductible	20% after deductible	Same as Network benefit
Outpatient Services			
Outpatient Surgery ⁴	20% after deductible, plus \$250 per-occurrence deductible	20% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Durable Medical Equipment	20% after deductible	20% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	20% after deductible	20% after deductible	50% after deductible
Infertility Services (Benefits limited to \$2,000 per lifetime)	20% after deductible	20% after deductible	50% after deductible
Injections Received in a Physician's Office	\$25	\$25	50% after deductible
Mental Health & Substance Use Disorder Serv	ices		
Inpatient	20% after deductible	20% after deductible	50% after deductible
Outpatient	\$25	\$25	50% after deductible
Outpatient Prescription Drug Coverage			
Calendar Year Deductible (individual/family)	None	\$250 _/ does not ap	/\$500 ply to Tier 1
Tier 1	\$15	\$1	5
Tier 2	\$40	\$4	10
Tier 3	\$80	\$8	30
Tier 4	25% up to \$250	25% up	to \$250
Pediatric Dental & Vision Coverage ⁵			
Dental Exam (preventive/diagnostic)	No copayment	No copayment	50% after deductible
Vision Exam (routine)	No copayment	No copayment	50%
Glasses (frames & lenses)	20%	20%	50%
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¹ No benefits for Non-Network services, except for emergency health and urgent care services. Members must obtain an electronic referral from their primary care physician before seeing another network physician.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

³ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁴ The outpatient per-occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.

⁵ No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Prior to Jan. 1, 2020

Metallic Level		Gold	
Navigate Plan	40/1500/30%	50/1500/40%	
Network ¹	Network	Network	Non-Network
Annual Deductible ² (individual/family)	\$1,500/\$3,000	\$1,500/\$3,000	\$3,000/\$6,000
Annual Out-of-Pocket Limit ³ (individual/family)	\$7,900/\$15,800	\$8,150/\$16,300	\$16,300/\$32,600
Professional Services			
Office Visits - PCP	\$40	\$50	50% after deductible
Office Visits - Specialist	\$70	\$80	50% after deductible
Laboratory ⁴ (standard)	30% after deductible, plus \$250 per-occurrence deductible	40% after deductible for independent, non-hospital-affiliated provider; 50% after deductible for hospital-affiliated provider	50% after deductible
Radiology ⁴ (standard)	30% after deductible, plus \$250 per-occurrence deductible	40% after deductible for independent, non-hospital-affiliated provider; 50% after deductible for hospital-affiliated provider	50% after deductible
Maternity Care ⁵	\$40	\$50	50% after deductible
Preventive Care Services	No copayment	No copayment	No benefit
Hospitalization Services			
Inpatient Hospital Benefits	30% after deductible, plus \$250 per-occurrence deductible	40% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Inpatient Physician Care	30% after deductible	40% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	30% after deductible	40% after deductible	50% after deductible
Emergency Health Coverage			
Emergency Services	30% after deductible, plus \$250 per-occurrence deductible	40% after deductible, plus \$250 per-occurrence deductible	Same as Network benefit
Urgent Care Services	\$70	\$80	50% after deductible
Ambulance Services	30% after deductible	40% after deductible	Same as Network benefit
Outpatient Services			
Outpatient Surgery ⁴	30% after deductible, plus \$250 per-occurrence deductible	40% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Durable Medical Equipment	30% after deductible	40% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	30% after deductible	40% after deductible	50% after deductible
Infertility Services (Benefits limited to \$2,000 per lifetime)	30% after deductible	40% after deductible	50% after deductible
Injections Received in a Physician's Office	\$40	\$50	50% after deductible
Mental Health & Substance Use Disorder Serv	ices		
Inpatient	30% after deductible	40% after deductible	50% after deductible
Outpatient	\$40	\$50	50% after deductible
Outpatient Prescription Drug Coverage			
Calendar Year Deductible (individual/family)	\$250/\$500 does not apply to Tier 1	\$300, does not ap	/\$600 pply to Tier 1
Tier 1	\$20	\$2	
Tier 2	\$50		50
Tier 3	\$100		00
Tier 4	25% up to \$250	25% up	
Pediatric Dental & Vision Coverage ⁶			
Dental Exam (preventive/diagnostic)	No copayment	No copayment	50% after deductible
Vision Exam (routine)	No copayment	No copayment	50%
,			
Glasses (frames & lenses)	30%	40%	50%

¹ No benefits for Non-Network services, except for emergency health and urgent care services. Members must obtain an electronic referral from their primary care physician before seeing another network physician.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

³ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁴ The outpatient per-occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.

⁵ No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Prior to Jan. 1, 2020

Metallic Level	Gold		
Navigate Plan	45/2250/40%	45/2250/40% 50/2250/40%	
Network ¹	Network	Network	Non-Network
Annual Deductible ² (individual/family)	\$2,250/\$4,500	\$2,250/\$4,500	\$4,500/\$9,000
Annual Out-of-Pocket Limit ³ (individual/family)	\$7,900/\$15,800	\$8,150/\$16,300	\$16,300/\$32,600
Professional Services			
Office Visits - PCP	\$45	\$50	50% after deductible
Office Visits - Specialist	\$80	\$80	50% after deductible
Laboratory ⁴ (standard)	40% after deductible, plus \$250 per-occurrence deductible	40% after deductible for independent, non-hospital-affiliated provider; 50% after deductible for hospital-affiliated provider	50% after deductible
Radiology ⁴ (standard)	40% after deductible, plus \$250 per-occurrence deductible	40% after deductible for independent, non-hospital-affiliated provider; 50% after deductible for hospital-affiliated provider	50% after deductible
Maternity Care ⁵	\$45	\$50	50% after deductible
Preventive Care Services	No copayment	No copayment	No benefit
Hospitalization Services			
Inpatient Hospital Benefits	40% after deductible, plus \$250 per-occurrence deductible	40% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Inpatient Physician Care	40% after deductible	40% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	40% after deductible	40% after deductible	50% after deductible
Emergency Health Coverage			
Emergency Services	40% after deductible, plus \$250 per-occurrence deductible	40% after deductible, plus \$250 per-occurrence deductible	Same as Network benefit
Urgent Care Services	\$80	\$80	50% after deductible
Ambulance Services	40% after deductible	40% after deductible	Same as Network benefit
Outpatient Services			
Outpatient Surgery ⁴	40% after deductible, plus \$250 per-occurrence deductible	40% after deductible, plus \$250 per-occurrence deductible	50% after deductible, plus \$250 per-occurrence deductible
Durable Medical Equipment	40% after deductible	40% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	40% after deductible	40% after deductible	50% after deductible
Infertility Services (Benefits limited to \$2,000 per lifetime)	40% after deductible	40% after deductible	50% after deductible
Injections Received in a Physician's Office	\$45	\$50	50% after deductible
Mental Health & Substance Use Disorder Serv	ices		
Inpatient	40% after deductible	40% after deductible	50% after deductible
Outpatient	\$45	\$50	50% after deductible
Outpatient Prescription Drug Coverage			
Calendar Year Deductible (individual/family)	\$250/\$500 does not apply to Tier 1	\$300, does not ap	/\$600 ply to Tier 1
Tier 1	\$20	\$2	20
Tier 2	\$50	\$5	50
Tier 3	\$100	\$10	00
Tier 4	25% up to \$250	25% up	to \$250
Pediatric Dental & Vision Coverage ⁵			
Dental Exam (preventive/diagnostic)	No copayment	No copayment	50% after deductible
Vision Exam (routine)	No copayment	No copayment	50%
Glasses (frames & lenses)	40%	40%	50%
S. 20000 (11211100 & 1011000)	1070	1070	00/0

¹ No benefits for Non-Network services, except for emergency health and urgent care services. Members must obtain an electronic referral from their primary care physician before seeing another network physician.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

³ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

⁴ The outpatient per-occurrence deductible may be waived for outpatient services received at a network independent, non-hospital-affiliated provider.

⁵ No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Navigate HDHP Silver Plan Mapping – All Plans Mapped to Core

Prior to Jan. 1, 2020

Metallic Level		Silver	
Navigate Plan	HDHP w/UnitedHealthcare Motion® 2300/30%	HDHP w/Mo	tion 2300/30%
Network ¹	Network	Network	Non-Network
Annual Deductible ² (individual/family)	\$2,300/\$2,7005	\$2,300/\$2,8005	\$4,600/\$5,6005
Annual Out-of-Pocket Limit ³ individual/family)	\$6,650/\$13,300	\$6,650/\$13,300	\$13,300/\$26,600
Professional Services			
Office Visits - PCP	30% after deductible	30% after deductible	50% after deductible
Office Visits - Specialist	30% after deductible	30% after deductible	50% after deductible
_aboratory (standard)	30% after deductible	30% after deductible	50% after deductible
Radiology (standard)	30% after deductible	30% after deductible	50% after deductible
Maternity Care	30% after deductible	30% after deductible	50% after deductible
Preventive Care Services	No copayment	No copayment	No benefit
Hospitalization Services			
Inpatient Hospital Benefits	30% after deductible	30% after deductible	50% after deductible
Inpatient Physician Care	30% after deductible	30% after deductible	50% after deductible
Skilled Nursing Facility Care 100 days per benefit period)	30% after deductible	30% after deductible	50% after deductible
Emergency Health Coverage			
Emergency Services	30% after deductible	30% after deductible	Same as Network benefit
Jrgent Care Services	30% after deductible	30% after deductible	50% after deductible
Ambulance Services	30% after deductible	30% after deductible	Same as Network benefit
Outpatient Services			
Outpatient Surgery	30% after deductible	30% after deductible	50% after deductible
Durable Medical Equipment	30% after deductible	30% after deductible	50% after deductible
Home Health Services Up to 100 visits per calendar year)	30% after deductible	30% after deductible	50% after deductible
nfertility Services Benefits limited to \$2,000 per lifetime)	30% after deductible	30% after deductible	50% after deductible
njections Received in a Physician's Office	30% after deductible	30% after deductible	50% after deductible
Mental Health & Substance Use Disorder Serv	ices		
npatient	30% after deductible	30% after deductible	50% after deductible
Outpatient	30% after deductible	30% after deductible	50% after deductible
Outpatient Prescription Drug Coverage			
Calendar Year Deductible (individual/family)	Annual Deductible applies	Annual Ded	uctible applies
Tier 1	\$20		\$20
Γier 2	\$50	5	\$50
Fier 3	\$100	\$	100
Γier 4	25% up to \$250	25% u	p to \$250
Pediatric Dental & Vision Coverage ⁴			
Dental Exam (preventive/diagnostic)	No copayment	No copayment	50% after deductible
Vision Exam (routine)	No copayment	No copayment	50% after deductible
Glasses (frames & lenses)	30% after deductible	30% after deductible	50% after deductible

¹ No benefits for Non-Network, except for emergency health and urgent care services. Members must obtain an electronic referral from their primary care physician before seeing another network physician.

² The Annual Deductible is combined for medical and pharmacy benefits.

³ Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit. When a member of a family unit satisfies the individual Out-of-Pocket Limit amount for the calendar year, no further copayments will be required for him or her for that calendar year.

⁴ One routine vision exam and one pair of glasses per calendar year for children under age 19.

⁵ The entire Family Deductible must be met before benefits can be paid for each eligible member of a family. One or more eligible members of a family unit may satisfy the Family Deductible.

⁶ When a member of a family unit satisfies the individual Deductible for the calendar year, no further deductible will be required for him or her for that calendar year.

Navigate HDHP Bronze Plan Mapping – All Plans Mapped to Core

Prior to Jan. 1, 2020

Metallic Level	Bronze		
Navigate Plan	HDHP 6650/0%	HDHP 6	900/0%
Network¹	Network	Network	Non-Network
Annual Deductible ² (individual/family)	\$6,650/\$13,300 ⁶	\$6,900/\$13,800°	\$13,800/\$27,600 ⁶
Annual Out-of-Pocket Limit ³ (individual/family)	\$6,650/\$13,300	\$6,900/\$13,800	\$13,800/\$27,600
Professional Services			
Office Visits - PCP	No copay after deductible	No copay after deductible	No copay after deductible
Office Visits - Specialist	No copay after deductible	No copay after deductible	No copay after deductible
_aboratory (standard)	No copay after deductible	No copay after deductible	No copay after deductible
Radiology (standard)	No copay after deductible	No copay after deductible	No copay after deductible
Maternity Care	No copay after deductible	No copay after deductible	No copay after deductible
Preventive Care Services	No copayment	No copayment	No benefit
Hospitalization Services			
Inpatient Hospital Benefits	No copay after deductible	No copay after deductible	No copay after deductible
Inpatient Physician Care	No copay after deductible	No copay after deductible	No copay after deductible
Skilled Nursing Facility Care 100 days per benefit period)	No copay after deductible	No copay after deductible	No copay after deductible
Emergency Health Coverage			
Emergency Services	No copay after deductible	No copay after deductible	No copay after deductible
Jrgent Care Services	No copay after deductible	No copay after deductible	No copay after deductible
Ambulance Services	No copay after deductible	No copay after deductible	No copay after deductible
Outpatient Services			
Outpatient Surgery	No copay after deductible	No copay after deductible	No copay after deductible
Durable Medical Equipment	No copay after deductible	No copay after deductible	No copay after deductible
Home Health Services Up to 100 visits per calendar year)	No copay after deductible	No copay after deductible	No copay after deductible
nfertility Services Benefits limited to \$2,000 per lifetime)	No copay after deductible	No copay after deductible	No copay after deductible
njections Received in a Physician's Office	No copay after deductible	No copay after deductible	No copay after deductible
Mental Health & Substance Use Disorder Service	es		
npatient	No copay after deductible	No copay after deductible	No copay after deductible
Outpatient	No copay after deductible	No copay after deductible	No copay after deductible
Outpatient Prescription Drug Coverage			
Calendar Year Deductible (individual/family)	Annual Deductible applies	Annual Deductible applies	
Tier 1	No copayment	No copayment	
Γier 2	No copayment	No copayment	
Tier 3	No copayment	No copayment	
Γier 4	No copayment	No copayment	
Pediatric Dental & Vision Coverage ⁴			
Dental Exam (preventive/diagnostic)	No copayment	No copayment	No copay after deductible
Vision Exam (routine)	No copayment	No copayment	No copay after deductible
Glasses (frames & lenses)	No copay after deductible	No copay after deductible	No copay after deductible

¹ No benefits for Non-Network, except for emergency health and urgent care services. Members must obtain an electronic referral from their primary care physician before seeing another network physician.

 $^{^{\}rm 2}$ The Annual Deductible is combined for medical and pharmacy benefits.

³ Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit. When a member of a family unit satisfies the individual Out-of-Pocket Limit amount for the calendar year, no further copayments will be required for him or her for that calendar year.

 $^{^{\}rm 4}$ One routine vision exam and one pair of glasses per calendar year for children under age 19.

The entire Family Deductible must be met before benefits can be paid for each eligible member of a family. One or more eligible members of a family unit may satisfy the Family Deductible.

⁶ When a member of a family unit satisfies the individual Deductible for the calendar year, no further deductible will be required for him or her for that calendar year.

Navigate State Platinum Plan Mapping

Prior to Jan. 1, 2020

Metallic Level	Plat	inum	
Navigate Plan	15/10%	15/10%	
Network ¹	Network	Network	
Annual Deductible ² (individual/family)	None	None	
Annual Out-of-Pocket Limit ⁴ (individual/family)	\$3,350/\$6,700	\$4,500/\$9,000	
Professional Services			
Office Visits - PCP	\$15	\$15	
Office Visits - Specialist	\$30	\$30	
Laboratory (standard)	\$15	\$15	
Radiology (standard)	\$30	\$30	
Maternity Care ⁵	\$15	\$15	
Preventive Care Services	No copayment	No copayment	
Hospitalization Services			
Inpatient Hospital Benefits	10%	10%	
Inpatient Physician Care	10%	10%	
Skilled Nursing Facility Care (100 days per benefit period)	10%	10%	
Emergency Health Coverage			
Emergency Services	\$150	\$150	
Urgent Care Services	\$15	\$15	
Ambulance Services	\$150	\$150	
Outpatient Services			
Outpatient Surgery	10%	10%	
Durable Medical Equipment	10%	10%	
Home Health Services (Up to 100 visits per calendar year)	10%	10%	
Infertility Services (Benefits limited to \$2,000 per lifetime)	10%	10%	
Injections Received in a Physician's Office	\$15	\$15	
Mental Health & Substance Use Disorder Services			
Inpatient	10%	10%	
Outpatient	\$15	\$15	
Outpatient Prescription Drug Coverage			
Calendar Year Deductible (individual/family)	None	None	
Tier 1	\$5	\$5	
Tier 2	\$15	\$15	
Tier 3	\$25	\$25	
Tier 4	10% up to \$250	10% up to \$250	
Pediatric Dental & Vision Coverage ⁶			
Dental Exam (preventive/diagnostic)	No copayment	No copayment	
Vision Exam (routine)	No copayment	No copayment	
Glasses (frames & lenses)	No copayment	No copayment	

¹ No benefits for Non-Network services, except for emergency health and urgent care services. Members must obtain an electronic referral from their primary care physician before seeing another network physician.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

The Annual Deductible is combined for medical and pharmacy benefits.

⁴ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

 $^{^{\}mbox{\scriptsize 5}}$ No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Navigate State Gold Plan Mapping

Prior to Jan. 1, 2020

	F1101 to Jan. 1, 2020	Lifective dall. 1, 2020	
Metallic Level		Gold	
Navigate Plan	30/20%	25/250/20%	
Network ¹	Network	Network	
Annual Deductible ² (individual/family)	None \$250/\$500		
Annual Out-of-Pocket Limit ⁴ (individual/family)	\$7,200/\$14,400 \$7,800/\$15,600		
Professional Services			
Office Visits - PCP	\$30	\$25	
Office Visits - Specialist	\$55	\$50	
Laboratory (standard)	\$35	\$25	
Radiology (standard)	\$55	\$65	
Maternity Care ⁵	\$30	\$25	
Preventive Care Services	No copayment	No copayment	
Hospitalization Services			
Inpatient Hospital Benefits	20%	20% after deductible	
Inpatient Physician Care	20%	20% after deductible	
Skilled Nursing Facility Care (100 days per benefit period)	20%	20% after deductible	
Emergency Health Coverage			
Emergency Services	\$325	\$250 after deductible	
Urgent Care Services	\$30	\$25	
Ambulance Services	\$250	\$250 after deductible	
Outpatient Services			
Outpatient Surgery	20%	20%	
Durable Medical Equipment	20%	20%	
Home Health Services (Up to 100 visits per calendar year)	20%	20%	
Infertility Services (Benefits limited to \$2,000 per lifetime)	20%	20%	
Injections Received in a Physician's Office	\$30	\$25	
Mental Health & Substance Use Disorder Services			
Inpatient	20%	20% after deductible	
Outpatient	\$30	\$25	
Outpatient Prescription Drug Coverage			
Calendar Year Deductible (individual/family)	None	None	
Tier 1	\$15	\$15	
Tier 2	\$55	\$50	
Tier 3	\$75	\$80	
Tier 4	20% up to \$250	20% up to \$250	
Pediatric Dental & Vision Coverage ⁶			
Dental Exam (preventive/diagnostic)	No copayment	No copayment	
Vision Exam (routine)	No copayment	No copayment	
Glasses (frames & lenses)	No copayment	No copayment	

¹ No benefits for Non-Network services, except for emergency health and urgent care services. Members must obtain an electronic referral from their primary care physician before seeing another network physician.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

The Annual Deductible is combined for medical and pharmacy benefits.

⁴ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

 $^{^{\}mbox{\scriptsize 5}}$ No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Navigate State Silver Plan Mapping

Prior to Jan. 1, 2020

Navigate Plan 45/2009/20% 50/2200/20% Network Network Network Annual Deduction ("radicular/lamily) \$2,000,430.00 \$2,250/45.00 Annual Doduction ("radicular/lamily) \$7,550/\$15.100 \$7,800/\$15.600 Profesional Services ************************************	Metallic Level	Silver		
Annual Deductible' (individual/family) \$2,200/\$4,000 \$2,280/\$4,500 Annual Duto-FPocket Limit' (individual/family) \$7,550/\$15,100 \$7,800/\$15,800 Professional Services **** \$5.0 Office Visits - Specialist \$45 \$5.0 Clifice Visits - Specialist \$80 \$85 Laboratory (standard) \$40 \$4.0 Adalcilogy standard) \$75 \$85 Maternity Care* \$45 \$50 Preventive Care Services No copayment No copayment Hospitalization Services No copayment No copayment Inpatient Hospital Berefits 20% after deductible 20% after deductible Inpatient Physician Care 20% after deductible 20% after deductible Inpatient Physician Care 20% after deductible 20% after deductible Inpatient Physician Care 20% after deductible 20% after deductible Inpatient Physician Care \$350 \$400 after deductible Preventive Services \$45 \$50 William Care Services \$45 \$50 Ungent Care Servic	Navigate Plan	45/2000/20%	50/2250/20%	
Annual Out-of-Pocket Limit* (individual/family) \$7,550/\$15,100 \$7,800/\$15,000 Professional Services S50 \$50 Office Visits - POP \$45 \$50 Claboratory (standard) \$40 \$40 Radiology (standard) \$75 \$86 Maternity Care* \$45 \$50 Preventive Care Services No copayment No copayment Preventive Care Services No copayment No copayment Preventive Care Services No copayment No copayment Preventive Care Services No copayment 20% after deductible Inpatient Physician Care 20% after deductible 20% after deductible Inpatient Physician Care 20% after deductible 20% after deductible Impatient Physician Care \$350 \$400 after deductible Emergency Services \$350 \$400 after deductible Urgent Care Services \$45 \$50 Armbulance Services \$45 \$50 Urgent Care Services \$45 \$50 Purable Medical Equipment 20% 20%	Network ¹	Network	Network	
Statistical parallel Statistical parallel Statistical parallel parall	Annual Deductible ² (individual/family)	\$2,000/\$4,000	\$2,250/\$4,500	
Office Visits - PCP \$45 \$50 Office Visits - Specialist \$80 \$86 Laboratory (standard) \$40 \$40 Baddology (standard) \$75 \$86 Maternity Care* \$45 \$50 Preventive Care Services No copayment No copayment Hospitalization Services ************************************		\$7,550/\$15,100	\$7,800/\$15,600	
Office Visits - Specialist \$80 \$85 Laboratory (standard) \$40 \$40 Radiology (standard) \$75 \$85 Radiology (standard) \$45 \$50 Maternity Care Services No copsyment No copsyment Hospitalization Services Inpatient Proysicial Eneritis 20% after deductible 20% after deductible Inpatient Prysician Care 20% after deductible 20% after deductible Sidled Nursing Facility Care (100 days per benefit period) 20% after deductible 20% after deductible Urgent Care Services \$350 \$400 after deductible Urgent Care Services \$350 \$400 after deductible Urgent Care Services \$350 \$400 after deductible Urgent Care Services \$250 after deductible \$20% Urgent Surgery 20% 20% Urgent Surgery 20% 20% Urgent Benefits Services \$20% 20% Urgent Benefits Services \$20% 20% Urgent Benefits Services \$20% 20%	Professional Services			
Laboratory (standard) \$40 \$40 Radiology (standard) \$75 \$85 Maternity Care* \$45 \$50 Preventive Care Services No copayment No copayment Hospitalization Services No copayment No copayment Inpatient Hospital Benefits 20% after deductible 20% after deductible Inpatient Physician Care 20% after deductible 20% after deductible Silled Nursing Facilly Core 20% after deductible 20% after deductible Brown Previous 20% after deductible 20% after deductible Emergency Health Coverage \$45 \$400 after deductible Urgent Care Services \$45 \$50 Urgent Care Services \$45 \$50 Ambulance Services \$45 \$50 Urgent Care Services \$20% \$20% Urgent Care Services </td <td>Office Visits - PCP</td> <td>\$45</td> <td>\$50</td>	Office Visits - PCP	\$45	\$50	
Radiology (standard) \$75 \$85 Maternity Care ² \$45 \$50 Preventive Care Services No copayment No copayment Hospitalization Services No copayment No copayment Hospitalization Services Use of the patient Physician Care 20% after deductible 20% after deductible Skilled Nursing Facility Care 20% after deductible 20% after deductible Skilled Nursing Facility Care 20% after deductible 20% after deductible Skilled Nursing Facility Care 20% after deductible 20% after deductible Skilled Nursing Facility Care 20% after deductible 20% after deductible Brown Pealth Coverage \$350 \$400 after deductible Urgent Care Services \$45 \$50 Ambulance Services \$45 \$50 Ambulance Services \$20 after deductible 20% Urgent Care Services \$20 after deductible 20% Durable Medical Equipment 20% 20% Love Jatent Survices 20% 20% Up to Version Services 20% 20%	Office Visits - Specialist	\$80	\$85	
Maternity Care* \$45 \$50 Preventive Care Services No copayment No copayment Hospitalization Services No copayment No copayment Inpatient Phospital Benefits 20% after deductible 20% after deductible Inpatient Phospical Care 20% after deductible 20% after deductible Skilled Nursing Facility Care 20% after deductible 20% after deductible Skilled Nursing Facility Care 20% after deductible 20% after deductible Skilled Nursing Facility Care 20% after deductible 20% after deductible Skilled Nursing Facility Care 20% after deductible 20% after deductible Skilled Nursing Facility Care 350 \$400 after deductible Urgent Care Services \$350 \$400 after deductible Urgent Care Services \$45 \$50 Ambulance Services \$45 \$50 Urgent Care Services \$20% after deductible \$20% Unpatient Services \$20% \$20% Up at the Services \$20% \$20% Up to Vests per calendar year) \$20% \$20% <	Laboratory (standard)	\$40	\$40	
Preventive Care Services No copayment No copayment Hospitalization Services Inpatient Hospital Benefits 20% after deductible 20% after deductible Inpatient Physician Care 20% after deductible 20% after deductible Skilled Nursing Facility Care (100 days per benefit period) 20% after deductible Emergency Health Coverage 8350 \$400 after deductible Emergency Services \$350 \$400 after deductible Urgent Care Services \$45 \$50 Ambulance Services \$250 after deductible \$250 after deductible Utgent Care Services \$20% \$50 Ambulance Services \$250 after deductible \$250 after deductible Utgent Care Services \$20% \$20% Ambulance Services \$20% \$20% Utgent Care Services \$20% \$20% Dutgetient Services \$20% \$20% Dutgetient Services \$20% \$20% Home Health Services \$20% \$20% (Benefits limited to \$2,000 per lifetime) \$45 \$50 Injections Received in	Radiology (standard)	\$75	\$85	
Hospitalization Services Inpatient Hospital Benefits 20% after deductible 20% after deductible Inpatient Physician Care 20% after deductible 20% after deductible Skilliad Nursing Facility Care (1000 days per benefit period) 20% after deductible Emergency Health Coverage 8350 \$400 after deductible Urgent Care Services \$350 \$400 after deductible Urgent Care Services \$250 after deductible \$250 after deductible Urgent Care Services \$250 after deductible \$250 after deductible Urgent Care Services \$250 after deductible \$250 after deductible Urgent Surgery 20% 20% Durable Medical Equipment 20% 20% Home Health Services 20% 20% Up to 100 visits per celendar year) 20% 20% Infectility Services 20% 20% Repeated to to \$2,000 per lifetime) \$45 \$50 Injections Received in a Physician's Office \$45 \$50 Mental Health & Substance Use Disorder Services \$45 \$50 Cutpatient Prescription Drug Coverage	Maternity Care ⁵	\$45	\$50	
Inpatient Hospital Benefits 20% after deductible 20% after deductible Inpatient Physician Care 20% after deductible 20% after deductible Skilled Nursing Facility Carce (100 days per benefit period) 20% after deductible 20% after deductible Emergency Health Coverage ***S50 \$400 after deductible Emergency Services \$350 \$400 after deductible Urgent Carc Services \$45 \$50 Ambulance Services \$45 \$50 Ambulance Services \$45 \$50 Cutpatient Surgery 20% 20% Durable Medical Equipment 20% 20% Home Health Services 20% 20% Up to 100 visits per calendar year) 20% 20% Infectility Services 20% 20% Repeated to \$2,000 per lifetime) 20% 20% Infectility Services \$45 \$50 Repeated to the \$2,000 per lifetime) 20% after deductible 20% after deductible Updatient \$45 \$50 \$0 Mental Health & Substance Use Disorder Services	Preventive Care Services	No copayment	No copayment	
Inpatient Physician Care 20% after deductible 20% after deductible Skilled Nursing Facility Care (100 days per benefit period) 20% after deductible 20% after deductible Emergency Health Coverage ************************************	Hospitalization Services			
Skilled Nursing Facility Care (100 days per benefit period) 20% after deductible Emergency Health Coverage 20% after deductible Emergency Services \$350 \$400 after deductible Urgent Care Services \$45 \$50 Ambulance Services \$250 after deductible \$250 after deductible Outpatient Services 20% 20% Durable Medical Equipment 20% 20% Home Health Services (Up to 100 visits per calendar year) 20% 20% Unjections Received in a Physician's Office \$45 \$50 Injections Received in a Physician's Office \$45 \$50 Mental Health & Substance Use Disorder Services \$45 \$50 Injections Received in a Physician's Office \$45 \$50 Mental Health & Substance Use Disorder Services \$45 \$50 Updatient Prescription Drug Coverage \$45 \$50 Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90	Inpatient Hospital Benefits	20% after deductible	20% after deductible	
Code days per benefit period 20% after deductible 20% after de	Inpatient Physician Care	20% after deductible	20% after deductible	
Emergency Services \$350 \$400 after deductible Urgent Care Services \$45 \$50 Ambulance Services \$250 after deductible \$250 after deductible Outpatient Services Outpatient Surgery 20% 20% Durable Medical Equipment 20% 20% Home Health Services (Up to 100 visits per calendar year) 20% 20% Infertility Services (Benefits limited to \$2,000 per lifetime) 20% 20% Injections Received in a Physician's Office \$45 \$50 Mental Health & Substance Use Disorder Services Unpatient Prescription Drug Coverage Calendar Year Deductible (individual/family) \$20% after deductible 20% after deductible Outpatient Prescription Drug Coverage \$50 \$50 Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage*		20% after deductible	20% after deductible	
Urgent Care Services \$45 \$50 Ambulance Services \$250 after deductible \$250 after deductible Outpatient Services Urbatient Surgery 20% 20% Durable Medical Equipment 20% 20% Home Health Services (Up to 100 visits per calendar year) 20% 20% Infertility Services (Benefits limited to \$2,000 per lifetime) 20% 20% Injections Received in a Physician's Office \$45 \$50 Mental Health & Substance Use Disorder Services 845 \$50 Outpatient 20% after deductible 20% after deductible Outpatient Prescription Drug Coverage \$45 \$50 Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage* 20% up to \$250 No copayment Vision Exam (routine) No copayment No copayment	Emergency Health Coverage			
Ambulance Services \$250 after deductible \$250 after deductible Outpatient Services Up atteint Surgery 20% 20% Durable Medical Equipment 20% 20% Home Health Services (Up to 100 visits per calendar year) 20% 20% Infertility Services (Benefits limited to \$2,000 per lifetime) 20% 20% Injections Received in a Physician's Office \$45 \$50 Mental Health & Substance Use Disorder Services Inpatient 20% after deductible 20% after deductible Outpatient Prescription Drug Coverage \$45 \$50 Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage* Dental Exam (preventive/diagnostic) No copayment No copayment	Emergency Services	\$350	\$400 after deductible	
Outpatient Services Outpatient Surgery 20% 20% Durable Medical Equipment 20% 20% Home Health Services (Up to 100 visits per calendar year) Infertility Services (Benefits limited to \$2,000 per lifetime) 20% 20% Renefits limited to \$2,000 per lifetime) \$45 \$50 Injections Received in a Physician's Office \$45 \$50 Mental Health & Substance Use Disorder Services Inpatient 20% after deductible 20% after deductible Outpatient \$45 \$50 Outpatient Prescription Drug Coverage Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage* Dental Exam (preventive/diagnostic) No copayment No copayment	Urgent Care Services	\$45	\$50	
Outpatient Surgery 20% 20% Durable Medical Equipment 20% 20% Home Health Services (Up to 100 visits per calendar year) 20% 20% Infertility Services (Benefits limited to \$2,000 per lifetime) 20% 20% Renefits limited to \$2,000 per lifetime) \$45 \$50 Mental Health & Substance Use Disorder Services Inpatient 20% after deductible 20% after deductible Outpatient Prescription Drug Coverage \$50 \$50 Outpatient Prescription Drug Coverage \$20% after deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 \$17 \$16 \$17 Tier 2 \$55 \$65 \$65 \$90 \$10 <t< td=""><td>Ambulance Services</td><td>\$250 after deductible</td><td>\$250 after deductible</td></t<>	Ambulance Services	\$250 after deductible	\$250 after deductible	
Durable Medical Equipment 20% 20% Home Health Services (Up to 100 visits per calendar year) 20% 20% Infertility Services (Benefits limited to \$2,000 per lifetime) 20% 20% Injections Received in a Physician's Office \$45 \$50 Mental Health & Substance Use Disorder Services Inpatient 20% after deductible 20% after deductible Outpatient Prescription Drug Coverage \$50 \$50 Outpatient Prescription Drug Coverage Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage* Dental Exam (preventive/diagnostic) No copayment No copayment Vision Exam (routine) No copayment No copayment	Outpatient Services			
Home Health Services	Outpatient Surgery	20%	20%	
(Up to 100 visits per calendar year) 20% 20% Infertility Services (Benefits limited to \$2,000 per lifetime) 20% \$50 Injections Received in a Physician's Office \$45 \$50 Mental Health & Substance Use Disorder Services Inpatient 20% after deductible 20% after deductible Outpatient Prescription Drug Coverage \$50 \$50 Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage® Dental Exam (preventive/diagnostic) No copayment No copayment Vision Exam (routine) No copayment No copayment	Durable Medical Equipment	20%	20%	
(Benefits limited to \$2,000 per lifetime) 20% Injections Received in a Physician's Office \$45 Mental Health & Substance Use Disorder Services Inpatient 20% after deductible Outpatient Prescription Drug Coverage \$50 Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage® Dental Exam (preventive/diagnostic) No copayment No copayment Vision Exam (routine) No copayment No copayment	(Up to 100 visits per calendar year)	20%	20%	
Mental Health & Substance Use Disorder Services Inpatient 20% after deductible Outpatient \$45 \$50 Outpatient Prescription Drug Coverage Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage® Dental Exam (preventive/diagnostic) No copayment No copayment Vision Exam (routine) No copayment No copayment		20%	20%	
Inpatient 20% after deductible 20% after deductible Outpatient \$45 \$50 Outpatient Prescription Drug Coverage Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage® Dental Exam (preventive/diagnostic) No copayment No copayment Vision Exam (routine) No copayment No copayment		\$45	\$50	
Outpatient \$45 \$50 Outpatient Prescription Drug Coverage Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage ⁶ Dental Exam (preventive/diagnostic) No copayment No copayment Vision Exam (routine) No copayment No copayment	Mental Health & Substance Use Disorder Services			
Outpatient Prescription Drug Coverage Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage ⁶ Dental Exam (preventive/diagnostic) No copayment No copayment Vision Exam (routine) No copayment No copayment	Inpatient	20% after deductible	20% after deductible	
Calendar Year Deductible (individual/family) \$200/\$400 \$300/\$600 Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage ⁶ Dental Exam (preventive/diagnostic) No copayment No copayment Vision Exam (routine) No copayment No copayment	Outpatient	\$45	\$50	
Tier 1 \$15 \$17 Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage® Dental Exam (preventive/diagnostic) No copayment No copayment Vision Exam (routine) No copayment No copayment	Outpatient Prescription Drug Coverage			
Tier 2 \$55 \$65 Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage ⁶ Dental Exam (preventive/diagnostic) No copayment No copayment Vision Exam (routine) No copayment No copayment	Calendar Year Deductible (individual/family)	\$200/\$400	\$300/\$600	
Tier 3 \$85 \$90 Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage® Dental Exam (preventive/diagnostic) No copayment No copayment Vision Exam (routine) No copayment No copayment	Tier 1	\$15	\$17	
Tier 4 20% up to \$250 20% up to \$250 Pediatric Dental & Vision Coverage ⁶ Dental Exam (preventive/diagnostic) No copayment No copayment Vision Exam (routine) No copayment No copayment	Tier 2	\$55	\$65	
Pediatric Dental & Vision Coverage ⁶ Dental Exam (preventive/diagnostic) No copayment No copayment Vision Exam (routine) No copayment No copayment	Tier 3	\$85	\$90	
Dental Exam (preventive/diagnostic) No copayment No copayment No copayment No copayment	Tier 4	20% up to \$250	20% up to \$250	
Vision Exam (routine) No copayment No copayment	Pediatric Dental & Vision Coverage ⁶			
	Dental Exam (preventive/diagnostic)	No copayment	No copayment	
Glasses (frames & lenses) No copayment No copayment	Vision Exam (routine)	No copayment	No copayment	
	Glasses (frames & lenses)	No copayment	No copayment	

¹ No benefits for Non-Network services, except for emergency health and urgent care services. Members must obtain an electronic referral from their primary care physician before seeing another network physician.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

The Annual Deductible is combined for medical and pharmacy benefits.

⁴ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

 $^{^{\}mbox{\scriptsize 5}}$ No copayment applies to physician office visits for prenatal care.

⁶ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Navigate State Bronze Plan Mapping

	Prior to Jan. 1, 2020	Effective Jan. 1, 2020	Prior to Jan. 1, 2020	Effective Jan. 1, 2020
Metallic Level	Bro	nze	Bro	nze
Navigate Plan	75/6300/100%	65/6300/40%	HDHP 6000/40%	65/6300/40%
Network ¹	Network	Network	Network	Network
Annual Deductible ² (individual/family)	\$6,300/\$12,600	\$6,300/\$12,600	\$6,000/\$12,000 ³	\$6,300/\$12,600
Annual Out-of-Pocket Limit ⁴ (individual/family)	\$7,550/\$15,100	\$7,800/\$15,600	\$6,650/\$13,300	\$7,800/\$15,600
Professional Services				
Office Visits - PCP	\$75 for first 3 visits, then deductible applies	\$65 for first 3 visits, then deductible applies	40% after deductible	\$65 for first 3 visits, then deductible applies
Office Visits - Specialist	\$105 for first 3 visits, then deductible applies	\$95 for first 3 visits, then deductible applies	40% after deductible	\$95 for first 3 visits, then deductible applies
Laboratory (standard)	\$40	\$40	40% after deductible	\$40
Radiology (standard)	100% after deductible	40% after deductible	40% after deductible	40% after deductible
Maternity Care ⁵	\$75	\$65	40% after deductible	\$65
Preventive Care Services	No copayment	No copayment	No copayment	No copayment
Hospitalization Services				
Inpatient Hospital Benefits	100% after deductible	40% after deductible	40% after deductible	40% after deductible
Inpatient Physician Care	100% after deductible	40% after deductible	40% after deductible	40% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	100% after deductible	40% after deductible	40% after deductible	40% after deductible
Emergency Health Coverage				
Emergency Services	100% after deductible	40% after deductible	40% after deductible	40% after deductible
Urgent Care Services	\$75 for first 3 visits, then deductible applies	\$65 for first 3 visits, then deductible applies	40% after deductible	\$65 for first 3 visits, then deductible applies
Ambulance Services	100% after deductible	40% after deductible	40% after deductible	40% after deductible
Outpatient Services				
Outpatient Surgery	100% after deductible	40% after deductible	40% after deductible	40% after deductible
Durable Medical Equipment	100% after deductible	40% after deductible	40% after deductible	40% after deductible
Home Health Services (Up to 100 visits per calendar year)	100% after deductible	40% after deductible	40% after deductible	40% after deductible
Infertility Services (Benefits limited to \$2,000 per lifetime)	100% after deductible	40% after deductible	40% after deductible	40% after deductible
Injections Received in a Physician's Office	\$75	\$65	40% after deductible	\$65
Mental Health & Substance Use Disorder Serv	rices			
Inpatient	100% after deductible	40% after deductible	40% after deductible	40% after deductible
Outpatient	No copayment	No copayment	40% after deductible	No copayment
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	\$500/\$1,000	\$500/\$1,000	Annual Deductible applies	\$500/\$1,000
Tier 1	100% up to \$500	\$18	40% up to \$500	\$18
Tier 2	100% up to \$500	40% up to \$500	40% up to \$500	40% up to \$500
Tier 3	100% up to \$500	40% up to \$500	40% up to \$500	40% up to \$500
Tier 4	100% up to \$500	40% up to \$500	40% up to \$500	40% up to \$500
Pediatric Dental & Vision Coverage ⁶				
Dental Exam (preventive/diagnostic)	No copayment	No copayment	No copayment	No copayment
Vision Exam (routine)	No copayment	No copayment	No copayment	No copayment
Glasses (frames & lenses)	No copayment	40%	No copayment	40%

¹ No benefits for Non-Network services, except for emergency health and urgent care services. Members must obtain an electronic referral from their primary care physician before seeing another network physician.

² When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per-occurrence deductible does not apply to the Annual Deductible.

³ The Annual Deductible is combined for medical and pharmacy benefits.

⁴ Member cost share, including office visits, annual deductible, per-occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Limit.

 $^{^{\}mbox{\scriptsize 5}}$ No copayment applies to physician office visits for prenatal care.

 $^{^{\}rm 6}$ One routine vision exam and one pair of glasses per calendar year for children under age 19.

Notes	

Notes	



This offer is being issued under UHCBPCA. Select, Choice and Core products are Pending Regulatory Approval.



UnitedHealthcare Motion is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. Receiving an activity tracker and/or certain credits and/or purchasing an activity tracker with earnings may have tax implications. You should consult an appropriate text professional to determine if you have any tax obligations from receiving an activity tracker and/or certain credits under this program, as applicable. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-855-256-8669 or at the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Subject to HSA elicibility, as applicable.

These benefit grids are intended only to highlight plan benefits and should not be relied upon to fully determine coverage. Every effort has been made to ensure accuracy in information printed in this book; however, UnitedHealthcare and its affiliates cannot guarantee that there are no errors. In the event of a conflict between this document and the terms of an individual member's Certificate of Coverage/Evidence of Coverage, the Certificate of Coverage/Evidence of Coverage prevails.

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