California Small Business (1–100)

Plan Benefit Changes

For groups renewing January 1, 2019 and after

UnitedHealthcare®

Select Plus/Core/Navigate* Platinum Plan Mapping

Plan Benefits	Platinum 10/10% Prior to January 1, 2019		Platinum 10/10% Effective January 1, 2019	
	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (individual/family)	None	$1,000/$2,000	None	$1,000/$2,000
Annual Out-of-Pocket Limit (individual/family)	$3,000/$6,000	$6,000/$12,000	$3,200/$6,400	$6,400/$12,800
Professional Services				
Office Visits - PCP	$10	50% after deductible	$10	50% after deductible
Office Visits - Specialist	$20	50% after deductible	$20	50% after deductible
Laboratory (standard)	10%	50% after deductible	10%	50% after deductible
Radiology (standard)	10%	50% after deductible	10%	50% after deductible
Maternity Care	$10	50% after deductible	$10	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	10%	50% after deductible	10%	50% after deductible
Inpatient Physician Care	10%	50% after deductible	10%	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	10%	50% after deductible	10%	50% after deductible
Emergency Health Coverage				
Emergency Services	$100	Same as Network benefit	10% plus $150 per occurrence deductible	Same as Network benefit
Urgent Care Services	$50	50% after deductible	$50	50% after deductible
Ambulance Services	10%	Same as Network benefit	10%	Same as Network benefit
Outpatient Services				
Outpatient Surgery	10%	50% after deductible	10%	50% after deductible
Durable Medical Equipment	10%	50% after deductible	10%	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	10%	50% after deductible	10%	50% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	10%	50% after deductible	10%	50% after deductible
Injections Received in a Physician's Office	$10	50% after deductible	$10	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	10%	50% after deductible	10%	50% after deductible
Outpatient	$10	50% after deductible	$10	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (inidividual/family)	None		None	
Tier 1	$10		$10	
Tier 2	$30		$35	
Tier 3	$60		$70	
Tier 4	25% up to $250		10% up to $250	
Pediatric Dental & Vision Coverage				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	20%
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	10%	50%	10%	50%

*Navigate is Network only

Select Plus/Core/Navigate* Platinum Plan Mapping

Plan Benefits	Platinum 15/20%		Platinum 15/250/20%	
	Prior to January 1, 2019		Effective January 1, 2019	
	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (individual/family)	None	$1,000/$2,000	$250/$500	$1,000/$2,000
Annual Out-of-Pocket Limit (individual/family)	$4,700/$9,400	$9,400/$18,800	$3,200/$6,400	$6,400/$12,800
Professional Services				
Office Visits - PCP	$15	50% after deductible	$15	50% after deductible
Office Visits - Specialist	$30	50% after deductible	$30	50% after deductible
Laboratory (standard)	20%	50% after deductible	20% after deductible	50% after deductible
Radiology (standard)	20%	50% after deductible	20% after deductible	50% after deductible
Maternity Care	$15	50% after deductible	$15	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	20%	50% after deductible	20% after deductible	50% after deductible
Inpatient Physician Care	20%	50% after deductible	20% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20%	50% after deductible	20% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	$100	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%	Same as Network benefit	20% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery	20%	50% after deductible	20% after deductible	50% after deductible
Durable Medical Equipment	20%	50% after deductible	20% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	20%	50% after deductible	20% after deductible	50% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	20%	50% after deductible	20% after deductible	50% after deductible
Injections Received in a Physician's Office	$15	50% after deductible	$15	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	20%	50% after deductible	20% after deductible	50% after deductible
Outpatient	$15	50% after deductible	$15	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (inidividual/family)	None		None	
Tier 1	$10		$10	
Tier 2	$30		$35	
Tier 3	$60		$70	
Tier 4	25% up to $250		10% up to $250	
Pediatric Dental & Vision Coverage				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	20%
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	20%	50%	20%	50%

*Navigate is Network only

Select Plus/Core/Navigate* Gold Plan Mapping

Plan Benefits	Gold 25/500/20%		Gold 25/250/20%	
	Prior to January 1, 2019		Effective January 1, 2019	
	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (individual/family)	$500/$1,000	$1,000/$2,000	$250/$500	$1,000/$2,000
Annual Out-of-Pocket Limit (individual/family)	$6,000/$12,000	$12,000/$24,000	$6,000/$12,000	$12,000/$24,000
Professional Services				
Office Visits - PCP	$25	50% after deductible	$25	50% after deductible
Office Visits - Specialist	$50	50% after deductible	$50	50% after deductible
Laboratory (standard)	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
Radiology (standard)	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
Maternity Care	$25	50% after deductible	$25	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Inpatient Physician Care	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	$150	Same as Network benefit	20% after deductible, plus $250 per occurrence deductible	Same as Network benefit
Urgent Care Services	$75	50% after deductible	$75	50% after deductible
Ambulance Services	20% after deductible	Same as Network benefit	20% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Durable Medical Equipment	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Injections Received in a Physician's Office	$25	50% after deductible	$25	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	$25	50% after deductible	$25	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (inidividual/family)	None		None	
Tier 1	$15		$15	
Tier 2	$35		$40	
Tier 3	$70		$80	
Tier 4	25% up to $250		25% up to $250	
Pediatric Dental & Vision Coverage				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	20%
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	20%	50%	20%	50%

*Navigate is Network only

Select Plus/Core/Navigate* Gold Plan Mapping

Plan Benefits	Gold 25/1000/20%		Gold 25/750/20%	
	Prior to January 1, 2019		Effective January 1, 2019	
	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (individual/family)	$1,000/$2,000	$2,000/$4,000	$750/$1,500	$1,500/$3,000
Annual Out-of-Pocket Limit (individual/family)	$6,000/$12,000	$12,000/$24,000	$6,000/$12,000	$12,000/$24,000
Professional Services				
Office Visits - PCP	$25	50% after deductible	$25	50% after deductible
Office Visits - Specialist	$50	50% after deductible	$50	50% after deductible
Laboratory (standard)	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
Radiology (standard)	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
Maternity Care	$25	50% after deductible	$25	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Inpatient Physician Care	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	$150	Same as Network benefit	20% after deductible, plus $250 per occurrence deductible	Same as Network benefit
Urgent Care Services	$75	50% after deductible	$75	50% after deductible
Ambulance Services	20% after deductible	Same as Network benefit	20% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Durable Medical Equipment	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Injections Received in a Physician's Office	$25	50% after deductible	$25	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	$25	50% after deductible	$25	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (inidividual/family)	None		None	
Tier 1	$15		$15	
Tier 2	$35		$40	
Tier 3	$70		$80	
Tier 4	25% up to $250		25% up to $250	
Pediatric Dental & Vision Coverage				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	20%
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	20%	50%	20%	50%

*Navigate is Network only

Select Plus/Core/Navigate* Gold Plan Mapping

Plan Benefits	Gold 25/1500/20%		Gold 25/1250/20%	
	Prior to January 1, 2019		Effective January 1, 2019	
	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (individual/family)	$1,500/$3,000	$3,000/$6,000	$1,250/$2,500	$2,500/$5,000
Annual Out-of-Pocket Limit (individual/family)	$6,000/$12,000	$12,000/$24,000	$6,000/$12,000	$12,000/$24,000
Professional Services				
Office Visits - PCP	$25	50% after deductible	$25	50% after deductible
Office Visits - Specialist	$50	50% after deductible	$50	50% after deductible
Laboratory (standard)	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
Radiology (standard)	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
Maternity Care	$25	50% after deductible	$25	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Inpatient Physician Care	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	$150	Same as Network benefit	20% after deductible, plus $250 per occurrence deductible	Same as Network benefit
Urgent Care Services	$75	50% after deductible	$75	50% after deductible
Ambulance Services	20% after deductible	Same as Network benefit	20% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Durable Medical Equipment	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Injections Received in a Physician's Office	$25	50% after deductible	$25	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	$25	50% after deductible	$25	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (inidividual/family)	None		None	
Tier 1	$15		$15	
Tier 2	$35		$40	
Tier 3	$70		$80	
Tier 4	25% up to $250		25% up to $250	
Pediatric Dental & Vision Coverage				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	20%
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	20%	50%	20%	50%

*Navigate is Network only

Select Plus/Core/Navigate*
Silver Plan Mapping

Plan Benefits	Silver 40/1500/30%		Silver 40/1500/30%	
	Prior to January 1, 2019		Effective January 1, 2019	
	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (individual/family)	$1,500/$3,000	$3,000/$6,000	$1,500/$3,000	$3,000/$6,000
Annual Out-of-Pocket Limit (individual/family)	$7,350/$14,700	$14,700/$29,400	$7,900/$15,800	$15,800/$31,600
Professional Services				
Office Visits - PCP	$40	50% after deductible	$40	50% after deductible
Office Visits - Specialist	$70	50% after deductible	$70	50% after deductible
Laboratory (standard)	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
Radiology (standard)	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
Maternity Care	$40	50% after deductible	$40	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	30% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	30% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Inpatient Physician Care	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	30% after deductible	Same as Network benefit	30% after deductible, plus $300 per occurrence deductible	Same as Network benefit
Urgent Care Services	$100	50% after deductible	$70	50% after deductible
Ambulance Services	30% after deductible	Same as Network benefit	30% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery	30% after deductible, 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	$40	50% after deductible	$40	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Outpatient	$40	50% after deductible	$40	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (inidividual/family)	$200/$400 does not apply to Tier 1		$250/$500 does not apply to Tier 1	
Tier 1	$20		$20	
Tier 2	$50		$50	
Tier 3	$100		$100	
Tier 4	25% up to $250		25% up to $250	
Pediatric Dental & Vision Coverage				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	20%
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	30%	50%	30%	50%

*Navigate is Network only

Select Plus/Core/Navigate* Silver Plan Mapping

Plan Benefits	Silver 40/2250/40%		Silver 45/2250/40%	
	Prior to January 1, 2019		Effective January 1, 2019	
	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (individual/family)	$2,250/$4,500	$4,500/$9,000	$2,250/$4,500	$4,500/$9,000
Annual Out-of-Pocket Limit (individual/family)	$7,350/$14,700	$14,700/$29,400	$7,900/$15,800	$15,800/$31,600
Professional Services				
Office Visits - PCP	$40	50% after deductible	$45	50% after deductible
Office Visits - Specialist	$70	50% after deductible	$80	50% after deductible
Laboratory (standard)	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
Radiology (standard)	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
Maternity Care	$40	50% after deductible	$45	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	40% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	40% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Inpatient Physician Care	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	40% after deductible, plus $400 per occurrence deductible	Same as Network benefit	40% after deductible, plus $300 per occurrence deductible	Same as Network benefit
Urgent Care Services	$100	50% after deductible	$80	50% after deductible
Ambulance Services	40% after deductible	Same as Network benefit	40% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery	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	$40	50% after deductible	$45	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient	$40	50% after deductible	$45	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (inidividual/family)	$200/$400 does not apply to Tier 1		$250/$500 does not apply to Tier 1	
Tier 1	$20		$20	
Tier 2	$50		$50	
Tier 3	$100		$100	
Tier 4	25% up to $250		25% up to $250	
Pediatric Dental & Vision Coverage				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	20%
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	40%	50%	40%	50%

*Navigate is Network only

Select Plus/Core/Navigate*
HDHP Silver Plan Mapping

Plan Benefits	Silver 2000/20%		Silver 2300/30%	
	Prior to January 1, 2019		Effective January 1, 2019	
	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (individual/family)	$2,000/$2,700	$13,000/$26,000	$2,300/$2,700	$4,600/$5,400
Annual Out-of-Pocket Limit (individual/family)	$6,500/$13,000	$26,000/$52,000	$6,650/$13,300	$13,300/$26,600
Professional Services				
Office Visits - PCP	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Office Visits - Specialist	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Laboratory (standard)	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Radiology (standard)	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Maternity Care	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Inpatient Physician Care	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	20% after deductible	Same as Network benefit	30% after deductible	Same as Network benefit
Urgent Care Services	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Ambulance Services	20% after deductible	Same as Network benefit	30% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Durable Medical Equipment	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Injections Received in a Physician's Office	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Outpatient	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (inidividual/family)	Annual Deductible applies		Annual Deductible applies	
Tier 1	$20		$20	
Tier 2	$50		$50	
Tier 3	$100		$100	
Tier 4	25% up to $250		25% up to $250	
Pediatric Dental & Vision Coverage				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	20%
Vision Exam (routine)	No copayment	50% after deductible	No copayment	50% after deductible
Glasses (frames & lenses)	20% after deductible	50% after deductible	30% after deductible	50% after deductible

*Navigate is Network only

Select Plus/Core/Navigate*
HDHP Bronze Plan Mapping

Plan Benefits	Bronze 4800/40%		Bronze 6650/0%	
	Prior to January 1, 2019		Effective January 1, 2019	
	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (individual/family)	$4,800/$9,600	$9,600/$19,200	$6,650/$13,300	$13,300/$26,600
Annual Out-of-Pocket Limit (individual/family)	$6,550/$13,100	$13,100/$26,200	$6,650/$13,300	$13,300/$26,600
Professional Services				
Office Visits - PCP	40% after deductible	50% after deductible	No copay after deductible	50% after deductible
Office Visits - Specialist	40% after deductible	50% after deductible	No copay after deductible	50% after deductible
Laboratory (standard)	40% after deductible	50% after deductible	No copay after deductible	50% after deductible
Radiology (standard)	40% after deductible	50% after deductible	No copay after deductible	50% after deductible
Maternity Care	40% after deductible	50% after deductible	No copay after deductible	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	40% after deductible	50% after deductible	No copay after deductible	50% after deductible
Inpatient Physician Care	40% after deductible	50% after deductible	No copay after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	40% after deductible	50% after deductible	No copay after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	40% after deductible	Same as Network benefit	No copay after deductible	Same as Network benefit
Urgent Care Services	40% after deductible	50% after deductible	No copay after deductible	50% after deductible
Ambulance Services	40% after deductible	Same as Network benefit	No copay after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery	40% after deductible	50% after deductible	No copay after deductible	50% after deductible
Durable Medical Equipment	40% after deductible	50% after deductible	No copay after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	40% after deductible	50% after deductible	No copay after deductible	50% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	40% after deductible	50% after deductible	No copay after deductible	50% after deductible
Injections Received in a Physician's Office	40% after deductible	50% after deductible	No copay after deductible	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	40% after deductible	50% after deductible	No copay after deductible	50% after deductible
Outpatient	40% after deductible	50% after deductible	No copay after deductible	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (inidividual/family)	Annual Deductible applies		Annual Deductible applies	
Tier 1	40% up to $500		No copayment	
Tier 2	40% up to $500		No copayment	
Tier 3	40% up to $500		No copayment	
Tier 4	40% up to $500		No copayment	
Pediatric Dental & Vision Coverage				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	20%
Vision Exam (routine)	No copayment	50% after deductible	No copayment	50% after deductible
Glasses (frames & lenses)	40% after deductible	50% after deductible	No copay after deductible	50% after deductible

*Navigate is Network only

Non-Differential PPO Plan Mapping

Plan Benefits	Silver 2250/30% - No Changes Effective January 1, 2019 Network & Out-of-Network
Annual Deductible (individual/family)	$2,250/$4,500
Annual Out-of-Pocket Limit (individual/family)	$7,350/$14,700
Professional Services	
Office Visits - PCP	30% after deductible
Office Visits - Specialist	30% after deductible
Laboratory (standard)	30% after deductible
Radiology (standard)	30% after deductible
Maternity Care	30% after deductible
Preventive Care Services	No copayment
Hospitalization Services	
Inpatient Hospital Benefits	30% after deductible
Inpatient Physician Care	30% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	30% after deductible
Emergency Health Coverage	
Emergency Services	30% after deductible
Urgent Care Services	30% after deductible
Ambulance Services	30% after deductible
Outpatient Services	
Outpatient Surgery	30% after deductible
Durable Medical Equipment	30% after deductible
Home Health Services (Up to 100 visits per calendar year)	30% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	30% after deductible
Injections Received in a Physician's Office	30% after deductible
Mental Health & Substance Use Disorder Services	
Inpatient	30% after deductible
Outpatient	30% after deductible
Outpatient Prescription Drug Coverage	
Calendar Year Deductible (inidividual/family)	$200/$400 does not apply to Tier 1
Tier 1	$20
Tier 2	$50
Tier 3	$100
Tier 4	25% up to $250
Pediatric Dental & Vision Coverage	
Dental Exam (preventive/diagnostic)	No copayment
Vision Exam (routine)	No copayment
Glasses (frames & lenses)	30%

Select Plus/Core/Navigate (Network Only) State Platinum Plan Mapping

Plan Benefits	Platinum 15/10% - No Changes Effective January 1, 2019	
	Network	Out-of-Network
Annual Deductible (individual/family)	None	$1,000/$2,000
Annual Out-of-Pocket Limit (individual/family)	$3,350/$6,700	$8,000/$16,000
Professional Services		
Office Visits - PCP	$15	50% after deductible
Office Visits - Specialist	$30	50% after deductible
Laboratory (standard)	$15	50% after deductible
Radiology (standard)	$30	50% after deductible
Maternity Care	$15	50% after deductible
Preventive Care Services	No copayment	No benefit
Hospitalization Services		
Inpatient Hospital Benefits	10%	50% after deductible
Inpatient Physician Care	10%	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	10%	50% after deductible
Emergency Health Coverage		
Emergency Services	$150	Same as Network benefit
Urgent Care Services	$15	50% after deductible
Ambulance Services	$150	Same as Network benefit
Outpatient Services		
Outpatient Surgery	10%	50% after deductible
Durable Medical Equipment	10%	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	10%	50% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	10%	50% after deductible
Injections Received in a Physician's Office	$15	50% after deductible
Mental Health & Substance Use Disorder Services		
Inpatient	10%	50% after deductible
Outpatient	$15	50% after deductible
Outpatient Prescription Drug Coverage		
Calendar Year Deductible (inidividual/family)	None	
Tier 1	$5	
Tier 2	$15	
Tier 3	$25	
Tier 4	10% up to $250	
Pediatric Dental & Vision Coverage		
Dental Exam (preventive/diagnostic)	No copayment	20%
Vision Exam (routine)	No copayment	50%
Glasses (frames & lenses)	No copayment	50%

Select Plus/Core/Navigate (Network Only) State Gold Plan Mapping

Plan Benefits	Gold 25/20%		Gold 30/20%	
	Prior to January 1, 2019		Effective January 1, 2019	
	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (individual/family)	None	$1,000/$2,000	None	$1,000/$2,000
Annual Out-of-Pocket Limit (individual/family)	$6,000/$12,000	$13,500/$27,000	$7,200/$14,400	$13,500/$27,000
Professional Services				
Office Visits - PCP	$25	50% after deductible	$30	50% after deductible
Office Visits - Specialist	$55	50% after deductible	$55	50% after deductible
Laboratory (standard)	$35	50% after deductible	$35	50% after deductible
Radiology (standard)	$55	50% after deductible	$55	50% after deductible
Maternity Care	$25	50% after deductible	$30	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	20%	50% after deductible	20%	50% after deductible
Inpatient Physician Care	20%	50% after deductible	20%	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20%	50% after deductible	20%	50% after deductible
Emergency Health Coverage				
Emergency Services	$325	Same as Network benefit	$325	Same as Network benefit
Urgent Care Services	$25	50% after deductible	$30	50% after deductible
Ambulance Services	$250	Same as Network benefit	$250	Same as Network benefit
Outpatient Services				
Outpatient Surgery	20%	50% after deductible	20%	50% after deductible
Durable Medical Equipment	20%	50% after deductible	20%	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	20%	50% after deductible	20%	50% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	20%	50% after deductible	20%	50% after deductible
Injections Received in a Physician's Office	$25	50% after deductible	$30	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	20%	50% after deductible	20%	50% after deductible
Outpatient	$25	50% after deductible	$30	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (inidividual/family)	None		None	
Tier 1	$15		$15	
Tier 2	$55		$55	
Tier 3	$75		$75	
Tier 4	20% up to $250		20% up to $250	
Pediatric Dental & Vision Coverage				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	20%
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	No copayment	50%	No copayment	50%

Select Plus/Core/Navigate (Network Only) State Silver Plan Mapping

Plan Benefits	Silver 45/2000/20%		Silver 45/2000/20%	
	Prior to January 1, 2019		Effective January 1, 2019	
	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (individual/family)	$2,000/$4,000	$4,000/$8000	$2,000/$4,000	$4,000/$8000
Annual Out-of-Pocket Limit (individual/family)	$7,000/$14,000	$14,000/$28,000	$7,550/$15,100	$14,000/$28,000
Professional Services				
Office Visits - PCP	$45	50% after deductible	$45	50% after deductible
Office Visits - Specialist	$75	50% after deductible	$80	50% after deductible
Laboratory (standard)	$40	50% after deductible	$40	50% after deductible
Radiology (standard)	$70	50% after deductible	$75	50% after deductible
Maternity Care	$45	50% after deductible	$45	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Inpatient Physician Care	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	$350	Same as Network benefit	$350	Same as Network benefit
Urgent Care Services	$45	50% after deductible	$45	50% after deductible
Ambulance Services	$250 after deductible	Same as Network benefit	$250 after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery	20%	50% after deductible	20%	50% after deductible
Durable Medical Equipment	20%	50% after deductible	20%	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	20%	50% after deductible	20%	50% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	20%	50% after deductible	20%	50% after deductible
Injections Received in a Physician's Office	$45	50% after deductible	$45	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	$45	50% after deductible	$45	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (inidividual/family)	$125/$250		$200/$400	
Tier 1	$15		$15	
Tier 2	$55		$55	
Tier 3	$85		$85	
Tier 4	20% up to $250		20% up to $250	
Pediatric Dental & Vision Coverage				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	20%
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	No copayment	50%	No copayment	50%

Select Plus/Core/Navigate (Network Only) State Bronze Plan Mapping

Plan Benefits	Bronze 75/6300/100% Prior to January 1, 2019		Bronze 75/6300/100% Effective January 1, 2019	
	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (individual/family)	$6,300/$12,600	$12,600/$25,200	$6,300/$12,600	$12,600/$25,200
Annual Out-of-Pocket Limit (individual/family)	$7,000/$14,000	$14,000/$28,000	$7,550/$15,100	$14,000/$28,000
Professional Services				
Office Visits - PCP	$75 for first 3 visits, then deductible applies	50% after deductible	$75 for first 3 visits, then deductible applies	50% after deductible
Office Visits - Specialist	$105 for first 3 visits, then deductible applies	50% after deductible	$105 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	100% after deductible	50% after deductible
Maternity Care	$75	50% after deductible	$75	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	100% after deductible	50% after deductible	100% after deductible	50% after deductible
Inpatient Physician Care	100% after deductible	50% after deductible	100% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	100% after deductible	50% after deductible	100% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	100% after deductible	Same as Network benefit	100% after deductible	Same as Network benefit
Urgent Care Services	$75 for first 3 visits, then deductible applies	50% after deductible	$75 for first 3 visits, then deductible applies	50% after deductible
Ambulance Services	100% after deductible	Same as Network benefit	100% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery	100% after deductible	50% after deductible	100% after deductible	50% after deductible
Durable Medical Equipment	100% after deductible	50% after deductible	100% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	100% after deductible	50% after deductible	100% after deductible	50% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	100% after deductible	50% after deductible	100% after deductible	50% after deductible
Injections Received in a Physician's Office	$75	50% after deductible	$75	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	100% after deductible	50% after deductible	100% after deductible	50% after deductible
Outpatient	No copayment	50% after deductible	No copayment	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (inidividual/family)	$500/$1,000 does not apply to Tier 1		$500/$1,000 does not apply to Tier 1	
Tier 1	100% up to $500		100% up to $500	
Tier 2	100% up to $500		100% up to $500	
Tier 3	100% up to $500		100% up to $500	
Tier 4	100% up to $500		100% up to $500	
Pediatric Dental & Vision Coverage				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	20%
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	No copayment	50%	No copayment	50%

Select Plus/Core/Navigate (Network Only) State Bronze Plan Mapping

Plan Benefits	Bronze HDHP 4800/40%		Bronze HDHP 6000/40%	
	Prior to January 1, 2019		Effective January 1, 2019	
	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (individual/family)	$4,800/$9,600	$9,600/$19,200	$6,000/$12,000	$9,600/$19,200
Annual Out-of-Pocket Limit (individual/family)	$6,550/$13,100	$13,100/$26,200	$6,650/$13,300	$13,100/$26,200
Professional Services				
Office Visits - PCP	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Office Visits - Specialist	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Laboratory (standard)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Radiology (standard)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Maternity Care	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Inpatient Physician Care	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	40% after deductible	Same as Network benefit	40% after deductible	Same as Network benefit
Urgent Care Services	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Ambulance Services	40% after deductible	Same as Network benefit	40% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Durable Medical Equipment	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Home Health Services (Up to 100 visits per calendar year)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Infertility Services (Benefits limited to $2,000 per lifetime)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Injections Received in a Physician's Office	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (inidividual/family)	Annual Deductible applies		Annual Deductible applies	
Tier 1	40% up to $500		40% up to $500	
Tier 2	40% up to $500		40% up to $500	
Tier 3	40% up to $500		40% up to $500	
Tier 4	40% up to $500		40% up to $500	
Pediatric Dental & Vision Coverage				
Dental Exam (preventive/diagnostic)	No copayment	20%	No copayment	20%
Vision Exam (routine)	No copayment	50% after deductible	No copayment	50% after deductible
Glasses (frames & lenses)	No copayment	50% after deductible	No copayment	50% after deductible

Signature, Advantage, Alliance and Focus Platinum Plan Mapping

Plan Benefits	Platinum 20-40/30% Prior to January 1, 2019 Network	Platinum 20-40/20% Effective January 1, 2019 Network
Annual Deductible (individual/family)	None	None
Annual Out-of-Pocket Limit (individual/family)	$2,500/$5,000	$3,000/$6,000
Professional Services		
Office Visits - PCP	$20	$20
Office Visits - Specialist	$40	$40
Laboratory (standard)	$15	$25
Radiology (standard)	$15	$25
Maternity Care	No charge	No charge
Preventive Care Services	No charge	No charge
Hospitalization Services		
Inpatient Hospital Benefits	30%	20%
Inpatient Physician Care	No charge	No charge
Skilled Nursing Facility Care (100 days per benefit period)	30%	20%
Emergency Health Coverage		
Emergency Services	30%	20%
Urgently Needed Services – within physician service area	$20	$20
– outside physician service area	$50	$50
Ambulance Services	$100	$100
Outpatient Services		
Outpatient Surgery	30%	20%
Durable Medical Equipment	$50	$50
Home Health Services (Up to 100 visits per calendar year)	$20	$20
Infertility Services	Not covered	Not covered
Injectable Drugs	$150	$150
Mental Health & Substance Use Disorder Services		
Inpatient	30%	20%
Outpatient	$20	$20
Outpatient Prescription Drug Coverage		
Calendar Year Deductible (individual/family)	None	None
Tier 1	$15	$15
Tier 2	$35	$35
Tier 3	$50	$70
Tier 4	25% up to $250	25% up to $250
Pediatric Dental & Vision Coverage		
Dental Exam (preventive/diagnostic)	No charge	No charge
Vision Exam (routine)	No charge	No charge
Glasses (frames & lenses)	30%	20%

Signature, Advantage, Alliance and Focus Gold Plan Mapping

Plan Benefits	Gold 30-50/30%	Gold 30-60/20%/250ded	Gold 30-50/30%/1000ded	Gold 30-60/30%/1000ded
	Prior to January 1, 2019	Effective January 1, 2019	Prior to January 1, 2019	Effective January 1, 2019
	Network	Network	Network	Network
Annual Deductible (individual/family)	None	$250/$500	$1,000/$2,000	$1,000/$2,000
Annual Out-of-Pocket Limit (individual/family)	$5,500/$11,000	$6,000/$12,000	$5,500/$11,000	$6,000/$12,000
Professional Services				
Office Visits - PCP	$30	$30	$30	$30
Office Visits - Specialist	$50	$60	$50	$60
Laboratory (standard)	$25	$30	$25	$30
Radiology (standard)	$25	$30	$25	$30
Maternity Care	No charge	No charge	No charge	No charge
Preventive Care Services	No charge	No charge	No charge	No charge
Hospitalization Services				
Inpatient Hospital Benefits	30%	20% after deductible	30% after deductible	30% after deductible
Inpatient Physician Care	30%	20%	30%	30%
Skilled Nursing Facility Care (100 days per benefit period)	30%	20% after deductible	30% after deductible	30% after deductible
Emergency Health Coverage				
Emergency Services	30%	$500 after deductible	30% after deductible	30% after deductible
Urgently Needed Services – within physician service area	$30	$30	$30	$30
– outside physician service area	$75	$75	$75	$75
Ambulance Services	$100	$100	$100	$100
Outpatient Services				
Outpatient Surgery	30%	20% 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	$30	$30
Infertility Services	Not covered	Not covered	Not covered	Not covered
Injectable Drugs	$150	$150	$150	$150
Mental Health & Substance Use Disorder Services				
Inpatient	30%	20% after deductible	30% after deductible	30% after deductible
Outpatient	$30	$30	$30	$30
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	None	$250/$500 does not apply to Tier 1	None	$250/$500 does not apply to Tier 1
Tier 1	$15	$15	$15	$15
Tier 2	$35	$40	$35	$40
Tier 3	$70	$80	$70	$80
Tier 4	25% up to $250	25% up to $250	25% up to $250	25% up to $250
Pediatric Dental & Vision Coverage				
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%	20%	30%	30%

Signature, Advantage, Alliance and Focus Silver Plan Mapping

Plan Benefits	Silver 50-75/40%/2250ded	Silver 50-75/40%/2250ded	Silver 30%/2000ded (Alliance Only)	Silver 30%/2200ded (Alliance Only)
	Prior to January 1, 2019	Effective January 1, 2019	Prior to January 1, 2019	Effective January 1, 2019
	Network	Network	Network	Network
Annual Deductible (individual/family)	$2,250/$4,500	$2,250/$4,500	$2,000/$4,000	$2,200/$4400
Annual Out-of-Pocket Limit (individual/family)	$7,350/$14,700	$7,900/$15,800	$6,750/$13,500	$7,900/$15,800
Professional Services				
Office Visits - PCP	$50	$50	30% after deductible	30% after deductible
Office Visits - Specialist	$75	$75	30% after deductible	30% after deductible
Laboratory (standard)	$40	$40	30% after deductible	30% after deductible
Radiology (standard)	$40	$40	30% after deductible	30% after deductible
Maternity Care	No charge	No charge	30% after deductible	30% after deductible
Preventive Care Services	No charge	No charge	No charge	No charge
Hospitalization Services				
Inpatient Hospital Benefits	40% after deductible	40% after deductible	30% after deductible	30% after deductible
Inpatient Physician Care	40%	40%	30% after deductible	30% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	40% after deductible	40% after deductible	30% after deductible	30% after deductible
Emergency Health Coverage				
Emergency Services	40% after deductible	40% after deductible	30% after deductible	30% after deductible
Urgently Needed Services – within physician service area	$50	$50	30% after deductible	30% after deductible
– outside physician service area	$100	$100	30% after deductible	30% after deductible
Ambulance Services	$100	$100	30% after deductible	30% after deductible
Outpatient Services				
Outpatient Surgery	40% after deductible	40% after deductible	30% after deductible	30% after deductible
Durable Medical Equipment	$50	$50	30% after deductible	30% after deductible
Home Health Services (Up to 100 visits per calendar year)	$50	$50	30% after deductible	30% after deductible
Infertility Services	Not covered	Not covered	Not covered	Not covered
Injectable Drugs	$150	$150	30% after deductible	30% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	40% after deductible	40% after deductible	30% after deductible	30% after deductible
Outpatient	$50	$50	30% after deductible	30% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	$200/$400 does not apply to Tier 1	$250/$500 does not apply to Tier 1	$200/$400 does not apply to Tier 1	$250/$500 does not apply to Tier 1
Tier 1	$25	$20	$20	$20
Tier 2	$50	$50	$50	$50
Tier 3	$100	$100	$100	$100
Tier 4	25% up to $250	25% up to $250	25% up to $250	25% up to $250
Pediatric Dental & Vision Coverage				
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%

Alliance Bronze Plan Mapping

Plan Benefits	Bronze 30%/6250ded	Bronze HDHP 0%/6500ded	Bronze HSA 0%/6500ded	Bronze HDHP 0%/6500ded*
	Prior to January 1, 2019	Effective January 1, 2019	Prior to January 1, 2019	Effective January 1, 2019
	Network	Network	Network	Network
Annual Deductible (individual/family)	$6,250/$12,500	$6,500/$13,000	$6,500/$13,000	$6,500/$13,000
Annual Out-of-Pocket Limit (individual/family)	$7,350/$14,700	$6,500/$13,000	$6,500/$13,000	$6,500/$13,000
Professional Services				
Office Visits - PCP	30% after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Office Visits - Specialist	30% after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Laboratory (standard)	30% after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Radiology (standard)	30% after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Maternity Care	30% after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Preventive Care Services	No charge	No charge	No charge	No charge
Hospitalization Services				
Inpatient Hospital Benefits	30% after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Inpatient Physician Care	30% after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Skilled Nursing Facility Care (100 days per benefit period)	30% after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Emergency Health Coverage				
Emergency Services	30% after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Urgently Needed Services – within physician service area	30% after deductible	No charge after deductible	No charge after deductible	No charge after deductible
– outside physician service area	30% after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Ambulance Services	30% after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient Services				
Outpatient Surgery	30% after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Durable Medical Equipment	30% after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Home Health Services (Up to 100 visits per calendar year)	30% 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	30% after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	30% after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient	30% after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	$250/$500 does not apply to Tier 1	Annual Deductible applies	Annual Deductible applies	Annual Deductible applies
Tier 1	$25	No charge	No charge	No charge
Tier 2	$100	No charge	No charge	No charge
Tier 3	$150	No charge	No charge	No charge
Tier 4	30% up to $500	No charge	No charge	No charge
Pediatric Dental & Vision Coverage				
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%	No charge after deductible	No charge after deductible	No charge after deductible

* Only change is in detailed Pediatric Dental copay schedule.

Signature, Advantage, Alliance and Focus State Plan Mapping

Plan Benefits	Platinum 90 HMO 0/15	Platinum 90 HMO 0/15*	Gold 80 HMO 0/25	Gold 80 HMO 0/30
	Prior to January 1, 2019	Effective January 1, 2019	Prior to January 1, 2019	Effective January 1, 2019
	Network	Network	Network	Network
Annual Deductible (individual/family)	None	None	None	None
Annual Out-of-Pocket Limit (individual/family)	$3,350/$6,700	$3,350/$6,700	$6,000/$12,000	$7,200/$14,400
Professional Services				
Office Visits - PCP	$15	$15	$25	$30
Office Visits - Specialist	$30	$30	$55	$55
Laboratory - Standard	$15	$15	$35	$35
Radiology - Standard	$30	$30	$55	$55
Maternity Care	No charge	No charge	No charge	No charge
Preventive Care Services	No charge	No charge	No charge	No charge
Hospitalization Services				
Inpatient Hospital Benefits	10%	10%	20%	20%
Inpatient Physician Care	10%	10%	20%	20%
Skilled Nursing Facility Care (100 days per benefit period)	10%	10%	20%	20%
Emergency Health Coverage				
Emergency Services	$150	$150	$325	$325
Urgently Needed Services	$15	$15	$25	$30
Ambulance Services	$150	$150	$250	$250
Outpatient Services				
Outpatient Surgery	10%	10%	20%	20%
Durable Medical Equipment	10%	10%	20%	20%
Home Health Services (Up to 100 visits per calendar year)	10%	10%	20%	20%
Infertility Services	Not covered	Not covered	Not covered	Not covered
Injectable Drugs	10%	10%	20%	20%
Mental Health & Substance Use Disorder Services				
Inpatient	10%	10%	20%	20%
Outpatient	$15	$15	$25	$30
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	None	None	None	None
Tier 1	$5	$5	$15	$15
Tier 2	$15	$15	$55	$55
Tier 3	$25	$25	$75	$75
Tier 4	10% up to $250	10% up to $250	20% up to $250	20% up to $250
Pediatric Dental & Vision Coverage				
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	No charge	No charge	No charge

* Only change is in detailed Pediatric Dental copay schedule.

Signature, Advantage, Alliance and Focus State Plan Mapping

Plan Benefits	Silver 70 HMO 2000/45	Silver 70 HMO 2000/45	Bronze 60 HMO HDHP 4800/40% (Alliance only)	Bronze 60 HMO HDHP 6000/40% (Alliance only)
	Prior to January 1, 2019	Effective January 1, 2019	Prior to January 1, 2019	Effective January 1, 2019
	Network	Network	Network	Network
Annual Deductible (individual/family)	$2,000/$4,000	$2,000/$4,000	$4,800/$9,600	$6,000/$12,000
Annual Out-of-Pocket Limit (individual/family)	$7,000/$14,000	$7,550/$15,100	$6,550/$13,100	$6,650/$13,300
Professional Services				
Office Visits - PCP	$45	$45	40% after deductible	40% after deductible
Office Visits - Specialist	$75	$80	40% after deductible	40% after deductible
Laboratory - Standard	$40	$40	40% after deductible	40% after deductible
Radiology - Standard	$70	$75	40% after deductible	40% after deductible
Maternity Care	No charge	No charge	40% after deductible	40% after deductible
Preventive Care Services	No charge	No charge	No charge	No charge
Hospitalization Services				
Inpatient Hospital Benefits	20% after deductible	20% after deductible	40% after deductible	40% after deductible
Inpatient Physician Care	20% after deductible	20% after deductible	40% after deductible	40% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	20% after deductible	40% after deductible	40% after deductible
Emergency Health Coverage				
Emergency Services	$350	$350	40% after deductible	40% after deductible
Urgently Needed Services	$45	$45	40% after deductible	40% after deductible
Ambulance Services	$250 after deductible	$250 after deductible	40% after deductible	40% after deductible
Outpatient Services				
Outpatient Surgery	20%	20%	40% after deductible	40% after deductible
Durable Medical Equipment	20%	20%	40% after deductible	40% after deductible
Home Health Services (Up to 100 visits per calendar year)	20%	20%	40% after deductible	40% after deductible
Infertility Services	Not covered	Not covered	Not covered	Not covered
Injectable Drugs	20%	20%	40% after deductible	40% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	20% after deductible	20% after deductible	40% after deductible	40% after deductible
Outpatient	$45	$45	40% after deductible	40% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	$125/$250	$200/$400	Annual Deductible applies	Annual Deductible applies
Tier 1	$15	$15	40% up to $500	40% up to $500
Tier 2	$55	$55	40% up to $500	40% up to $500
Tier 3	$85	$85	40% up to $500	40% up to $500
Tier 4	20% up to $250	20% up to $250	40% up to $500	40% up to $500
Pediatric Dental & Vision Coverage				
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	No charge	No charge	No charge

* Only change is in detailed Pediatric Dental copay schedule.

Notes

Contact your UnitedHealthcare representative for more information.

UnitedHealthcare®

Facebook.com/UnitedHealthcare **Twitter**.com/myUHC **YouTube**.com/UnitedHealthcare

MT-992965.2 12/18 ©2018 United HealthCare Services, Inc. 400-6548 UHCCA685815-008 18-9754