



# California Small Business (1–100) Plan Benefit Changes

For groups renewing January 1, 2020 and after

# UnitedHealthcare Select Plus and UnitedHealthcare Core Platinum Plan Mapping

Prior to Jan. 1, 2020

Effective Jan. 1, 2020

Metallic Level	Platinum			
Select Plus / Core HDHP Plan	10/10%		10/10%	
Network <sup>1</sup>	Network	Non-Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	None	\$1,000/\$2,000	None	\$1,000/\$2,000
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$3,200/\$6,400	\$6,400/\$12,800	\$3,500/\$7,000	\$7,000/\$14,000
<b>Professional Services</b>				
Office Visits - PCP	\$10	50% after deductible	\$10	50% after deductible
Office Visits - Specialist	\$20	50% after deductible	\$25	50% after deductible
Laboratory <sup>4</sup> (standard)	10%	50% after deductible	10%	50% after deductible
Radiology <sup>4</sup> (standard)	10%	50% after deductible	10%	50% after deductible
Maternity Care <sup>5</sup>	\$10	50% after deductible	\$10	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services<sup>6</sup></b>				
Outpatient Surgery <sup>4</sup>	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
<b>Mental Health &amp; Substance Use Disorder Services</b>				
Inpatient	10%	50% after deductible	10%	50% after deductible
Outpatient	\$10	50% after deductible	\$10	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>				
Calendar Year Deductible (individual/family)	None		None	
Tier 1	\$10		\$10	
Tier 2	\$35		\$35	No Benefit
Tier 3	\$70		\$70	
Tier 4	10% up to \$250		10% up to \$250	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>				
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%

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

<sup>2</sup> 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.

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

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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			
	15/250/20%		15/250/20%	
Select Plus / Core HDHP Plan				
Network <sup>1</sup>	Network	Non-Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$250/\$500	\$1,000/\$2,000	\$250/\$500	\$1,000/\$2,000
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$3,200/\$6,400	\$6,400/\$12,800	\$3,500/\$7,000	\$7,000/\$14,000
<b>Professional Services</b>				
Office Visits - PCP	\$15	50% after deductible	\$15	50% after deductible
Office Visits - Specialist	\$30	50% after deductible	\$30	50% after deductible
Laboratory <sup>4</sup> (standard)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Radiology <sup>4</sup> (standard)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Maternity Care <sup>5</sup>	\$15	50% after deductible	\$15	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services<sup>6</sup></b>				
Outpatient Surgery <sup>4</sup>	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
<b>Mental Health &amp; Substance Use Disorder Services</b>				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	\$15	50% after deductible	\$15	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>				
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	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>				
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%

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

<sup>2</sup> 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.

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

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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			
	250/20%		250/20%	
Select Plus / Core HDHP Plan				
Network <sup>1</sup>	Network	Non-Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$250/\$500	\$1,000/\$2,000	\$250/\$500	\$1,000/\$2,000
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$3,200/\$6,400	\$6,400/\$12,800	\$3,500/\$7,000	\$7,000/\$14,000
<b>Professional Services</b>				
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 <sup>4</sup> (standard)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Radiology <sup>4</sup> (standard)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Maternity Care <sup>5</sup>	No copayment	50% after deductible	No copayment	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services<sup>6</sup></b>				
Outpatient Surgery <sup>4</sup>	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
<b>Mental Health &amp; Substance Use Disorder Services</b>				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	No copayment	50% after deductible	No copayment	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>				
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	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>				
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%

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

<sup>2</sup> 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.

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

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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			
	25/20%		25/30%	
Select Plus / Core HDHP Plan				
Network <sup>1</sup>	Network	Non-Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	None	\$1,000/\$2,000	None	\$1,000/\$2,000
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$7,000/\$14,000	\$12,000/\$24,000	\$6,500/\$13,000	\$13,000/\$26,000
<b>Professional Services</b>				
Office Visits - PCP	\$25	50% after deductible	\$25	50% after deductible
Office Visits - Specialist	\$50	50% after deductible	\$50	50% after deductible
Laboratory <sup>4</sup> (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 <sup>4</sup> (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 <sup>5</sup>	\$25	50% after deductible	\$25	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services<sup>6</sup></b>				
Outpatient Surgery <sup>4</sup>	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
<b>Mental Health &amp; Substance Use Disorder Services</b>				
Inpatient	\$0	50% after deductible	30%	50% after deductible
Outpatient	\$25	50% after deductible	\$25	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>				
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	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>				
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%

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

<sup>2</sup> 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.

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

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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 <sup>1</sup>	Network	Non-Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$250/\$500	\$1,000/\$2,000	\$500/\$1,000	\$1,000/\$2,000
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$6,000/\$12,000	\$12,000/\$24,000	\$6,500/\$13,000	\$13,000/\$26,000
<b>Professional Services</b>				
Office Visits - PCP	\$25	50% after deductible	\$25	50% after deductible
Office Visits - Specialist	\$50	50% after deductible	\$50	50% after deductible
Laboratory <sup>4</sup> (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 <sup>4</sup> (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 <sup>5</sup>	\$25	50% after deductible	\$25	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services<sup>6</sup></b>				
Outpatient Surgery <sup>4</sup>	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
<b>Mental Health &amp; Substance Use Disorder Services</b>				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	\$25	50% after deductible	\$25	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>				
Calendar Year Deductible (individual/family)	None		\$250/\$500, does not apply to Tier 1	No Benefit
Tier 1	\$15		\$15	
Tier 2	\$40		\$40	
Tier 3	\$80		\$80	
Tier 4	25% up to \$250		25% up to \$250	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>				
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%

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

<sup>2</sup> 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.

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

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of-Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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 <sup>1</sup>	Network	Non-Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$750/\$1,500	\$1,500/\$3,000	\$1,000/\$2,000	\$2,000/\$4,000
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$6,000/\$12,000	\$12,000/\$24,000	\$6,500/\$13,000	\$13,000/\$26,000
<b>Professional Services</b>				
Office Visits - PCP	\$25	50% after deductible	\$25	50% after deductible
Office Visits - Specialist	\$50	50% after deductible	\$50	50% after deductible
Laboratory <sup>4</sup> (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 <sup>4</sup> (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 <sup>5</sup>	\$25	50% after deductible	\$25	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services<sup>6</sup></b>				
Outpatient Surgery <sup>4</sup>	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
<b>Mental Health &amp; Substance Use Disorder Services</b>				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	\$25	50% after deductible	\$25	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>				
Calendar Year Deductible (individual/family)	None		\$250/\$500, does not apply to Tier 1	No Benefit
Tier 1	\$15		\$15	
Tier 2	\$40		\$40	
Tier 3	\$80		\$80	
Tier 4	25% up to \$250		25% up to \$250	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>				
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%

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

<sup>2</sup> 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.

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

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of-Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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 <sup>1</sup>	Network	Non-Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$1,250/\$2,500	\$2,500/\$5,000	\$1,500/\$3,000	\$3,000/\$6,000
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$5,600/\$11,200	\$11,200/\$22,400	\$6,500/\$13,000	\$13,000/\$26,000
<b>Professional Services</b>				
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 <sup>4</sup> (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 <sup>4</sup> (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 <sup>5</sup>	No copayment	50% after deductible	No copayment	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services<sup>6</sup></b>				
Outpatient Surgery <sup>4</sup>	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
<b>Mental Health &amp; Substance Use Disorder Services</b>				
Inpatient	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Outpatient	No copayment	50% after deductible	No copayment	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>				
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	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>				
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%

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

<sup>2</sup> 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.

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

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of-Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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 <sup>1</sup>	Network	Non-Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$1,250/\$2,500	\$2,500/\$5,000	\$1,000/\$2,000	\$2,000/\$4,000
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$6,000/\$12,000	\$12,000/\$24,000	\$6,500/\$13,000	\$13,000/\$26,000
<b>Professional Services</b>				
Office Visits - PCP	\$25	50% after deductible	\$25	50% after deductible
Office Visits - Specialist	\$50	50% after deductible	\$50	50% after deductible
Laboratory <sup>4</sup> (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 <sup>4</sup> (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 <sup>5</sup>	\$25	50% after deductible	\$25	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services<sup>6</sup></b>				
Outpatient Surgery <sup>4</sup>	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
<b>Mental Health &amp; Substance Use Disorder Services</b>				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	\$25	50% after deductible	\$25	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>				
Calendar Year Deductible (individual/family)	None		\$250/\$500, does not apply to Tier 1	No Benefit
Tier 1	\$15		\$15	
Tier 2	\$40		\$40	
Tier 3	\$80		\$80	
Tier 4	25% up to \$250		25% up to \$250	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>				
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%

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

<sup>2</sup> 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.

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

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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 <sup>1</sup>	Network	Non-Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$1,500/\$3,000	\$3,000/\$6,000	\$1,500/\$3,000	\$3,000/\$6,000
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$7,900/\$15,800	\$15,800/\$31,600	\$8,150/\$16,300	\$16,300/\$32,600
<b>Professional Services</b>				
Office Visits - PCP	\$40	50% after deductible	\$50	50% after deductible
Office Visits - Specialist	\$70	50% after deductible	\$80	50% after deductible
Laboratory <sup>4</sup> (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 <sup>4</sup> (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 <sup>5</sup>	\$40	50% after deductible	\$50	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services<sup>6</sup></b>				
Outpatient Surgery <sup>4</sup>	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
<b>Mental Health &amp; Substance Use Disorder Services</b>				
Inpatient	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient	\$40	50% after deductible	\$50	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>				
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	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>				
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%

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

<sup>2</sup> 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.

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

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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 <sup>1</sup>	Network	Non-Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$2,250/\$4,500	\$4,500/\$9,000	\$2,250/\$4,500	\$4,500/\$9,000
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$7,900/\$15,800	\$15,800/\$31,600	\$8,150/\$16,300	\$16,300/\$32,600
<b>Professional Services</b>				
Office Visits - PCP	\$45	50% after deductible	\$50	50% after deductible
Office Visits - Specialist	\$80	50% after deductible	\$80	50% after deductible
Laboratory <sup>4</sup> (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 <sup>4</sup> (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 <sup>5</sup>	\$45	50% after deductible	\$50	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services<sup>6</sup></b>				
Outpatient Surgery <sup>4</sup>	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
<b>Mental Health &amp; Substance Use Disorder Services</b>				
Inpatient	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient	\$45	50% after deductible	\$50	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>				
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	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>				
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%

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

<sup>2</sup> 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.

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

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of-Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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 <sup>1</sup>	Network	Non-Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$2,300/\$2,700 <sup>5</sup>	\$4,600/\$5,400 <sup>5</sup>	\$2,300/\$2,800 <sup>5</sup>	\$4,600/\$5,600 <sup>5</sup>
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$6,650/\$13,300	\$13,300/\$26,600	\$6,650/\$13,300	\$13,300/\$26,600
<b>Professional Services</b>				
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
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services<sup>7</sup></b>				
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
<b>Mental Health &amp; Substance Use Disorder Services</b>				
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
<b>Outpatient Prescription Drug Coverage</b>				
Calendar Year Deductible (individual/family)	Annual Deductible applies		Annual Deductible applies	No Benefit
Tier 1	\$20		\$20	
Tier 2	\$50		\$50	
Tier 3	\$100		\$100	
Tier 4	25% up to \$250		25% up to \$250	
<b>Pediatric Dental &amp; Vision Coverage<sup>4</sup></b>				
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

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

<sup>2</sup> The Annual Deductible is combined for medical and pharmacy benefits.

<sup>3</sup> 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.

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

<sup>5</sup> 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.

<sup>6</sup> 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.

<sup>7</sup> Outpatient Services Caps on Out-of Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

# 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 <sup>1</sup>	Network	Non-Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$6,650/\$13,300 <sup>5</sup>	\$13,300/\$26,600 <sup>5</sup>	\$6,900/\$13,800 <sup>5</sup>	\$13,800/\$27,600 <sup>5</sup>
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$6,650/\$13,300	\$13,300/\$26,600	\$6,900/\$13,800	\$13,800/\$27,600
<b>Professional Services</b>				
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
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services<sup>7</sup></b>				
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
<b>Mental Health &amp; Substance Use Disorder Services</b>				
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
<b>Outpatient Prescription Drug Coverage</b>				
Calendar Year Deductible (individual/family)	Annual Deductible applies		Annual Deductible applies	No Benefit
Tier 1	No copayment		No copayment	
Tier 2	No copayment		No copayment	
Tier 3	No copayment		No copayment	
Tier 4	No copayment		No copayment	
<b>Pediatric Dental &amp; Vision Coverage<sup>4</sup></b>				
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

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

<sup>2</sup> The Annual Deductible is combined for medical and pharmacy benefits.

<sup>3</sup> 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.

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

<sup>5</sup> 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.

<sup>6</sup> 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.

<sup>7</sup> Outpatient Services Caps on Out-of Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

# Non-Differential PPO Plan Mapping

Metallic Level	Silver
Select Plus / Core HDHP Plan	2250/30%
Network <sup>1</sup>	Network & Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$2,250/\$4,500
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$7,350/\$14,700
<b>Professional Services</b>	
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
<b>Hospitalization Services</b>	
Inpatient Hospital Benefits	30% after deductible
Inpatient Physician Care	30% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	30% after deductible
<b>Emergency Health Coverage</b>	
Emergency Services	30% after deductible
Urgent Care Services	30% after deductible
Ambulance Services	30% after deductible
<b>Outpatient Services</b>	
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
<b>Mental Health &amp; Substance Use Disorder Services</b>	
Inpatient	30% after deductible
Outpatient	30% after deductible
<b>Outpatient Prescription Drug Coverage<sup>5</sup></b>	
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
<b>Pediatric Dental &amp; Vision Coverage<sup>4</sup></b>	
Dental Exam (preventive/diagnostic)	No copayment
Vision Exam (routine)	No copayment
Glasses (frames & lenses)	30%

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

<sup>2</sup> 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.

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

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

<sup>5</sup> No benefits Out-of-Network for Outpatient Prescription Drug Coverage.

# 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 <sup>1</sup>	Network	Non-Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	None	\$1,000/\$2,000	None	\$1,000/\$2,000
Annual Out-of-Pocket Limit <sup>4</sup> (individual/family)	\$3,350/\$6,700	\$8,000/\$16,000	\$4,500/\$9,000	\$9,000/\$18,000
<b>Professional Services</b>				
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 <sup>5</sup>	\$15	50% after deductible	\$15	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services<sup>6</sup></b>				
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	10%	50% after deductible	10%	50% after deductible
	(Benefits limited to \$2,000 combined for medical/Rx per lifetime)		(Benefits limited to \$2,000 medical and \$1,500 Rx per lifetime)	
Injections Received in a Physician's Office	\$15	50% after deductible	\$15	50% after deductible
<b>Mental Health &amp; Substance Use Disorder Services</b>				
Inpatient	10%	50% after deductible	10%	50% after deductible
Outpatient	\$15	50% after deductible	\$15	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>				
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	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>				
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%

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

<sup>2</sup> 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.

<sup>3</sup> The Annual Deductible is combined for medical and pharmacy benefits.

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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 <sup>1</sup>	Network	Non-Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	None	\$1,000/\$2,000	\$250/\$500	\$1,000/\$2,000
Annual Out-of-Pocket Limit <sup>4</sup> (individual/family)	\$7,200/\$14,400	\$13,500/\$27,000	\$7,800/\$15,600	\$15,600/\$31,200
<b>Professional Services</b>				
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 <sup>5</sup>	\$30	50% after deductible	\$25	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services<sup>6</sup></b>				
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	20%	50% after deductible	20%	50% after deductible
	(Benefits limited to \$2,000 combined for medical/Rx per lifetime)		(Benefits limited to \$2,000 medical and \$1,500 Rx per lifetime)	
Injections Received in a Physician's Office	\$30	50% after deductible	\$25	50% after deductible
<b>Mental Health &amp; Substance Use Disorder Services</b>				
Inpatient	20%	50% after deductible	20% after deductible	50% after deductible
Outpatient	\$30	50% after deductible	\$25	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>				
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	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>				
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%

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

<sup>2</sup> 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.

<sup>3</sup> The Annual Deductible is combined for medical and pharmacy benefits.

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of-Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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			
	45/2000/20%		50/2250/20%	
Select Plus / Core HDHP Plan				
Network <sup>1</sup>	Network	Non-Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$2,000/\$4,000	\$4,000/\$8,000	\$2,250/\$4,500	\$4,500/\$9,000
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$7,550/\$15,100	\$14,000/\$28,000	\$7,800/\$15,600	\$15,600/\$31,200
<b>Professional Services</b>				
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 <sup>5</sup>	\$45	50% after deductible	\$50	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services<sup>6</sup></b>				
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	20%	50% after deductible	20%	50% after deductible
	(Benefits limited to \$2,000 combined for medical/Rx per lifetime)		(Benefits limited to \$2,000 medical and \$1,500 Rx per lifetime)	
Injections Received in a Physician's Office	\$45	50% after deductible	\$50	50% after deductible
<b>Mental Health &amp; Substance Use Disorder Services</b>				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	\$45	50% after deductible	\$50	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>				
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	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>				
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%

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

<sup>2</sup> 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.

<sup>3</sup> The Annual Deductible is combined for medical and pharmacy benefits.

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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			
	75/6300/100%		65/6300/40%	
Select Plus / Core HDHP Plan				
Network <sup>1</sup>	Network	Non-Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$6,300/\$12,600	\$12,600/\$25,200	\$6,300/\$12,600	\$12,600/\$25,200
Annual Out-of-Pocket Limit <sup>4</sup> (individual/family)	\$7,550/\$15,100	\$14,000/\$28,000	\$7,800/\$15,600	\$15,600/\$31,200
<b>Professional Services</b>				
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 <sup>5</sup>	\$75	50% after deductible	\$65	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services<sup>6</sup></b>				
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	100% after deductible	50% after deductible	40% after deductible	50% after deductible
	(Benefits limited to \$2,000 combined for medical/Rx per lifetime)		(Benefits limited to \$2,000 medical and \$1,500 Rx per lifetime)	
Injections Received in a Physician's Office	\$75	50% after deductible	\$65	50% after deductible
<b>Mental Health &amp; Substance Use Disorder Services</b>				
Inpatient	100% after deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient	No copayment	50% after deductible	No copayment	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>				
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	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>				
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%

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

<sup>2</sup> 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.

<sup>3</sup> The Annual Deductible is combined for medical and pharmacy benefits.

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of-Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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 <sup>1</sup>	Network	Non-Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$6,000/\$12,000 <sup>3</sup>	\$9,600/\$19,200 <sup>3</sup>	\$6,300/\$12,600	\$12,600/\$25,200
Annual Out-of-Pocket Limit <sup>4</sup> (individual/family)	\$6,650/\$13,300	\$13,100/\$26,200	\$7,800/\$15,600	\$15,600/\$31,200
<b>Professional Services</b>				
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 <sup>5</sup>	40% after deductible	50% after deductible	\$65	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services<sup>6</sup></b>				
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	40% after deductible	50% after deductible	40% after deductible	50% after deductible
	(Benefits limited to \$2,000 combined for medical/Rx per lifetime)		(Benefits limited to \$2,000 medical and \$1,500 Rx per lifetime)	
Injections Received in a Physician's Office	40% after deductible	50% after deductible	\$65	50% after deductible
<b>Mental Health &amp; Substance Use Disorder Services</b>				
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
<b>Outpatient Prescription Drug Coverage</b>				
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	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>				
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%

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

<sup>2</sup> 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.

<sup>3</sup> The Annual Deductible is combined for medical and pharmacy benefits.

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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 <sup>1</sup> (individual/family)	None	None	None	None
Annual Out-of-Pocket Limit <sup>2</sup> (individual/family)	\$2,500/\$5,000	\$3,000/\$6,000	\$3,000/\$6,000	\$3,500/\$7,000
<b>Professional Services</b>				
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
<b>Hospitalization Services</b>				
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%
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services</b>				
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
<b>Mental Health &amp; Substance Use Disorder Services</b>				
Inpatient	\$500/day, max 4 days per stay	\$500/day, max 4 days per stay	20%	20%
Outpatient	\$20	\$20	\$20	\$20
<b>Outpatient Prescription Drug Coverage</b>				
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
<b>Pediatric Dental &amp; Vision Coverage<sup>3</sup></b>				
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%
<b>Optional Group Coverage – Infertility Services</b>	50%	50%	50%	50%

<sup>1</sup> 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.

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

<sup>3</sup> 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 <sup>1</sup> (individual/family)	None	None
Annual Out-of-Pocket Limit <sup>2</sup> (individual/family)	\$3,500/\$7,000	\$4,000/\$8,000
<b>Professional Services</b>		
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
<b>Hospitalization Services</b>		
Inpatient Hospital Benefits	20%	20%
Inpatient Physician Care	No charge	No charge
Skilled Nursing Facility Care (100 days per benefit period)	20%	20%
<b>Emergency Health Coverage</b>		
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
<b>Outpatient Services</b>		
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
<b>Mental Health &amp; Substance Use Disorder Services</b>		
Inpatient	20%	20%
Outpatient	No charge	No charge
<b>Outpatient Prescription Drug Coverage</b>		
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
<b>Pediatric Dental &amp; Vision Coverage<sup>3</sup></b>		
Dental Exam (preventive/diagnostic)	No charge	No charge
Vision Exam (routine)	No charge	No charge
Glasses (frames & lenses)	20%	20%
<b>Optional Group Coverage – Infertility Services</b>	50%	50%

<sup>1</sup> 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.

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

<sup>3</sup> 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 <sup>1</sup> (individual/family)	None	None	\$250/\$500	\$500/\$1,000
Annual Out-of-Pocket Limit <sup>2</sup> (individual/family)	\$6,000/\$12,000	\$6,000/\$12,000	\$6,000/\$12,000	\$6,500/\$13,000
<b>Professional Services</b>				
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
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services</b>				
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
<b>Mental Health &amp; Substance Use Disorder Services</b>				
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
<b>Outpatient Prescription Drug Coverage</b>				
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
<b>Pediatric Dental &amp; Vision Coverage<sup>3</sup></b>				
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%
<b>Optional Group Coverage – Infertility Services</b>	50%	50%	50%	50%

<sup>1</sup> 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.

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

<sup>3</sup> 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 <sup>1</sup> (individual/family)	\$1,000/\$2,000	\$1,250/\$2,500	\$1,250/\$2,500	\$1,500/\$3,000
Annual Out-of-Pocket Limit <sup>2</sup> (individual/family)	\$6,000/\$12,000	\$6,500/\$13,000	\$7,000/\$14,000	\$7,500/\$15,000
<b>Professional Services</b>				
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
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services</b>				
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
<b>Mental Health &amp; Substance Use Disorder Services</b>				
Inpatient	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Outpatient	\$30	\$30	No charge	No charge
<b>Outpatient Prescription Drug Coverage</b>				
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
<b>Pediatric Dental &amp; Vision Coverage<sup>3</sup></b>				
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%
<b>Optional Group Coverage – Infertility Services</b>	50%	50%	50%	50%

<sup>1</sup> 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.

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

<sup>3</sup> 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 <sup>1</sup> (individual/family)	\$2,250/\$4,500	\$2,250/\$4,500	\$2,200/\$4400	\$2,250/\$4,500
Annual Out-of-Pocket Limit <sup>2</sup> (individual/family)	\$7,900/\$15,800	\$8,150/\$16,300	\$7,900/\$15,800	\$8,150/\$16,300
<b>Professional Services</b>				
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
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services</b>				
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
<b>Mental Health &amp; Substance Use Disorder Services</b>				
Inpatient	40% after deductible	40% after deductible	30% after deductible	30% after deductible
Outpatient	\$50	\$55	30% after deductible	30% after deductible
<b>Outpatient Prescription Drug Coverage</b>				
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
<b>Pediatric Dental &amp; Vision Coverage<sup>3</sup></b>				
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%
<b>Optional Group Coverage – Infertility Services</b>	50%	50%	50% after deductible	50% after deductible

<sup>1</sup> 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.

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

<sup>3</sup> 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 <sup>1</sup> (individual/family)	\$6,500/\$13,000	\$6,900/\$13,800	\$6,500/\$13,000	\$6,900/\$13,800
Annual Out-of-Pocket Limit <sup>2</sup> (individual/family)	\$6,500/\$13,000	\$6,900/\$13,800	\$6,500/\$13,000	\$6,900/\$13,800
<b>Professional Services</b>				
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
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services</b>				
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
<b>Mental Health &amp; Substance Use Disorder Services</b>				
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
<b>Outpatient Prescription Drug Coverage</b>				
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
<b>Pediatric Dental &amp; Vision Coverage<sup>3</sup></b>				
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
<b>Optional Group Coverage – Infertility Services</b>	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible

<sup>1</sup> 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.

<sup>2</sup> Annual deductible applies to the Out-of-Pocket Limit.

<sup>3</sup> 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 <sup>1</sup> (individual/family)	None	None
Annual Out-of-Pocket Limit <sup>2</sup> (individual/family)	\$3,350/\$6,700	\$4,500/\$9,000
<b>Professional Services</b>		
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
<b>Hospitalization Services</b>		
Inpatient Hospital Benefits	10%	10%
Inpatient Physician Care	10%	10%
Skilled Nursing Facility Care (100 days per benefit period)	10%	10%
<b>Emergency Health Coverage</b>		
Emergency Services	\$150	\$150
Urgently Needed Services – within physician service area	\$15	\$15
– outside physician service area	\$15	\$15
Ambulance Services	\$150	\$150
<b>Outpatient Services</b>		
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%
<b>Mental Health &amp; Substance Use Disorder Services</b>		
Inpatient	10%	10%
Outpatient	\$15	\$15
<b>Outpatient Prescription Drug Coverage</b>		
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
<b>Pediatric Dental &amp; Vision Coverage<sup>4</sup></b>		
Dental Exam (preventive/diagnostic)	No charge	No charge
Vision Exam (routine)	No charge	No charge
Glasses (frames & lenses)	No charge	No charge
<b>Optional Group Coverage – Infertility Services</b>	50%	50%

<sup>1</sup> 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.

<sup>2</sup> The Annual Deductible is combined for medical and pharmacy benefits.

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

<sup>4</sup> 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 <sup>1</sup> (individual/family)	None	\$250/\$500
Annual Out-of-Pocket Limit <sup>2</sup> (individual/family)	\$7,200/\$14,400	\$7,800/\$15,600
<b>Professional Services</b>		
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
<b>Hospitalization Services</b>		
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
<b>Emergency Health Coverage</b>		
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
<b>Outpatient Services</b>		
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%
<b>Mental Health &amp; Substance Use Disorder Services</b>		
Inpatient	20%	20% after deductible
Outpatient	\$30	\$25
<b>Outpatient Prescription Drug Coverage</b>		
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
<b>Pediatric Dental &amp; Vision Coverage<sup>4</sup></b>		
Dental Exam (preventive/diagnostic)	No charge	No charge
Vision Exam (routine)	No charge	No charge
Glasses (frames & lenses)	No charge	No charge
<b>Optional Group Coverage – Infertility Services</b>	50%	50%

<sup>1</sup> 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.

<sup>2</sup> The Annual Deductible is combined for medical and pharmacy benefits.

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

<sup>4</sup> 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 <sup>1</sup> (individual/family)	\$2,000/\$4,000	\$2,250/\$4,500
Annual Out-of-Pocket Limit <sup>2</sup> (individual/family)	\$7,550/\$15,100	\$7,800/\$15,600
<b>Professional Services</b>		
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
<b>Hospitalization Services</b>		
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
<b>Emergency Health Coverage</b>		
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
<b>Outpatient Services</b>		
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%
<b>Mental Health &amp; Substance Use Disorder Services</b>		
Inpatient	20% after deductible	20% after deductible
Outpatient	\$45	\$50
<b>Outpatient Prescription Drug Coverage</b>		
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
<b>Pediatric Dental &amp; Vision Coverage<sup>4</sup></b>		
Dental Exam (preventive/diagnostic)	No charge	No charge
Vision Exam (routine)	No charge	No charge
Glasses (frames & lenses)	No charge	No charge
<b>Optional Group Coverage – Infertility Services</b>	50%	50%

<sup>1</sup> 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.

<sup>2</sup> The Annual Deductible is combined for medical and pharmacy benefits.

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

<sup>4</sup> 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 <sup>1</sup> (individual/family)	\$6,000/\$12,000 <sup>2</sup>	\$6,900/\$13,800 <sup>2</sup>
Annual Out-of-Pocket Limit <sup>2</sup> (individual/family)	\$6,650/\$13,300	\$6,900/\$13,800
<b>Professional Services</b>		
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
<b>Hospitalization Services</b>		
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
<b>Emergency Health Coverage</b>		
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
<b>Outpatient Services</b>		
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
<b>Mental Health &amp; Substance Use Disorder Services</b>		
Inpatient	40% after deductible	No charge after deductible
Outpatient	40% after deductible	No charge after deductible
<b>Outpatient Prescription Drug Coverage</b>		
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
<b>Pediatric Dental &amp; Vision Coverage<sup>4</sup></b>		
Dental Exam (preventive/diagnostic)	No charge	No charge
Vision Exam (routine)	No charge	No charge
Glasses (frames & lenses)	No charge	No charge
<b>Optional Group Coverage – Infertility Services</b>	50% after deductible	50% after deductible

<sup>1</sup> 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.

<sup>2</sup> The Annual Deductible is combined for medical and pharmacy benefits.

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

<sup>4</sup> 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 <sup>1</sup>	Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	None	None	\$1,000/\$2,000
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$3,200/\$6,400	\$3,500/\$7,000	\$7,000/\$14,000
<b>Professional Services</b>			
Office Visits - PCP	\$10	\$10	50% after deductible
Office Visits - Specialist	\$20	\$25	50% after deductible
Laboratory <sup>4</sup> (standard)	10%	10%	50% after deductible
Radiology <sup>4</sup> (standard)	10%	10%	50% after deductible
Maternity Care <sup>5</sup>	\$10	\$10	50% after deductible
Preventive Care Services	No copayment	No copayment	No benefit
<b>Hospitalization Services</b>			
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
<b>Emergency Health Coverage</b>			
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
<b>Outpatient Services<sup>6</sup></b>			
Outpatient Surgery <sup>4</sup>	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
<b>Mental Health &amp; Substance Use Disorder Services</b>			
Inpatient	10%	10%	50% after deductible
Outpatient	\$10	\$10	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>			
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	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>			
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%

<sup>1</sup> 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.

<sup>2</sup> 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.

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

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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 <sup>1</sup>	Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$250/\$500	\$250/\$500	\$1,000/\$2,000
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$3,200/\$6,400	\$3,500/\$7,000	\$7,000/\$14,000
<b>Professional Services</b>			
Office Visits - PCP	\$15	\$15	50% after deductible
Office Visits - Specialist	\$30	\$30	50% after deductible
Laboratory <sup>4</sup> (standard)	20% after deductible	20% after deductible	50% after deductible
Radiology <sup>4</sup> (standard)	20% after deductible	20% after deductible	50% after deductible
Maternity Care <sup>5</sup>	\$15	\$15	50% after deductible
Preventive Care Services	No copayment	No copayment	No benefit
<b>Hospitalization Services</b>			
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
<b>Emergency Health Coverage</b>			
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
<b>Outpatient Services<sup>6</sup></b>			
Outpatient Surgery <sup>4</sup>	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
<b>Mental Health &amp; Substance Use Disorder Services</b>			
Inpatient	20% after deductible	20% after deductible	50% after deductible
Outpatient	\$15	\$15	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>			
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	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>			
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%

<sup>1</sup> 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.

<sup>2</sup> 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.

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

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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 <sup>1</sup>	Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$250/\$500	\$500/\$1,000	\$1,000/\$2,000
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$6,000/\$12,000	\$6,500/\$13,000	\$13,000/\$26,000
<b>Professional Services</b>			
Office Visits - PCP	\$25	\$25	50% after deductible
Office Visits - Specialist	\$50	\$50	50% after deductible
Laboratory <sup>4</sup> (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 <sup>4</sup> (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 <sup>5</sup>	\$25	\$25	50% after deductible
Preventive Care Services	No copayment	No copayment	No benefit
<b>Hospitalization Services</b>			
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
<b>Emergency Health Coverage</b>			
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
<b>Outpatient Services<sup>6</sup></b>			
Outpatient Surgery <sup>4</sup>	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
<b>Mental Health &amp; Substance Use Disorder Services</b>			
Inpatient	20% after deductible	20% after deductible	50% after deductible
Outpatient	\$25	\$25	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>			
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	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>			
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%

<sup>1</sup> 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.

<sup>2</sup> 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.

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

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of-Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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 <sup>1</sup>	Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$750/\$1,500	\$1,000/\$2,000	\$2,000/\$4,000
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$6,000/\$12,000	\$6,500/\$13,000	\$13,000/\$26,000
<b>Professional Services</b>			
Office Visits - PCP	\$25	\$25	50% after deductible
Office Visits - Specialist	\$50	\$50	50% after deductible
Laboratory <sup>4</sup> (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 <sup>4</sup> (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 <sup>5</sup>	\$25	\$25	50% after deductible
Preventive Care Services	No copayment	No copayment	No benefit
<b>Hospitalization Services</b>			
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
<b>Emergency Health Coverage</b>			
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
<b>Outpatient Services<sup>6</sup></b>			
Outpatient Surgery <sup>4</sup>	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
<b>Mental Health &amp; Substance Use Disorder Services</b>			
Inpatient	20% after deductible	20% after deductible	50% after deductible
Outpatient	\$25	\$25	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>			
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	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>			
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%

<sup>1</sup> 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.

<sup>2</sup> 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.

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

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of-Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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 <sup>1</sup>	Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$1,250/\$2,500	\$1,000/\$2,000	\$2,000/\$4,000
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$6,000/\$12,000	\$6,500/\$13,000	\$13,000/\$26,000
<b>Professional Services</b>			
Office Visits - PCP	\$25	\$25	50% after deductible
Office Visits - Specialist	\$50	\$50	50% after deductible
Laboratory <sup>4</sup> (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 <sup>4</sup> (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 <sup>5</sup>	\$25	\$25	50% after deductible
Preventive Care Services	No copayment	No copayment	No benefit
<b>Hospitalization Services</b>			
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
<b>Emergency Health Coverage</b>			
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
<b>Outpatient Services<sup>6</sup></b>			
Outpatient Surgery <sup>4</sup>	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
<b>Mental Health &amp; Substance Use Disorder Services</b>			
Inpatient	20% after deductible	20% after deductible	50% after deductible
Outpatient	\$25	\$25	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>			
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	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>			
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%

<sup>1</sup> 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.

<sup>2</sup> 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.

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

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of-Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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 <sup>1</sup>	Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$1,500/\$3,000	\$1,500/\$3,000	\$3,000/\$6,000
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$7,900/\$15,800	\$8,150/\$16,300	\$16,300/\$32,600
<b>Professional Services</b>			
Office Visits - PCP	\$40	\$50	50% after deductible
Office Visits - Specialist	\$70	\$80	50% after deductible
Laboratory <sup>4</sup> (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 <sup>4</sup> (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 <sup>5</sup>	\$40	\$50	50% after deductible
Preventive Care Services	No copayment	No copayment	No benefit
<b>Hospitalization Services</b>			
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
<b>Emergency Health Coverage</b>			
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
<b>Outpatient Services<sup>6</sup></b>			
Outpatient Surgery <sup>4</sup>	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
<b>Mental Health &amp; Substance Use Disorder Services</b>			
Inpatient	30% after deductible	40% after deductible	50% after deductible
Outpatient	\$40	\$50	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>			
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	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>			
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%

<sup>1</sup> 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.

<sup>2</sup> 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.

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

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of-Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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 <sup>1</sup>	Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$2,250/\$4,500	\$2,250/\$4,500	\$4,500/\$9,000
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$7,900/\$15,800	\$8,150/\$16,300	\$16,300/\$32,600
<b>Professional Services</b>			
Office Visits - PCP	\$45	\$50	50% after deductible
Office Visits - Specialist	\$80	\$80	50% after deductible
Laboratory <sup>4</sup> (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 <sup>4</sup> (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 <sup>5</sup>	\$45	\$50	50% after deductible
Preventive Care Services	No copayment	No copayment	No benefit
<b>Hospitalization Services</b>			
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
<b>Emergency Health Coverage</b>			
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
<b>Outpatient Services<sup>6</sup></b>			
Outpatient Surgery <sup>4</sup>	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
<b>Mental Health &amp; Substance Use Disorder Services</b>			
Inpatient	40% after deductible	40% after deductible	50% after deductible
Outpatient	\$45	\$50	50% after deductible
<b>Outpatient Prescription Drug Coverage</b>			
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	
<b>Pediatric Dental &amp; Vision Coverage<sup>7</sup></b>			
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%

<sup>1</sup> 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.

<sup>2</sup> 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.

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

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

<sup>5</sup> No copayment applies to physician office visits for prenatal care.

<sup>6</sup> Outpatient Services Caps on Out-of Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

<sup>7</sup> 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 <sup>1</sup>	Network	Network	Non-Network	
Annual Deductible <sup>2</sup> (individual/family)	\$2,300/\$2,700 <sup>5</sup>	\$2,300/\$2,800 <sup>5</sup>	\$4,600/\$5,600 <sup>5</sup>	
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$6,650/\$13,300	\$6,650/\$13,300	\$13,300/\$26,600	
<b>Professional Services</b>				
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	
<b>Hospitalization Services</b>				
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	
<b>Emergency Health Coverage</b>				
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	
<b>Outpatient Services<sup>7</sup></b>				
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	
<b>Mental Health &amp; Substance Use Disorder Services</b>				
Inpatient	30% after deductible	30% after deductible	50% after deductible	
Outpatient	30% after deductible	30% after deductible	50% after deductible	
<b>Outpatient Prescription Drug Coverage</b>				
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	
<b>Pediatric Dental &amp; Vision Coverage<sup>4</sup></b>				
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	

<sup>1</sup> 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.

<sup>2</sup> The Annual Deductible is combined for medical and pharmacy benefits.

<sup>3</sup> 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.

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

<sup>5</sup> 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.

<sup>6</sup> 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.

<sup>7</sup> Outpatient Services Caps on Out-of-Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

# 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 <sup>1</sup>	Network	Network	Non-Network
Annual Deductible <sup>2</sup> (individual/family)	\$6,650/\$13,300 <sup>6</sup>	\$6,900/\$13,800 <sup>6</sup>	\$13,800/\$27,600 <sup>6</sup>
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$6,650/\$13,300	\$6,900/\$13,800	\$13,800/\$27,600
<b>Professional Services</b>			
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
<b>Hospitalization Services</b>			
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
<b>Emergency Health Coverage</b>			
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
<b>Outpatient Services<sup>7</sup></b>			
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
<b>Mental Health &amp; Substance Use Disorder Services</b>			
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
<b>Outpatient Prescription Drug Coverage</b>			
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	
<b>Pediatric Dental &amp; Vision Coverage<sup>4</sup></b>			
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

<sup>1</sup> 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.

<sup>2</sup> The Annual Deductible is combined for medical and pharmacy benefits.

<sup>3</sup> 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.

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

<sup>5</sup> 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.

<sup>6</sup> 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.

<sup>7</sup> Outpatient Services Caps on Out-of Network Coverage: Outpatient Surgery: Allowed amounts for facility fee limited to \$760 per date of service; Home Health: \$150 maximum allowed per visit; out-of-network benefits are not available for acupuncture services and physical therapy, occupational therapy and manipulative treatment.

# Navigate State Platinum Plan Mapping

Prior to Jan. 1, 2020

Effective Jan. 1, 2020

Metallic Level	Platinum	
Navigate Plan	15/10%	15/10%
Network <sup>1</sup>	Network	Network
Annual Deductible <sup>2</sup> (individual/family)	None	None
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$3,350/\$6,700	\$4,500/\$9,000
<b>Professional Services</b>		
Office Visits - PCP	\$15	\$15
Office Visits - Specialist	\$30	\$30
Laboratory (standard)	\$15	\$15
Radiology (standard)	\$30	\$30
Maternity Care <sup>4</sup>	\$15	\$15
Preventive Care Services	No copayment	No copayment
<b>Hospitalization Services</b>		
Inpatient Hospital Benefits	10%	10%
Inpatient Physician Care	10%	10%
Skilled Nursing Facility Care (100 days per benefit period)	10%	10%
<b>Emergency Health Coverage</b>		
Emergency Services	\$150	\$150
Urgent Care Services	\$15	\$15
Ambulance Services	\$150	\$150
<b>Outpatient Services</b>		
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
<b>Mental Health &amp; Substance Use Disorder Services</b>		
Inpatient	10%	10%
Outpatient	\$15	\$15
<b>Outpatient Prescription Drug Coverage</b>		
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
<b>Pediatric Dental &amp; Vision Coverage<sup>5</sup></b>		
Dental Exam (preventive/diagnostic)	No copayment	No copayment
Vision Exam (routine)	No copayment	No copayment
Glasses (frames & lenses)	No copayment	No copayment

<sup>1</sup> 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.

<sup>2</sup> 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.

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

<sup>4</sup> No copayment applies to physician office visits for prenatal care.

<sup>5</sup> 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 <sup>1</sup>	Network	Network
Annual Deductible <sup>2</sup> (individual/family)	None	\$250/\$500
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$7,200/\$14,400	\$7,800/\$15,600
<b>Professional Services</b>		
Office Visits - PCP	\$30	\$25
Office Visits - Specialist	\$55	\$50
Laboratory (standard)	\$35	\$25
Radiology (standard)	\$55	\$65
Maternity Care <sup>4</sup>	\$30	\$25
Preventive Care Services	No copayment	No copayment
<b>Hospitalization Services</b>		
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
<b>Emergency Health Coverage</b>		
Emergency Services	\$325	\$250 after deductible
Urgent Care Services	\$30	\$25
Ambulance Services	\$250	\$250 after deductible
<b>Outpatient Services</b>		
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
<b>Mental Health &amp; Substance Use Disorder Services</b>		
Inpatient	20%	20% after deductible
Outpatient	\$30	\$25
<b>Outpatient Prescription Drug Coverage</b>		
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
<b>Pediatric Dental &amp; Vision Coverage<sup>5</sup></b>		
Dental Exam (preventive/diagnostic)	No copayment	No copayment
Vision Exam (routine)	No copayment	No copayment
Glasses (frames & lenses)	No copayment	No copayment

<sup>1</sup> 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.  
<sup>2</sup> 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.

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

<sup>4</sup> No copayment applies to physician office visits for prenatal care.

<sup>5</sup> 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 <sup>1</sup>	Network	Network
Annual Deductible <sup>2</sup> (individual/family)	\$2,000/\$4,000	\$2,250/\$4,500
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$7,550/\$15,100	\$7,800/\$15,600
<b>Professional Services</b>		
Office Visits - PCP	\$45	\$50
Office Visits - Specialist	\$80	\$85
Laboratory (standard)	\$40	\$40
Radiology (standard)	\$75	\$85
Maternity Care <sup>4</sup>	\$45	\$50
Preventive Care Services	No copayment	No copayment
<b>Hospitalization Services</b>		
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
<b>Emergency Health Coverage</b>		
Emergency Services	\$350	\$400 after deductible
Urgent Care Services	\$45	\$50
Ambulance Services	\$250 after deductible	\$250 after deductible
<b>Outpatient Services</b>		
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
<b>Mental Health &amp; Substance Use Disorder Services</b>		
Inpatient	20% after deductible	20% after deductible
Outpatient	\$45	\$50
<b>Outpatient Prescription Drug Coverage</b>		
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
<b>Pediatric Dental &amp; Vision Coverage<sup>5</sup></b>		
Dental Exam (preventive/diagnostic)	No copayment	No copayment
Vision Exam (routine)	No copayment	No copayment
Glasses (frames & lenses)	No copayment	No copayment

<sup>1</sup> 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.

<sup>2</sup> 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.

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

<sup>4</sup> No copayment applies to physician office visits for prenatal care.

<sup>5</sup> 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 <sup>1</sup>	Network	Network	Network	Network
Annual Deductible <sup>2</sup> (individual/family)	\$6,300/\$12,600	\$6,300/\$12,600	\$6,000/\$12,000	\$6,300/\$12,600
Annual Out-of-Pocket Limit <sup>3</sup> (individual/family)	\$7,550/\$15,100	\$7,800/\$15,600	\$6,650/\$13,300	\$7,800/\$15,600
<b>Professional Services</b>				
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 <sup>4</sup>	\$75	\$65	40% after deductible	\$65
Preventive Care Services	No copayment	No copayment	No copayment	No copayment
<b>Hospitalization Services</b>				
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
<b>Emergency Health Coverage</b>				
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
<b>Outpatient Services</b>				
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
<b>Mental Health &amp; Substance Use Disorder Services</b>				
Inpatient	100% after deductible	40% after deductible	40% after deductible	40% after deductible
Outpatient	No copayment	No copayment	40% after deductible	No copayment
<b>Outpatient Prescription Drug Coverage</b>				
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
<b>Pediatric Dental &amp; Vision Coverage<sup>5</sup></b>				
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%

<sup>1</sup> 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.

<sup>2</sup> 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.

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

<sup>4</sup> No copayment applies to physician office visits for prenatal care.

<sup>5</sup> One routine vision exam and one pair of glasses per calendar year for children under age 19.





**Contact your UnitedHealthcare representative for more information.**



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

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