California Small Business (1–100)

Plan Benefit Changes

For groups renewing January 1, 2020 and after

UnitedHealthcare®

UnitedHealthcare Select Plus and UnitedHealthcare Core Platinum Plan Mapping

	Prior to Jan. 1, 2020		Effective Jan. 1, 2020	
Metallic Level	**Platinum**			
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[3] (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 Services				
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)	None		None	
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		Effective Jan. 1, 2020	
Metallic Level	**Platinum**			
Select Plus / Core HDHP Plan	**15/250/20%**		**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 Services				
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)	None		None	
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)	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 Platinum Plan Mapping

	Prior to Jan. 1, 2020		Effective Jan. 1, 2020	
Metallic Level	**Platinum**			
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 Services				
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)	None		None	
Tier 1	$5		$5	
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)	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 Gold Plan Mapping

	Prior to Jan. 1, 2020		Effective Jan. 1, 2020	
Metallic Level	**Gold**			
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 Services				
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)	None		None	
Tier 1	$15		$15	
Tier 2	$40		$40	
Tier 3	$80		$80	
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%	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.

Select Plus and Core Gold Plan Mapping

	Prior to Jan. 1, 2020		Effective Jan. 1, 2020	
Metallic Level	**Gold**			
Select Plus / Core HDHP Plan	**25/250/20%**		**25/500/20%**	
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
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 Services				
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)	None		$250/$500, does not apply to Tier 1	
Tier 1	$15		$15	
Tier 2	$40		$40	
Tier 3	$80		$80	
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 Gold Plan Mapping

	Prior to Jan. 1, 2020		Effective Jan. 1, 2020	
Metallic Level	**Gold**			
Select Plus / Core HDHP Plan	**25/750/20%**		**25/1000/20%**	
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 Services				
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)	None		$250/$500, does not apply to Tier 1	
Tier 1	$15		$15	
Tier 2	$40		$40	
Tier 3	$80		$80	
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 Gold Plan Mapping

	Prior to Jan. 1, 2020		Effective 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 Services				
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 not apply to Tiers 1 & 2		$250/$500, does not apply to Tier 1	
Tier 1	$5		$5	
Tier 2	$50		$50	
Tier 3	$100		$100	
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.

Select Plus and Core Gold Plan Mapping

	Prior to Jan. 1, 2020		Effective Jan. 1, 2020	
Metallic Level	**Gold**			
Select Plus / Core HDHP Plan	**25/1250/20%**		**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 Services				
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)	None		$250/$500, does not apply to Tier 1	
Tier 1	$15		$15	
Tier 2	$40		$40	
Tier 3	$80		$80	
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		Effective Jan. 1, 2020	
Metallic Level	**Silver**			
Select Plus / Core HDHP Plan	**40/1500/30%**		**50/1500/40%**	
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 Services				
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	$50		$50	
Tier 3	$100		$100	
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%	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		Effective Jan. 1, 2020	
Metallic Level	**Silver**			
Select Plus / Core HDHP Plan	**45/2250/40%**		**50/2250/40%**	
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 Services				
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	$20		$20	
Tier 2	$50		$50	
Tier 3	$100		$100	
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		Effective Jan. 1, 2020	
Metallic Level	**Silver**			
Select Plus / Core HDHP Plan	**HDHP w/UnitedHealthcare Motion® 2300/30%**		**HDHP w/Motion 2300/30%**	
Network[1]	**Network**	**Non-Network**	**Network**	**Non-Network**
Annual Deductible[2] (individual/family)	$2,300/$2,700[5]	$4,600/$5,400[5]	$2,300/$2,800[5]	$4,600/$5,600[5]
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 Services				
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 Deductible applies		Annual Deductible applies	
Tier 1	$20		$20	
Tier 2	$50		$50	
Tier 3	$100		$100	
Tier 4	25% up to $250		25% up 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.

[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.

[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		Effective Jan. 1, 2020	
Metallic Level	**Bronze**			
Select Plus / Core HDHP Plan	**HDHP w/UnitedHealthcare Motion® 6650/0%**		**HDHP w/Motion 6900/0%**	
Network[1]	**Network**	**Non-Network**	**Network**	**Non-Network**
Annual Deductible[2] (individual/family)	$6,650/$13,300[6]	$13,300/$26,600[6]	$6,900/$13,800[6]	$13,800/$27,600[6]
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 Services				
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 Deductible applies		Annual Deductible applies	
Tier 1	No copayment		No copayment	
Tier 2	No copayment		No copayment	
Tier 3	No copayment		No copayment	
Tier 4	No copayment		No copayment	
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.

[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.

[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
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)	$7,350/$14,700
Professional Services	
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 Services	
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%

[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		Effective Jan. 1, 2020	
Metallic Level	**Platinum**			
Select Plus / Core HDHP Plan	**15/10%**		**15/10%**	
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 benefit
Urgent Care Services	$15	50% after deductible	$15	50% after deductible
Ambulance Services	$150	Same as Network benefit	$150	Same as Network benefit
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 Services				
Inpatient	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)	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	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.
[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		Effective Jan. 1, 2020	
Metallic Level	**Gold**			
Select Plus / Core HDHP Plan	**30/20%**		**25/250/20%**	
Network[1]	**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 Services				
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)	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[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.
[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		Effective Jan. 1, 2020	
Metallic Level	**Silver**			
Select Plus / Core HDHP Plan	**45/2000/20%**		**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 Services				
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/$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	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.
[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		Effective 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 benefit
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 benefit
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 Services				
Inpatient	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 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		Effective Jan. 1, 2020	
Metallic Level	**Bronze**			
Select Plus / Core HDHP Plan	**HDHP 6000/40%**		**65/6300/40%**	
Network[1]	**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 Services				
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 Deductible applies		$500/$1,000	
Tier 1	40% up 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	**Platinum**		**Platinum**	
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
Infertility Services	Not covered	Not covered	Not covered	Not covered
Injectable Drugs	$150	$150	$150	$150
Mental Health & Substance Use Disorder Services				
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] 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	Effective 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 Services		
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] 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	**Gold**		**Gold**	
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 Services				
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	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] 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	**Gold**		**Gold**	
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 Services				
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)	$250/$500 (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	$5	$5
Tier 2	$40	$40	$50	$50
Tier 3	$80	$80	$100	$100
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)	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	**Silver**		**Silver**	
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 Services				
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	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)	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 Services				
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.

[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	Effective 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	Effective Jan. 1, 2020
Metallic Level	**Gold**	
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	Effective Jan. 1, 2020
Metallic Level	**Silver**	
HMO Plan	**Silver 70 HMO 2000/45**	**Silver 70 HMO 2250/50**
Annual Deductible[1] (individual/family)	$2,000/$4,000	$2,250/$4,500
Annual Out-of-Pocket Limit[3] (individual/family)	$7,550/$15,100	$7,800/$15,600
Professional Services		
Office Visits - PCP	$45	$50
Office Visits - Specialist	$80	$85
Laboratory (standard)	$40	$40
Radiology (standard)	$75	$85
Maternity Care	No charge	No charge
Preventive Care Services	No charge	No charge
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	20% after deductible
Emergency Health Coverage		
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 (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[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 Bronze State Plan Mapping – All Plans Mapped to Alliance

	Prior to Jan. 1, 2020	Effective 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.
[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	Effective Jan. 1, 2020	
Metallic Level	**Platinum**		
Navigate Plan	**10/10%**	**10/10%**	
Network[1]	**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
Laboratory[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
Hospitalization Services			
Inpatient Hospital Benefits	10%	10%	50% after deductible
Inpatient Physician Care	10%	10%	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	10%	10%	50% after deductible
Emergency Health Coverage			
Emergency Services	10% plus $150 per-occurrence deductible	10% plus $150 per-occurrence deductible	Same as Network benefit
Urgent 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
Durable Medical Equipment	10%	10%	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	10%	10%	50% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	10%	10%	50% after deductible
Injections Received in a Physician's Office	$10	$10	50% after deductible
Mental Health & Substance Use Disorder Services			
Inpatient	10%	10%	50% after deductible
Outpatient	$10	$10	50% after deductible
Outpatient Prescription Drug Coverage			
Calendar Year Deductible (individual/family)	None	None	
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[6]			
Dental Exam (preventive/diagnostic)	No copayment	No copayment	50% after deductible
Vision 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.

[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 Platinum Plan Mapping – All Plans Mapped to Core

	Prior to Jan. 1, 2020	Effective 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
Laboratory[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			
Inpatient Hospital Benefits	20% after deductible	20% after deductible	50% after 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 $150 per-occurrence deductible	20% after deductible, plus $150 per-occurrence deductible	Same as Network benefit
Urgent Care Services	$50	$50	50% after deductible
Ambulance Services	20% after deductible	20% after deductible	Same as Network benefit
Outpatient Services			
Outpatient 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
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	$15	$15	50% after deductible
Mental Health & Substance Use Disorder Services			
Inpatient	20% after deductible	20% after deductible	50% after deductible
Outpatient	$15	$15	50% after deductible
Outpatient Prescription Drug Coverage			
Calendar Year Deductible (individual/family)	None	None	
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	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.

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

Navigate Gold Plan Mapping – All Plans Mapped to Core

	Prior to Jan. 1, 2020	Effective Jan. 1, 2020	
Metallic Level	**Gold**		
Navigate Plan	**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 Services			
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/$500 does not apply to Tier 1	
Tier 1	$15	$15	
Tier 2	$40	$40	
Tier 3	$80	$80	
Tier 4	25% up to $250	25% up to $250	
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)	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.

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

Navigate Gold Plan Mapping – All Plans Mapped to Core

	Prior to Jan. 1, 2020	Effective Jan. 1, 2020	
Metallic Level	**Gold**		
Navigate Plan	**25/750/20%**	**25/1000/20%**	
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 Services			
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/$500 does not apply to Tier 1	
Tier 1	$15	$15	
Tier 2	$40	$40	
Tier 3	$80	$80	
Tier 4	25% up to $250	25% up to $250	
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)	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.

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

Navigate Gold Plan Mapping – All Plans Mapped to Core

	Prior to Jan. 1, 2020	Effective Jan. 1, 2020	
Metallic Level	**Gold**		
Navigate Plan	**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 Services			
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/$500 does not apply to Tier 1	
Tier 1	$15	$15	
Tier 2	$40	$40	
Tier 3	$80	$80	
Tier 4	25% up to $250	25% up to $250	
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)	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.

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

Navigate Gold Plan Mapping – All Plans Mapped to Core

	Prior to Jan. 1, 2020	Effective 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 Services			
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/$600 does not apply to Tier 1	
Tier 1	$20	$20	
Tier 2	$50	$50	
Tier 3	$100	$100	
Tier 4	25% up to $250	25% up to $250	
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.

Navigate Gold Plan Mapping – All Plans Mapped to Core

	Prior to Jan. 1, 2020	Effective Jan. 1, 2020	
Metallic Level	**Gold**		
Navigate Plan	**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 Services			
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/$600 does not apply to Tier 1	
Tier 1	$20	$20	
Tier 2	$50	$50	
Tier 3	$100	$100	
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%

[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	Effective Jan. 1, 2020	
Metallic Level	**Silver**		
Navigate Plan	**HDHP w/UnitedHealthcare Motion® 2300/30%**	**HDHP w/Motion 2300/30%**	
Network[1]	**Network**	**Network**	**Non-Network**
Annual Deductible[2] (individual/family)	$2,300/$2,700[5]	$2,300/$2,800[5]	$4,600/$5,600[5]
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
Laboratory (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
Urgent 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
Infertility Services (Benefits limited to $2,000 per lifetime)	30% after deductible	30% after deductible	50% after deductible
Injections Received in a Physician's Office	30% after deductible	30% after deductible	50% after deductible
Mental Health & Substance Use Disorder Services			
Inpatient	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 Deductible applies	
Tier 1	$20	$20	
Tier 2	$50	$50	
Tier 3	$100	$100	
Tier 4	25% up to $250	25% up 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	Effective Jan. 1, 2020	
Metallic Level	**Bronze**		
Navigate Plan	**HDHP 6650/0%**	**HDHP 6900/0%**	
Network[1]	**Network**	**Network**	**Non-Network**
Annual Deductible[2] (individual/family)	$6,650/$13,300[6]	$6,900/$13,800[6]	$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
Laboratory (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
Urgent 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
Infertility Services (Benefits limited to $2,000 per lifetime)	No copay after deductible	No copay after deductible	No copay after deductible
Injections Received in a Physician's Office	No copay after deductible	No copay after deductible	No copay after deductible
Mental Health & Substance Use Disorder Services			
Inpatient	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	
Tier 2	No copayment	No copayment	
Tier 3	No copayment	No copayment	
Tier 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.

[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 State Platinum Plan Mapping

	Prior to Jan. 1, 2020	Effective Jan. 1, 2020
Metallic Level	**Platinum**	
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.

[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.

[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	Effective Jan. 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.

[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.

[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	Effective Jan. 1, 2020
Metallic Level	**Silver**	
Navigate Plan	**45/2000/20%**	**50/2250/20%**
Network[1]	**Network**	**Network**
Annual Deductible[2] (individual/family)	$2,000/$4,000	$2,250/$4,500
Annual Out-of-Pocket Limit[4] (individual/family)	$7,550/$15,100	$7,800/$15,600
Professional Services		
Office Visits - PCP	$45	$50
Office Visits - Specialist	$80	$85
Laboratory (standard)	$40	$40
Radiology (standard)	$75	$85
Maternity Care[5]	$45	$50
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	20% after deductible
Emergency Health Coverage		
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		
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[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.

[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.

[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	**Bronze**		**Bronze**	
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 Services				
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.

[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.

Notes

Notes

Contact your UnitedHealthcare representative for more information.

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

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