Benefit Plan Changes.

Small Business (1–100)

For groups renewing Jan. 1, 2021, and after

United Healthcare

Signature, Advantage, Alliance, Harmony Plans – All Focus Network Plans Discontinued as of Jan. 1, 2021

	Prior to Jan. 1, 2021	Effective Jan. 1, 2021	Prior to Jan. 1, 2021	Effective Jan. 1, 2021
Metallic Level	**Platinum**			
HMO Plan	**20-40/500ded**	**20-40/400ded**	**20-40/20%**	**20-40/20%**
Annual Deductible[1] (individual/family)	None	None	None	None
Annual Out-of-Pocket Limit[2] (individual/family)	$3,000/$6,000	$3,000/$6,000	$3,500/$7,000	$3,500/$7,000
Professional Services				
Office Visits – PCP	$20	$20	$20	$20
Office Visits – Specialist	$40	$40	$40	$40
Laboratory (standard)	$15	$15	$25	$25
Radiology (standard)	$15	$15	$25	$25
Maternity Care	No charge	No charge	No charge	No charge
Preventive Care Services	No charge	No charge	No charge	No charge
Hospitalization Services				
Inpatient Hospital Benefits	$500/day, max 4 days per stay	$400/day, max 5 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 5 days per stay	20%	20%
Emergency Health Coverage				
Emergency Services	$400	$400	20%	20%
Urgently Needed Services - within physician servicearea	$20	$20	$20	$20
- outside physician service area	$50	$50	$50	$50
Ambulance Services	$100	$100	$100	$100
Outpatient Services				
Outpatient Surgery	$250	$250	20%	20%
Durable Medical Equipment	$50	$50	$50	$50
Home Health Services (up to 100 visits per calendar year)	$20	$20	$20	$20
Infertility Services	Not Covered	Not Covered	Not Covered	Not Covered
Injectable Drugs	$150	$150	$150	$150
Mental Health & Substance Use Disorder Services				
Inpatient	$500/day, max 4 days per stay	$400/day, max 5 days per stay	20%	20%
Outpatient	$20	$20	$20	$20
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	None	None	None	None
Tier 1	$15	$10	$15	$10
Tier 2	$35	$35	$35	$35
Tier 3	$70	$70	$70	$70
Tier 4	25% up to $250	25% up to $250	25% up to $250	25% up to $250
Pediatric Dental & Vision Coverage[3]				
Dental Exam (preventive/diagnostic)	No charge	No charge	No charge	No charge
Vision Exam (routine)	No charge	No charge	No charge	No charge
Glasses (frames & lenses)	10%	10%	20%	20%
Optional Group Coverage – Infertility Services	50%	50%	50%	50%

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

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

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

Signature, Advantage, Alliance, Harmony Plans – All Focus Network Plans Discontinued as of Jan. 1, 2021

	Prior to Jan. 1, 2021	Effective Jan. 1, 2021	Prior to Jan. 1, 2021	Effective Jan. 1, 2021
Metallic Level	**Platinum**		**Gold**	
HMO Plan	**0-80/20%**	**0-80/20% (Signature & Advantage Only)**	**30-60/1000ded**	**30-70/800ded**
Annual Deductible[1] (individual/family)	None	None	None	None
Annual Out-of-Pocket Limit[2] (individual/family)	$4,000/$8,000	$4,500/$9,000	$6,000/$12,000	$7,000/$14,000
Professional Services				
Office Visits – PCP	No charge	No charge	$30	$30
Office Visits – Specialist	$80	$80	$60	$70
Laboratory (standard)	$25	$25	$30	$30
Radiology (standard)	$25	$25	$30	$30
Maternity Care	No charge	No charge	No charge	No charge
Preventive Care Services	No charge	No charge	No charge	No charge
Hospitalization Services				
Inpatient Hospital Benefits	20%	20%	$1,000/day, max 4 days per stay	$800/day, max 5 days per stay
Inpatient Physician Care	No charge	No charge	No charge	No charge
Skilled Nursing Facility Care (100 days per benefit period)	20%	20%	$300/day, max 4 days per stay	$300/day, max 5 days per stay
Emergency Health Coverage				
Emergency Services	20%	20%	$500	$500
Urgently Needed Services - within physician service area	No charge	No charge	$30	$30
- outside physician service area	$50	$50	$75	$75
Ambulance Services	$100	$100	$100	$100
Outpatient Services				
Outpatient Surgery	20%	20%	$500	$500
Durable Medical Equipment	$50	$50	$50	$50
Home Health Services (up to 100 visits per calendar year)	No charge	No charge	$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	20%	20%	$600/day, max 4 days per stay	$600/day, max 5 days per stay
Outpatient	No charge	No charge	$30	$30
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	None	None	$100/$200 (does not apply to Tier 1)	$100/$200 (does not apply to Tier 1)
Tier 1	$5	$5	$15	$10
Tier 2	$35	$40	$40	$40
Tier 3	$70	$80	$80	$85
Tier 4	25% up to $250	25% up to $250	25% up to $250	25% up to $250
Pediatric Dental & Vision Coverage[3]				
Dental Exam (preventive/diagnostic)	No charge	No charge	No charge	No charge
Vision Exam (routine)	No charge	No charge	No charge	No charge
Glasses (frames & lenses)	20%	20%	10%	10%
Optional Group Coverage – Infertility Services	50%	50%	50%	50%

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

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

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

Signature, Advantage, Alliance, Harmony Plans – All Focus Network Plans Discontinued as of Jan. 1, 2021

	Prior to Jan. 1, 2021	Effective Jan. 1, 2021	Prior to Jan. 1, 2021	Effective Jan. 1, 2021
Metallic Level	**Gold**			
HMO Plan	**30-60/20%/500ded**	**30-70/20%/500ded**	**30-60/30%/1250ded**	**30-70/30%/1250ded**
Annual Deductible[1] (individual/family)	$500/$1,000	$500/$1,000	$1,250/$2,500	$1,250/$2,500
Annual Out-of-Pocket Limit[2] (individual/family)	$6,500/$13,000	$7,500/$15,000	$6,500/$13,000	$7,800/$15,600
Professional Services				
Office Visits – PCP	$30	$30	$30	$30
Office Visits – Specialist	$60	$70	$60	$70
Laboratory (standard)	$30	$30	$30	$30
Radiology (standard)	$30	$30	$30	$30
Maternity Care	No charge	No charge	No charge	No charge
Preventive Care Services	No charge	No charge	No charge	No charge
Hospitalization Services				
Inpatient Hospital Benefits	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Inpatient Physician Care	20%	20%	30%	30%
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Emergency Health Coverage				
Emergency Services	$500 after deductible	$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	20% after deductible	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	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Outpatient	$30	$30	$30	$30
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	$250/$500 (does not apply to Tier 1)	$250/$500 (does not apply to Tier 1)	$250/$500 (does not apply to Tier 1)	$250/$500 (does not apply to Tier 1)
Tier 1	$15	$10	$15	$10
Tier 2	$40	$40	$40	$40
Tier 3	$80	$85	$80	$85
Tier 4	25% up to $250	25% up to $250	25% up to $250	25% up to $250
Pediatric Dental & Vision Coverage[3]				
Dental Exam (preventive/diagnostic)	No charge	No charge	No charge	No charge
Vision Exam (routine)	No charge	No charge	No charge	No charge
Glasses (frames & lenses)	20%	20%	30%	30%
Optional Group Coverage – Infertility Services	50%	50%	50%	50%

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

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

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

Signature, Advantage, Alliance, Harmony Plans – All Focus Network Plans Discontinued as of Jan. 1, 2021

	Prior to Jan. 1, 2021	Effective Jan. 1, 2021	Prior to Jan. 1, 2021	Effective Jan. 1, 2021
Metallic Level	**Gold**		**Silver**	
HMO Plan	**0-80/30%/1500ded**	**0-90/30%/1750ded (Signature & Advantage Only)**	**55-80/40%/2250ded**	**50-90/40%/2250ded**
Annual Deductible[1] (individual/family)	$1,500/$3,000	$1,750/$3,500	$2,250/$4,500	$2,250/$4,500
Annual Out-of-Pocket Limit[2] (individual/family)	$7,500/$15,000	$8,000/$16,000	$8,150/$16,300	$8,550/$17,100
Professional Services				
Office Visits – PCP	No charge	No charge	$55	$50
Office Visits – Specialist	$80	$90	$80	$90
Laboratory (standard)	$30	$30	$45	$45
Radiology (standard)	$30	$30	$45	$45
Maternity Care	No charge	No charge	No charge	No charge
Preventive Care Services	No charge	No charge	No charge	No charge
Hospitalization Services				
Inpatient Hospital Benefits	30% after deductible	30% after deductible	40% after deductible	40% after deductible
Inpatient Physician Care	30%	30%	40%	40%
Skilled Nursing Facility Care (100 days per benefit period)	30% after deductible	30% after deductible	40% after deductible	40% after deductible
Emergency Health Coverage				
Emergency Services	30% after deductible	30% after deductible	40% after deductible	40% after deductible
Urgently Needed Services - within physician service area	No charge	No charge	$55	$50
- outside physician service area	$75	$75	$100	$100
Ambulance Services	$100	$100	$100	$100
Outpatient Services				
Outpatient Surgery	30% after deductible	30% after deductible	40% after deductible	40% after deductible
Durable Medical Equipment	$50	$50	$50	$50
Home Health Services (up to 100 visits per calendar year)	No charge	No charge	$55	$50
Infertility Services	Not covered	Not covered	Not covered	Not covered
Injectable Drugs	$150	$150	$150	$150
Mental Health & Substance Use Disorder Services				
Inpatient	30% after deductible	30% after deductible	40% after deductible	40% after deductible
Outpatient	No charge	No charge	$55	$50
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	$250/$500 (does not apply to Tier 1)	$250/$500 (does not apply to Tier 1)	$300/$600 (does not apply to Tier 1)	$300/$600 (does not apply to Tier 1)
Tier 1	$5	$5	$20	$15
Tier 2	$50	$50	$50	$50
Tier 3	$100	$100	$100	$100
Tier 4	25% up to $250	25% up to $250	25% up to $250	25% up to $250
Pediatric Dental & Vision Coverage[3]				
Dental Exam (preventive/diagnostic)	No charge	No charge	No charge	No charge
Vision Exam (routine)	No charge	No charge	No charge	No charge
Glasses (frames & lenses)	30%	30%	40%	40%
Optional Group Coverage – Infertility Services	50%	50%	50%	50%

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

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

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

Signature, Advantage, Alliance, Harmony Plans – All Focus Network Plans Discontinued as of Jan. 1, 2021

	Prior to Jan. 1, 2021	Effective Jan. 1, 2021
Metallic Level	**Silver**	
HMO Plan	**30%/2250ded (Alliance & Harmony only)**	**30%/2250ded (Harmony only)**
Annual Deductible[1] (individual/family)	$2,250/$4,500	$2,250/$4,500
Annual Out-of-Pocket Limit[2] (individual/family)	$8,150/$16,300	$8,550/$17,100
Professional Services		
Office Visits – PCP	30% after deductible	30% after deductible
Office Visits – Specialist	30% after deductible	30% after deductible
Laboratory (standard)	30% after deductible	30% after deductible
Radiology (standard)	30% after deductible	30% after deductible
Maternity Care	30% after deductible	30% after deductible
Preventive Care Services	No charge	No charge
Hospitalization Services		
Inpatient Hospital Benefits	30% after deductible	30% after deductible
Inpatient Physician Care	30% after deductible	30% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	30% after deductible	30% after deductible
Emergency Health Coverage		
Emergency Services	30% after deductible	30% after deductible
Urgently Needed Services - within physician service area	30% after deductible	30% after deductible
- outside physician service area	30% after deductible	30% after deductible
Ambulance Services	30% after deductible	30% after deductible
Outpatient Services		
Outpatient Surgery	30% after deductible	30% after deductible
Durable Medical Equipment	30% after deductible	30% after deductible
Home Health Services (up to 100 visits per calendar year)	30% after deductible	30% after deductible
Infertility Services	Not covered	Not covered
Injectable Drugs	30% after deductible	30% after deductible
Mental Health & Substance Use Disorder Services		
Inpatient	30% after deductible	30% after deductible
Outpatient	30% after deductible	30% after deductible
Outpatient Prescription Drug Coverage		
Calendar Year Deductible (individual/family)	$300/$600 (does not apply to Tier 1)	$300/$600 (does not apply to Tier 1)
Tier 1	$20	$15
Tier 2	$50	$50
Tier 3	$100	$100
Tier 4	25% up to $250	25% up to $250
Pediatric Dental & Vision Coverage[3]		
Dental Exam (preventive/diagnostic)	No charge	No charge
Vision Exam (routine)	No charge	No charge
Glasses (frames & lenses)	30%	30%
Optional Group Coverage – Infertility Services	50% after deductible	50% after deductible

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

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

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

Alliance State Plans

	Prior to Jan. 1, 2021	Effective Jan. 1, 2021	Prior to Jan. 1, 2021	Effective Jan. 1, 2021
Metallic Level	**Platinum**		**Gold**	
HMO Plan	**Platinum 90 HMO 0/15**	**Platinum 90 HMO 0/15**	**Gold 80 HMO 250/25**	**Gold 80 HMO 350/25**
Annual Deductible[1] (individual/family)	None	None	$250/$500	$350/$700
Annual Out-of-Pocket Limit[2] (individual/family)	$4,500/$9,000	$4,500/$9,000	$7,800/$15,600	$7,800/$15,600
Professional Services				
Office Visits – PCP	$15	$15	$25	$25
Office Visits – Specialist	$30	$30	$50	$50
Laboratory (standard)	$15	$15	$25	$25
Radiology (standard)	$30	$30	$65	$65
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% after deductible	20% after deductible
Inpatient Physician Care	10%	10%	20% after deductible	20% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	10%	10%	20% after deductible	20% after deductible
Emergency Health Coverage				
Emergency Services	$150	$200	$250 after deductible	20% after deductible
Urgently Needed Services - within physician service area	$15	$15	$25	$25
- outside physician service area	$15	$15	$25	$25
Ambulance Services	$150	$150	$250 after deductible	20% after deductible
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%	$30	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% after deductible	20% after deductible
Outpatient	$15	$15	$25	$25
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	None	None	None	None
Tier 1	$5	$10	$15	$15
Tier 2	$15	$25	$50	$50
Tier 3	$25	$40	$80	$80
Tier 4	10% up to $250	10% up to $250	20% up to $250	20% up to $250
Pediatric Dental & Vision Coverage[3]				
Dental Exam (preventive/diagnostic)	No charge	No charge	No charge	No charge
Vision Exam (routine)	No charge	No charge	No charge	No charge
Glasses (frames & lenses)	No charge	No charge	No charge	No charge
Optional Group Coverage – Infertility Services	50%	50%	50%	50%

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

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

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

Alliance State Plans

	Prior to Jan. 1, 2021	Effective Jan. 1, 2021
Metallic Level	**Silver**	
HMO Plan	**Silver 70 HMO 2250/50**	**Silver 70 HMO 2250/50**
Annual Deductible[1] (individual/family)	$2,250/$4,500	$2,250/$4,500
Annual Out-of-Pocket Limit[2] (individual/family)	$7,800/$15,600	$8,200/$16,400
Professional Services		
Office Visits – PCP	$50	$50
Office Visits – Specialist	$85	$85
Laboratory (standard)	$40	$50
Radiology (standard)	$85	$85
Maternity Care	No charge	No charge
Preventive Care Services	No charge	No charge
Hospitalization Services		
Inpatient Hospital Benefits	20% after deductible	30% after deductible
Inpatient Physician Care	20% after deductible	30% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	30% after deductible
Emergency Health Coverage		
Emergency Services	$400 after deductible	30% after deductible
Urgently Needed Services - within physician service area	$50	$50
- outside physician service area	$50	$50
Ambulance Services	$250 after deductible	30% after deductible
Outpatient Services		
Outpatient Surgery	20%	30% after deductible
Durable Medical Equipment	20%	30%
Home Health Services (up to 100 visits per calendar year)	20%	30%
Infertility Services	Not covered	Not covered
Injectable Drugs	20%	30%
Mental Health & Substance Use Disorder Services		
Inpatient	20% after deductible	30% after deductible
Outpatient	$50	$50
Outpatient Prescription Drug Coverage		
Calendar Year Deductible (individual/family)	$300/$600	$300/$600 (does not apply to Tier 1)
Tier 1	$17	$17
Tier 2	$65	$70
Tier 3	$90	$100
Tier 4	20% up to $250	30% up to $250
Pediatric Dental & Vision Coverage[3]		
Dental Exam (preventive/diagnostic)	No charge	No charge
Vision Exam (routine)	No charge	No charge
Glasses (frames & lenses)	No charge	No charge
Optional Group Coverage – Infertility Services	50%	50%

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

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

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

Select Plus and Core Plans

	Prior to Jan. 1, 2021		Effective Jan. 1, 2021	
Metallic Level	**Platinum**			
PPO Plan	**10/10%**		**15/10%**	
Network	**Network**	**Non-Network[1]**	**Network**	**Non-Network[1]**
Annual Deductible[2] (individual/family)	None	$1,000/$2,000	None	$1,000/$2,000
Annual Out-of-Pocket Maximum[3] (individual/family)	$3,500/$7,000	$7,000/$14,000	$3,600/$7,200	$7,200/$14,400
Professional Services				
Office Visits – PCP	$10	50% after deductible	$15	50% after deductible
Office Visits – Specialist	$25	50% after deductible	$40	50% after deductible
Laboratory[4] (standard)	10%	50% after deductible	10%	No benefit
Radiology[4] (standard)	10%	50% after deductible	10%	50% after deductible
Maternity Care[5]	$10	50% after deductible	$15	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	10%	50% after deductible	10%	50% after deductible
Inpatient Physician Care	10%	50% after deductible	10%	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	10%	50% after deductible	10%	50% after deductible
Emergency Health Coverage				
Emergency Services	10% plus $150 per occurrence deductible	Same as Network benefit	10% plus $150 per occurrence deductible	Same as Network benefit
Urgent Care Services	$50	50% after deductible	$50	50% after deductible
Ambulance Services	10%	Same as Network benefit	10%	Same as Network benefit
Outpatient Services				
Outpatient Surgery[4]	10%	50% after deductible	10%	50% after deductible
Durable Medical Equipment	10%	50% after deductible	10%	50% after deductible
Home Health Services (up to 100 visits per calendar year)	10%	50% after deductible	10%	50% after deductible
Infertility Services (benefits limited to $2,000 per lifetime)	10%	50% after deductible	10%	50% after deductible
Injections Received in a Physician's Office	$10	50% after deductible	$15	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	10%	50% after deductible	10%	50% after deductible
Outpatient	$10	50% after deductible	$15	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	None	No benefit	None	No benefit
Tier 1	$10		$5	
Tier 2	$35		$35	
Tier 3	$70		$80	
Tier 4	10% up to $250		25% up to $250	
Pediatric Dental & Vision Coverage[6]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	10%	50%	10%	50%

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

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

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

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

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

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

Select Plus and Core Plans

	Prior to Jan. 1, 2021		Effective Jan. 1, 2021	
Metallic Level	**Platinum**			
PPO Plan	**15/250/20%**		**15/250/20%**	
Network	**Network**	**Non-Network[1]**	**Network**	**Non-Network[1]**
Annual Deductible[2] (individual/family)	$250/$500	$1,000/$2,000	$250/$500	$1,000/$2,000
Annual Out-of-Pocket Maximum[3] (individual/family)	$3,500/$7,000	$7,000/$14,000	$3,600/$7,200	$7,200/$14,400
Professional Services				
Office Visits – PCP	$15	50% after deductible	$15	50% after deductible
Office Visits – Specialist	$30	50% after deductible	$40	50% after deductible
Laboratory[4] (standard)	20% after deductible	50% after deductible	20% after deductible	No benefit
Radiology[4] (standard)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Maternity Care[5]	$15	50% after deductible	$15	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Inpatient Physician Care	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	20% after deductible, plus $150 per occurrence deductible	Same as Network benefit	20% after deductible, plus $150 per occurrence deductible	Same as Network benefit
Urgent Care Services	$50	50% after deductible	$50	50% after deductible
Ambulance Services	20% after deductible	Same as Network benefit	20% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery[4]	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Durable Medical Equipment	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Home Health Services (up to 100 visits per calendar year)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Infertility Services (benefits limited to $2,000 per lifetime)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Injections Received in a Physician's Office	$15	50% after deductible	$15	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	$15	50% after deductible	$15	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	None	No benefit	None	No benefit
Tier 1	$10		$5	
Tier 2	$35		$35	
Tier 3	$70		$80	
Tier 4	10% up to $250		25% up to $250	
Pediatric Dental & Vision Coverage[6]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	20%	50%	20%	50%

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

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

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

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

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

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

Select Plus and Core Plans

	Prior to Jan. 1, 2021		Effective Jan. 1, 2021	
Metallic Level	**Platinum**			
PPO Plan	**250/20%**		**250/20%**	
Network	**Network**	**Non-Network[1]**	**Network**	**Non-Network[1]**
Annual Deductible[2] (individual/family)	$250/$500	$1,000/$2,000	$250/$500	$1,000/$2,000
Annual Out-of-Pocket Maximum[3] (individual/family)	$3,500/$7,000	$7,000/$14,000	$3,600/$7,200	$7,200/$14,400
Professional Services				
Office Visits – PCP	No copayment	50% after deductible	No copayment	50% after deductible
Office Visits – Specialist	$75	50% after deductible	$75	50% after deductible
Laboratory[4] (standard)	20% after deductible	50% after deductible	20% after deductible	No benefit
Radiology[4] (standard)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Maternity Care[5]	No copayment	50% after deductible	No copayment	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Inpatient Physician Care	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	20% after deductible, plus $150 per occurrence deductible	Same as Network benefit	20% after deductible, plus $150 per occurrence deductible	Same as Network benefit
Urgent Care Services	$50	50% after deductible	$50	50% after deductible
Ambulance Services	20% after deductible	Same as Network benefit	20% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery[4]	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Durable Medical Equipment	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Home Health Services (up to 100 visits per calendar year)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Infertility Services (benefits limited to $2,000 per lifetime)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Injections Received in a Physician's Office	No copayment	50% after deductible	No copayment	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	No copayment	50% after deductible	No copayment	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	None	No benefit	None	No benefit
Tier 1	$5		$5	
Tier 2	$35		$35	
Tier 3	$70		$80	
Tier 4	10% up to $250		25% up to $250	
Pediatric Dental & Vision Coverage[6]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	20%	50%	20%	50%

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

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

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

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

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

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

Select Plus and Core Plans

	Prior to Jan. 1, 2021		Effective Jan. 1, 2021	
Metallic Level	**Gold**			
PPO Plan	**25/30%**		**30/30%**	
Network	**Network**	**Non-Network[1]**	**Network**	**Non-Network[1]**
Annual Deductible[2] (individual/family)	None	$1,000/$2,000	None	$1,000/$2,000
Annual Out-of-Pocket Maximum[3] (individual/family)	$6,500/$13,000	$13,000/$26,000	$7,800/$15,600	$15,600/$31,200
Professional Services				
Office Visits – PCP	$25	50% after deductible	$30	50% after deductible
Office Visits – Specialist	$50	50% after deductible	$60	50% after deductible
Laboratory[4] (standard)	30% for independent, non-hospital affiliated provider; 50% for hospital affiliated provider	50% after deductible	30% for independent, non-hospital affiliated provider; 50% for hospital affiliated provider	No benefit
Radiology[4] (standard)		50% after deductible		50% after deductible
Maternity Care[5]	$25	50% after deductible	$30	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	30%	50% after deductible	30%	50% after deductible
Inpatient Physician Care	30%	50% after deductible	30%	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	30%	50% after deductible	30%	50% after deductible
Emergency Health Coverage				
Emergency Services	30% 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	30%	Same as Network benefit	30%	Same as Network benefit
Outpatient Services				
Outpatient Surgery[4]	30% 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	30%	50% after deductible	30%	50% after deductible
Home Health Services (up to 100 visits per calendar year)	30%	50% after deductible	30%	50% after deductible
Infertility Services (benefits limited to $2,000 per lifetime)	30%	50% after deductible	30%	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	30%	50% after deductible	30%	50% after deductible
Outpatient	$25	50% after deductible	$30	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	None	No benefit	None	No benefit
Tier 1	$15		$10	
Tier 2	$40		$40	
Tier 3	$80		$85	
Tier 4	25% up to $250		25% up to $250	
Pediatric Dental & Vision Coverage[6]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	30%	50%	30%	50%

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

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

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

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

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

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

Select Plus and Core Plans

	Prior to Jan. 1, 2021		Effective Jan. 1, 2021	
Metallic Level	**Gold**			
PPO Plan	**25/500/20%**		**30/500/20%**	
Network	**Network**	**Non-Network[1]**	**Network**	**Non-Network[1]**
Annual Deductible[2] (individual/family)	$500/$1,000	$1,000/$2,000	$500/$1,000	$1,000/$2,000
Annual Out-of-Pocket Maximum[3] (individual/family)	$6,500/$13,000	$13,000/$26,000	$7,800/$15,600	$15,600/$31,200
Professional Services				
Office Visits – PCP	$25	50% after deductible	$30	50% after deductible
Office Visits – Specialist	$50	50% after deductible	$60	50% after deductible
Laboratory[4] (standard)	20% after deductible for independent, non-hospital affiliated provider; 40% after deductible for hospital affiliated provider	50% after deductible	20% after deductible for independent, non-hospital affiliated provider; 40% after deductible for hospital affiliated provider	No benefit
Radiology[4] (standard)		50% after deductible		50% after deductible
Maternity Care[5]	$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% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Inpatient Physician Care	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	20% after deductible, plus $250 per occurrence deductible	Same as Network benefit	20% after deductible, plus $250 per occurrence deductible	Same as Network benefit
Urgent Care Services	$75	50% after deductible	$75	50% after deductible
Ambulance Services	20% after deductible	Same as Network benefit	20% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery[4]	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Durable Medical Equipment	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Home Health Services (up to 100 visits per calendar year)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Infertility Services (benefits limited to $2,000 per lifetime)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Injections Received in a Physician's Office	$25	50% after deductible	$25	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	$25	50% after deductible	$30	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	$250/$500 does not apply to Tier 1	No benefit	$300/$600 does not apply to Tier 1	No benefit
Tier 1	$15		$10	
Tier 2	$40		$40	
Tier 3	$80		$85	
Tier 4	25% up to $250		25% up to $250	
Pediatric Dental & Vision Coverage[6]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	20%	50%	20%	50%

[1] Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.
[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per occurrence deductible does not apply to the Annual Deductible.
[3] Member cost share, including office visits, annual deductible, per occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Maximum.
[4] The outpatient per occurrence deductible may be waived for outpatient services received at an in-network independent, non-hospital affiliated provider.
[5] No copayment applies to physician office visits for prenatal care.
[6] One routine vision exam and one pair of glasses per calendar year for children under age 19.

Select Plus and Core Plans

	Prior to Jan. 1, 2021		Effective Jan. 1, 2021	
Metallic Level	**Gold**			
PPO Plan	**25/1000/20%**		**35/1000/20%**	
Network	**Network**	**Non-Network[1]**	**Network**	**Non-Network[1]**
Annual Deductible[2] (individual/family)	$1,000/$2,000	$2,000/$4,000	$1,000/$2,000	$2,000/$4,000
Annual Out-of-Pocket Maximum[3] (individual/family)	$6,500/$13,000	$13,000/$26,000	$7,800/$15,600	$15,600/$31,200
Professional Services				
Office Visits – PCP	$25	50% after deductible	$35	50% after deductible
Office Visits – Specialist	$50	50% after deductible	$70	50% after deductible
Laboratory[4] (standard)	20% after deductible for independent, non-hospital affiliated provider; 40% after deductible for hospital affiliated provider	50% after deductible	20% after deductible for independent, non-hospital affiliated provider; 40% after deductible for hospital affiliated provider	No benefit
Radiology[4] (standard)		50% after deductible		50% after deductible
Maternity Care[5]	$25	50% after deductible	$35	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Inpatient Physician Care	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	20% after deductible, plus $250 per occurrence deductible	Same as Network benefit	20% after deductible, plus $250 per occurrence deductible	Same as Network benefit
Urgent Care Services	$75	50% after deductible	$75	50% after deductible
Ambulance Services	20% after deductible	Same as Network benefit	20% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery[4]	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	20% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Durable Medical Equipment	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Home Health Services (up to 100 visits per calendar year)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Infertility Services (benefits limited to $2,000 per lifetime)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Injections Received in a Physician's Office	$25	50% after deductible	$35	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	$35	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	$250/$500 does not apply to Tier 1	No benefit	$300/$600 does not apply to Tier 1	No benefit
Tier 1	$15		$10	
Tier 2	$40		$40	
Tier 3	$80		$85	
Tier 4	25% up to $250		25% up to $250	
Pediatric Dental & Vision Coverage[6]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	20%	50%	20%	50%

[1] Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.
[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per occurrence deductible does not apply to the Annual Deductible.
[3] Member cost share, including office visits, annual deductible, per occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Maximum.
[4] The outpatient per occurrence deductible may be waived for outpatient services received at an in-network independent, non-hospital affiliated provider.
[5] No copayment applies to physician office visits for prenatal care.
[6] One routine vision exam and one pair of glasses per calendar year for children under age 19.

Select Plus and Core Plans

	Prior to Jan. 1, 2021		Effective Jan. 1, 2021	
Metallic Level	**Gold**			
PPO Plan	**1500/30%**		**1500/30%**	
Network	**Network**	**Non-Network[1]**	**Network**	**Non-Network[1]**
Annual Deductible[2] (individual/family)	$1,500/$3,000	$3,000/$6,000	$1,500/$3,000	$3,000/$6,000
Annual Out-of-Pocket Maximum[3] (individual/family)	$6,500/$13,000	$13,000/$26,000	$8,000/$16,000	$16,000/$32,000
Professional Services				
Office Visits – PCP	No copayment	50% after deductible	No copayment	50% after deductible
Office Visits – Specialist	$75	50% after deductible	$90	50% after deductible
Laboratory[4] (standard)	30% after deductible for independent, non-hospital affiliated provider; 50% after deductible for hospital affiliated provider	50% after deductible	30% after deductible for independent, non-hospital affiliated provider; 50% after deductible for hospital affiliated provider	No benefit
Radiology[4] (standard)		50% after deductible		50% after deductible
Maternity Care[5]	No copayment	50% after deductible	No copayment	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	30% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	30% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Inpatient Physician Care	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	30% after deductible, plus $250 per occurrence deductible	Same as Network benefit	30% after deductible, plus $250 per occurrence deductible	Same as Network benefit
Urgent Care Services	$50	50% after deductible	$50	50% after deductible
Ambulance Services	30% after deductible	Same as Network benefit	30% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery[4]	30% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	30% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Durable Medical Equipment	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Home Health Services (up to 100 visits per calendar year)	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Infertility Services (benefits limited to $2,000 per lifetime)	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Injections Received in a Physician's Office	No copayment	50% after deductible	No copayment	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Outpatient	No copayment	50% after deductible	No copayment	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	$250/$500 does not apply to Tier 1	No benefit	$300/$600 does not apply to Tier 1	No benefit
Tier 1	$5		$5	
Tier 2	$50		$50	
Tier 3	$100		$100	
Tier 4	25% up to $250		25% up to $250	
Pediatric Dental & Vision Coverage[6]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	30%	50%	30%	50%

[1] Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.
[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per occurrence deductible does not apply to the Annual Deductible.
[3] Member cost share, including office visits, annual deductible, per occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Maximum.
[4] The outpatient per occurrence deductible may be waived for outpatient services received at an in-network independent, non-hospital affiliated provider.
[5] No copayment applies to physician office visits for prenatal care.
[6] One routine vision exam and one pair of glasses per calendar year for children under age 19.

Select Plus and Core Plans

	Prior to Jan. 1, 2021		Effective Jan. 1, 2021	
Metallic Level	**Silver**			
PPO Plan	**50/1500/40%**		**55/1750/40%**	
Network	**Network**	**Non-Network[1]**	**Network**	**Non-Network[1]**
Annual Deductible[2] (individual/family)	$1,500/$3,000	$3,000/$6,000	$1,750/$3,500	$3,500/$7,000
Annual Out-of-Pocket Maximum[3] (individual/family)	$8,150/$16,300	$16,300/$32,600	$8,500/$17,000	$17,000/$34,000
Professional Services				
Office Visits – PCP	$50	50% after deductible	$55	50% after deductible
Office Visits – Specialist	$80	50% after deductible	$95	50% after deductible
Laboratory[4] (standard)	40% after deductible for independent, non-hospital affiliated provider; 50% after deductible for hospital affiliated provider	50% after deductible	40% after deductible for independent, non-hospital affiliated provider; 50% after deductible for hospital affiliated provider	No benefit
Radiology[4] (standard)		50% after deductible		50% after deductible
Maternity Care[5]	$50	50% after deductible	$55	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	40% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	40% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Inpatient Physician Care	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	40% after deductible, plus $300 per occurrence deductible	Same as Network benefit	40% after deductible, plus $300 per occurrence deductible	Same as Network benefit
Urgent Care Services	$80	50% after deductible	$80	50% after deductible
Ambulance Services	40% after deductible	Same as Network benefit	40% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery[4]	40% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	40% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Durable Medical Equipment	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Home Health Services (up to 100 visits per calendar year)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Infertility Services (benefits limited to $2,000 per lifetime)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Injections Received in a Physician's Office	$50	50% after deductible	$55	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient	$50	50% after deductible	$55	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	$300/$600 does not apply to Tier 1	No benefit	$300/$600 does not apply to Tier 1	No benefit
Tier 1	$20		$15	
Tier 2	$50		$70	
Tier 3	$100		$115	
Tier 4	25% up to $250		25% up to $250	
Pediatric Dental & Vision Coverage[6]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	40%	50%	40%	50%

[1] Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.
[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per occurrence deductible does not apply to the Annual Deductible.
[3] Member cost share, including office visits, annual deductible, per occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Maximum.
[4] The outpatient per occurrence deductible may be waived for outpatient services received at an in-network independent, non-hospital affiliated provider.
[5] No copayment applies to physician office visits for prenatal care.
[6] One routine vision exam and one pair of glasses per calendar year for children under age 19.

Select Plus and Core Plans

	Prior to Jan. 1, 2021		Effective Jan. 1, 2021	
Metallic Level	**Silver**			
PPO Plan	**50/2250/40%**		**50/2250/40%**	
Network	**Network**	**Non-Network[1]**	**Network**	**Non-Network[1]**
Annual Deductible[2] (individual/family)	$2,250/$4,500	$4,500/$9,000	$2,250/$4,500	$4,500/$9,000
Annual Out-of-Pocket Maximum[3] (individual/family)	$8,150/$16,300	$16,300/$32,600	$8,500/$17,000	$17,000/$34,000
Professional Services				
Office Visits – PCP	$50	50% after deductible	$55	50% after deductible
Office Visits – Specialist	$80	50% after deductible	$95	50% after deductible
Laboratory[4] (standard)	40% after deductible for independent, non-hospital affiliated provider; 50% after deductible for hospital affiliated provider	50% after deductible	40% after deductible for independent, non-hospital affiliated provider; 50% after deductible for hospital affiliated provider	No benefit
Radiology[4] (standard)		50% after deductible		50% after deductible
Maternity Care[5]	$50	50% after deductible	$55	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	40% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	40% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Inpatient Physician Care	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	40% after deductible, plus $300 per occurrence deductible	Same as Network benefit	40% after deductible, plus $300 per occurrence deductible	Same as Network benefit
Urgent Care Services	$80	50% after deductible	$80	50% after deductible
Ambulance Services	40% after deductible	Same as Network benefit	40% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery[4]	40% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible	40% after deductible, plus $250 per occurrence deductible	50% after deductible, plus $250 per occurrence deductible
Durable Medical Equipment	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Home Health Services (up to 100 visits per calendar year)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Infertility Services (benefits limited to $2,000 per lifetime)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Injections Received in a Physician's Office	$50	50% after deductible	$55	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient	$50	50% after deductible	$55	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	$300/$600 does not apply to Tier 1	No benefit	$300/$600 does not apply to Tier 1	No benefit
Tier 1	$20		$15	
Tier 2	$50		$70	
Tier 3	$100		$115	
Tier 4	25% up to $250		25% up to $250	
Pediatric Dental & Vision Coverage[6]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	40%	50%	40%	50%

[1] Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.
[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per occurrence deductible does not apply to the Annual Deductible.
[3] Member cost share, including office visits, annual deductible, per occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Maximum.
[4] The outpatient per occurrence deductible may be waived for outpatient services received at an in-network independent, non-hospital affiliated provider.
[5] No copayment applies to physician office visits for prenatal care.
[6] One routine vision exam and one pair of glasses per calendar year for children under age 19.

Select Plus and Core Plans

	Prior to Jan. 1, 2021		Effective Jan. 1, 2021	
Metallic Level	**Silver**			
PPO Plan	**7200/40%**		**7200/40%**	
Network	**Network**	**Non-Network[1]**	**Network**	**Non-Network[1]**
Annual Deductible[2] (individual/family)	$7,200/$14,400	$14,400/$28,800	$7,200/$14,400	$14,400/$28,800
Annual Out-of-Pocket Maximum[3] (individual/family)	$8,150/$16,300	$16,300/$32,600	$8,500/$17,000	$17,000/$34,000
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[4] (standard)	40% after deductible	50% after deductible	40% after deductible	No benefit
Radiology[4] (standard)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Maternity Care[5]	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[4]	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 (individual/family)	$350/$700 does not apply to Tier 1	No benefit	$350/$700 does not apply to Tier 1	No benefit
Tier 1	$20		$15	
Tier 2	$50		$70	
Tier 3	$100		$115	
Tier 4	25% up to $500		25% up to $500	
Pediatric Dental & Vision Coverage[6]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	40%	50%	40%	50%

[1] Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.
[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year. The per occurrence deductible does not apply to the Annual Deductible.
[3] Member cost share, including office visits, annual deductible, per occurrence deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Maximum.
[4] The outpatient per occurrence deductible may be waived for outpatient services received at an in-network independent, non-hospital affiliated provider.
[5] No copayment applies to physician office visits for prenatal care.
[6] One routine vision exam and one pair of glasses per calendar year for children under age 19.

Select Plus and Core HDHP Plans

	Prior to Jan. 1, 2021		Effective Jan. 1, 2021	
Metallic Level	**Silver**			
PPO HDHP Plan	**HDHP w/Motion 2300/30%**		**HDHP w/Motion 2550/40%**	
Network	**Network**	**Non-Network[1]**	**Network**	**Non-Network[1]**
Annual Deductible[2] (individual/family)	$2,300/$2,800[5]	$4,600/$5,600[5]	$2,550/$2,800[5]	$5,100/$5,700[5]
Annual Out-of-Pocket Maximum[3] (individual/family)	$6,650/$13,300	$13,300/$26,600	$6,850/$13,700	$13,700/$27,400
Professional Services				
Office Visits – PCP	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Office Visits – Specialist	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Laboratory (standard)	30% after deductible	50% after deductible	40% after deductible	No benefit
Radiology (standard)	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Maternity Care	30% 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	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Inpatient Physician Care	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	30% after deductible	Same as Network benefit	40% after deductible	Same as Network benefit
Urgent Care Services	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Ambulance Services	30% after deductible	Same as Network benefit	40% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery	30% after deductible	50% after deductible	40% after deductible	50% after 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	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient	30% after deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	Annual Deductible applies	No benefit	Annual Deductible applies	No benefit
Tier 1	$20		$15	
Tier 2	$50		$70	
Tier 3	$100		$115	
Tier 4	25% up to $250		25% up to $250	
Pediatric Dental & Vision Coverage[4]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	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	40% after deductible	50% after deductible

[1] Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.
[2] The Annual Deductible is combined for medical and pharmacy benefits.
[3] Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Maximum. When a member of a family unit satisfies the individual Out-of-Pocket Maximum amount for the calendar year, no further copayments will be required for him or her for that calendar year.
[4] One routine vision exam and one pair of glasses per calendar year for children under age 19.
[5] The entire Family Deductible must be met before benefits can be paid for each eligible member of a family. One or more eligible members of a family unit may satisfy the Family Deductible.
[6] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

Select Plus and Core HDHP Plans

	Prior to Jan. 1, 2021		Effective Jan. 1, 2021	
Metallic Level	**Bronze**			
PPO HDHP Plan	**HDHP w/Motion 6900/0%**		**HDHP w/Motion 7000/0%**	
Network	**Network**	**Non-Network[1]**	**Network**	**Non-Network[1]**
Annual Deductible[2] (individual/family)	$6,900/$13,800[6]	$13,800/$27,600[6]	$7,000/$14,000[6]	$14,000/$28,000[6]
Annual Out-of-Pocket Maximum[3] (individual/family)	$6,900/$13,800	$13,800/$27,600	$7,000/$14,000	$14,000/$28,000
Professional Services				
Office Visits – PCP	No copay after deductible	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	No copay after deductible
Laboratory (standard)	No copay after deductible	No copay after deductible	No copay after deductible	No benefit
Radiology (standard)	No copay after deductible	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	No copay after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	No copay after deductible	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	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	No copay after deductible
Emergency Health Coverage				
Emergency Services	No copay after deductible	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	No copay after deductible
Ambulance Services	No copay after deductible	No copay after deductible	No copay after deductible	No copay after deductible
Outpatient Services				
Outpatient Surgery	No copay after deductible	No copay after deductible	No copay after deductible	No copay after deductible
Durable Medical Equipment	No copay after deductible	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	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	No copay after deductible
Injections Received in a Physician's Office	No copay after deductible	No copay after deductible	No copay after deductible	No copay after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	No copay after deductible	No copay after deductible	No copay after deductible	No copay after deductible
Outpatient	No copay after deductible	No copay after deductible	No copay after deductible	No copay after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	Annual Deductible applies	No benefit	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	
Pediatric Dental & Vision Coverage[4]				
Dental Exam (preventive/diagnostic)	No copayment	No copay after deductible	No copayment	No copay after deductible
Vision Exam (routine)	No copayment	No copay after deductible	No copayment	No copay after deductible
Glasses (frames & lenses)	No copay after deductible	No copay after deductible	No copay after deductible	No copay after deductible

[1] Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.
[2] The Annual Deductible is combined for medical and pharmacy benefits.
[3] Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Maximum. When a member of a family unit satisfies the individual Out-of-Pocket Maximum amount for the calendar year, no further copayments will be required for him or her for that calendar year.
[4] One routine vision exam and one pair of glasses per calendar year for children under age 19.
[5] The entire Family Deductible must be met before benefits can be paid for each eligible member of a family. One or more eligible members of a family unit may satisfy the Family Deductible.
[6] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.

Non-Differential PPO Plan

	Prior to Jan. 1, 2021	Effective Jan. 1, 2021
Metallic Level	**Silver**	
Non-Differential PPO Plan[1]	**HDHP w/Motion 6900/0%**	
Network	**Network & Non-Network[1]**	**Network & Non-Network[1]**
Annual Deductible[2] (individual/family)	$2,250/$4,500	$2,250/$4,500
Annual Out-of-Pocket Maximum[3] (individual/family)	$7,350/$14,700	$8,500/$17,000
Professional Services		
Office Visits – PCP	30% after deductible	30% after deductible
Office Visits – Specialist	30% after deductible	30% after deductible
Laboratory (standard)	30% after deductible	30% after deductible
Radiology (standard)	30% after deductible	30% after deductible
Maternity Care	30% after deductible	30% after deductible
Preventive Care Services	No copayment	No copayment
Hospitalization Services		
Inpatient Hospital Benefits	30% after deductible	30% after deductible
Inpatient Physician Care	30% after deductible	30% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	30% after deductible	30% after deductible
Emergency Health Coverage		
Emergency Services	30% after deductible	30% after deductible
Urgent Care Services	30% after deductible	30% after deductible
Ambulance Services	30% after deductible	30% after deductible
Outpatient Services		
Outpatient Surgery	30% after deductible	30% after deductible
Durable Medical Equipment	30% after deductible	30% after deductible
Home Health Services (up to 100 visits per calendaryear)	30% after deductible	30% after deductible
Infertility Services (benefits limited to $2,000 perlifetime)	30% after deductible	30% after deductible
Injections Received in a Physician'sOffice	30% after deductible	30% after deductible
Mental Health & Substance Use Disorder Services		
Inpatient	30% after deductible	30% after deductible
Outpatient	30% after deductible	30% after deductible
Outpatient Prescription Drug Coverage[4]		
Calendar YearDeductible (individual/family)	$200/$400 does not apply to Tier 1	$300/$600 does not apply to Tier 1
Tier 1	$20	$15
Tier 2	$50	$70
Tier 3	$100	$115
Tier 4	25% up to$250	25% up to$250
Pediatric Dental & Vision Coverage[5]		
Dental Exam (preventive/diagnostic)	No copayment	No copayment
Vision Exam (routine)	No copayment	No copayment
Glasses (frames & lenses)	30%	30%

[1] Out-of-area plan available outside of our contracted network service areas. Subject to underwriting guidelines.
[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendaryear.
[3] Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Maximum.
[4] Non-Network outpatient prescription drug coverage is not available.
[5] One routine vision exam and one pair of glasses per calendar year for children under age 19.

Core State Plans

	Prior to Jan. 1, 2021		Effective Jan. 1, 2021	
Metallic Level	**Platinum**			
PPO Plan	**15/10%**		**15/10%**	
Network	**Network**	**Non-Network[1]**	**Network**	**Non-Network[1]**
Annual Deductible[2] (individual/family)	None	$1,000/$2,000	None	$1,000/$2,000
Annual Out-of-Pocket Maximum[3] (individual/family)	$4,500/$9,000	$9,000/$18,000	$4,500/$9,000	$9,000/$18,000
Professional Services				
Office Visits – PCP	$15	50% after deductible	$15	50% after deductible
Office Visits – Specialist	$30	50% after deductible	$30	50% after deductible
Laboratory (standard)	$15	50% after deductible	$15	No benefit
Radiology (standard)	$30	50% after deductible	$30	50% after deductible
Maternity Care[4]	$15	50% after deductible	$15	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	10%	50% after deductible	10%	50% after deductible
Inpatient Physician Care	10%	50% after deductible	10%	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	10%	50% after deductible	10%	50% after deductible
Emergency Health Coverage				
Emergency Services	$150	Same as Network benefit	$150	Same as Network benefit
Urgent Care Services	$15	50% after deductible	$15	50% after deductible
Ambulance Services	$150	Same as Network benefit	$150	Same as Network benefit
Outpatient Services				
Outpatient Surgery	10%	50% after deductible	10%	50% after deductible
Durable Medical Equipment	10%	50% after deductible	10%	50% after deductible
Home Health Services (up to 100 visits per calendar year)	10%	50% after deductible	10%	50% after deductible
Infertility Services[6]				
Effective Jan. 1, 2021 – June 30, 2020 (Benefits limited to $2,000 per lifetime)	10%	50% after deductible	Not covered (See Optional Group Coverage below)	Not covered (See Optional Group Coverage below)
Effective July 1, 2020 – Dec. 31, 2020	Not covered (See Optional Group Coverage below)	Not covered (See Optional Group Coverage below)	Not covered (See Optional Group Coverage below)	Not covered (See Optional Group Coverage below)
Injections Received in a Physician's Office	$15	50% after deductible	$15	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	10%	50% after deductible	10%	50% after deductible
Outpatient	$15	50% after deductible	$15	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	None	No benefit	None	No benefit
Tier 1	$5		$5	
Tier 2	$15		$15	
Tier 3	$25		$25	
Tier 4	10% up to $250		10% up to $250	
Pediatric Dental & Vision Coverage[5]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	No copayment	50%	No copayment	50%
Optional Group Coverage – Infertility Services[6]				
Benefits limited to $2,000 medical and $1,500 drug coverage per lifetime	N/A	N/A	10%	50% after deductible

[1] Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.
[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.
[3] Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Maximum.
[4] No copayment applies to physician office visits for prenatal care.
[5] One routine vision exam and one pair of glasses per calendar year for children under age 19.
[6] Prior coverage of Infertility Services, effective Jan. 1, 2020 – June 30, 2020, included under medical. Effective July 1, 2020 – Dec. 31, 2020, excluded from medical and offered as optional group coverage.

Core State Plans

	Prior to Jan. 1, 2021		Effective Jan. 1, 2021	
Metallic Level	**Gold**			
PPO Plan	**25/250/20%**		**25/350/20%**	
Network	**Network**	**Non-Network[1]**	**Network**	**Non-Network[1]**
Annual Deductible[2] (individual/family)	$250/$500	$1,000/$2,000	$350/$700	$1,400/$2,800
Annual Out-of-Pocket Maximum[3] (individual/family)	$7,800/$15,600	$15,600/$31,200	$7,800/$15,600	$12,800/$25,600
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)	$25	50% after deductible	$25	No benefit
Radiology (standard)	$65	50% after deductible	$65	50% after deductible
Maternity Care[4]	$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	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	$250 after deductible	Same as Network benefit	20% after deductible	Same as Network benefit
Urgent Care Services	$25	50% after deductible	$25	50% after deductible
Ambulance Services	$250 after deductible	Same as Network benefit	20% 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[6]				
Effective Jan. 1, 2021 – June 30, 2020 (Benefits limited to $2,000 per lifetime)	20%	50% after deductible	Not covered (See Optional Group Coverage below)	Not covered (See Optional Group Coverage below)
Effective July 1, 2020 – Dec. 31, 2020	Not covered (See Optional Group Coverage below)	Not covered (See Optional Group Coverage below)	Not covered (See Optional Group Coverage below)	Not covered (See Optional Group Coverage below)
Injections Received in a Physician's Office	$25	50% after deductible	$25	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	$25	50% after deductible	$25	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	None	No benefit	None	No benefit
Tier 1	$15		$15	
Tier 2	$50		$50	
Tier 3	$80		$80	
Tier 4	20% up to $250		20% up to $250	
Pediatric Dental & Vision Coverage[5]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	No copayment	50%	No copayment	50%
Optional Group Coverage – Infertility Services[6]				
Benefits limited to $2,000 medical and $1,500 drug coverage per lifetime	N/A	N/A	20% after deductible	50% after deductible

[1] Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.
[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.
[3] Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Maximum.
[4] No copayment applies to physician office visits for prenatal care.
[5] One routine vision exam and one pair of glasses per calendar year for children under age 19.
[6] Prior coverage of Infertility Services, effective Jan. 1, 2020 – June 30, 2020, included under medical. Effective July 1, 2020 – Dec. 31, 2020, excluded from medical and offered as optional group coverage.

Core State Plans

	Prior to Jan. 1, 2021		Effective Jan. 1, 2021	
Metallic Level	**Silver**			
PPO Plan	**50/2250/20%**		**50/2250/20%**	
Network	**Network**	**Non-Network[1]**	**Network**	**Non-Network[1]**
Annual Deductible[2] (individual/family)	$2,250/$4,500	$4,500/$9,000	$2,250/$4,500	$4,500/$9,000
Annual Out-of-Pocket Maximum[3] (individual/family)	$7,800/$15,600	$15,600/$31,200	$8,200/$16,400	$15,900/$31,800
Professional Services				
Office Visits – PCP	$50	50% after deductible	$50	50% after deductible
Office Visits – Specialist	$85	50% after deductible	$85	50% after deductible
Laboratory (standard)	$40	50% after deductible	$50	No benefit
Radiology (standard)	$85	50% after deductible	$85	50% after deductible
Maternity Care[4]	$50	50% after deductible	$50	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	20% after deductible	50% after deductible	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	$400 after deductible	Same as Network benefit	30% after deductible	Same as Network benefit
Urgent Care Services	$50	50% after deductible	$50	50% after deductible
Ambulance Services	$250 after deductible	Same as Network benefit	30% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery	20%	50% after deductible	30% after deductible	50% after deductible
Durable Medical Equipment	20%	50% after deductible	30%	50% after deductible
Home Health Services (up to 100 visits per calendar year)	20%	50% after deductible	30%	50% after deductible
Infertility Services[6]				
Effective Jan. 1, 2021 – June 30, 2020 (Benefits limited to $2,000 per lifetime)	20%	50% after deductible	Not covered (See Optional Group Coverage below)	Not covered (See Optional Group Coverage below)
Effective July 1, 2020 – Dec. 31, 2020	Not covered (See Optional Group Coverage below)	Not covered (See Optional Group Coverage below)	Not covered (See Optional Group Coverage below)	Not covered (See Optional Group Coverage below)
Injections Received in a Physician's Office	$50	50% after deductible	$50	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Outpatient	$50	50% after deductible	$50	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	$300/$600	No benefit	$300/$600 does not apply to Tier 1	No benefit
Tier 1	$17		$17	
Tier 2	$65		$70	
Tier 3	$90		$100	
Tier 4	20% up to $250		30% up to $250	
Pediatric Dental & Vision Coverage[5]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	No copayment	50%	No copayment	50%
Optional Group Coverage – Infertility Services[6]				
Benefits limited to $2,000 medical and $1,500 drug coverage per lifetime	N/A	N/A	30% after deductible	50% after deductible

[1] Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.
[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.
[3] Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Maximum.
[4] No copayment applies to physician office visits for prenatal care.
[5] One routine vision exam and one pair of glasses per calendar year for children under age 19.
[6] Prior coverage of Infertility Services, effective Jan. 1, 2020 – June 30, 2020, included under medical. Effective July 1, 2020 – Dec. 31, 2020, excluded from medical and offered as optional group coverage.

Core State Plans

	Prior to Jan.1, 2021		Effective Jan.1, 2021	
Metallic Level	**Bronze**			
PPO Plan	**65/6300/40%**		**65/6300/40%**	
Network	**Network**	**Non-Network[1]**	**Network**	**Non-Network[1]**
Annual Deductible[2] (individual/family)	$6,300/$12,600	$12,600/$25,200	$6,300/$12,600	$12,600/$25,200
Annual Out-of-Pocket Maximum[3] (individual/family)	$7,800/$15,600	$15,600/$31,200	$8,200/$16,400	$15,900/$31,800
Professional Services				
Office Visits – PCP	$65 for first 3 visits, then deductible applies	50% after deductible	$65 for first 3 visits, then deductible applies	50% after deductible
Office Visits – Specialist	$95 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	No benefit
Radiology (standard)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Maternity Care[4]	$65	50% after deductible	$65	50% after deductible
Preventive Care Services	No copayment	No benefit	No copayment	No benefit
Hospitalization Services				
Inpatient Hospital Benefits	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Inpatient Physician Care	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Emergency Health Coverage				
Emergency Services	40% after deductible	Same as Network benefit	40% after deductible	Same as Network benefit
Urgent Care Services	$65 for first 3 visits, then deductible applies	50% after deductible	$65 for first 3 visits, then deductible applies	50% after deductible
Ambulance Services	40% after deductible	Same as Network benefit	40% after deductible	Same as Network benefit
Outpatient Services				
Outpatient Surgery	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Durable Medical Equipment	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Home Health Services (up to 100 visits per calendar year)	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Infertility Services[6]				
Effective Jan. 1, 2021 – June 30, 2020 (Benefits limited to $2,000 per lifetime)	40%	50% after deductible	Not covered (See Optional Group Coverage below)	Not covered (See Optional Group Coverage below)
Effective July 1, 2020 – Dec. 31, 2020	Not covered (See Optional Group Coverage below)	Not covered (See Optional Group Coverage below)	Not covered (See Optional Group Coverage below)	Not covered (See Optional Group Coverage below)
Injections Received in a Physician's Office	$65	50% after deductible	$65	50% after deductible
Mental Health & Substance Use Disorder Services				
Inpatient	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient	No copayment	50% after deductible	No copayment	50% after deductible
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	$500/$1,000	No benefit	$500/$1,000	No benefit
Tier 1	$18		$18	
Tier 2	40% up to $500		40% up to $500	
Tier 3	40% up to $500		40% up to $500	
Tier 4	40% up to $500		40% up to $500	
Pediatric Dental & Vision Coverage[5]				
Dental Exam (preventive/diagnostic)	No copayment	50% after deductible	No copayment	50% after deductible
Vision Exam (routine)	No copayment	50%	No copayment	50%
Glasses (frames & lenses)	40%	50%	40%	50%
Optional Group Coverage – Infertility Services[6]				
(Benefits limited to $2,000 medical and $1,500 drug coverage per lifetime)	N/A	N/A	40% after deductible	50% after deductible

[1] Reimbursement for Non-Network services is based on a percentage of the published rates allowed by Medicare for the same or similar services.
[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.
[3] Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Maximum.
[4] No copayment applies to physician office visits for prenatal care.
[5] One routine vision exam and one pair of glasses per calendar year for children under age 19.
[6] Prior coverage of Infertility Services, effective 1/1/2020 - 6/30/2020, included under medical. Effective 7/1/2020-12/31/2020, excluded from medical and offered as optional group coverage.

Navigate State Plans

	Prior to Jan. 1, 2021	Effective Jan. 1, 2021	Prior to Jan. 1, 2021	Effective Jan. 1, 2021
Metallic Level	**Platinum**		**Gold**	
EPO Plan	**15/10%**	**15/10%**	**25/250/20%**	**25/350/20%**
Network	**Network[1]**	**Network[1]**	**Network[1]**	**Network[1]**
Annual Deductible[2] (individual/family)	None	None	$250/$500	$350/$700
Annual Out-of-Pocket Maximum[3] (individual/family)	$4,500/$9,000	$4,500/$9,000	$7,800/$15,600	$7,800/$15,600
Professional Services				
Office Visits – PCP	$15	$15	$25	$25
Office Visits – Specialist	$30	$30	$50	$50
Laboratory (standard)	$15	$15	$25	$25
Radiology (standard)	$30	$30	$65	$65
Maternity Care[4]	$15	$15	$25	$25
Preventive Care Services	No copayment	No copayment	No copayment	No copayment
Hospitalization Services				
Inpatient Hospital Benefits	10%	10%	20% after deductible	20% after deductible
Inpatient Physician Care	10%	10%	20% after deductible	20% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	10%	10%	20% after deductible	20% after deductible
Emergency Health Coverage				
Emergency Services	$150	$200	$250 after deductible	20% after deductible
Urgent Care Services	$15	$15	$25	$25
Ambulance Services	$150	$150	$250 after deductible	20% after deductible
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 (benefits limited to $2,000 per lifetime)	10%	10%	20%	20%
Injections Received in a Physician's Office	$15	$15	$25	$25
Mental Health & Substance Use Disorder Services				
Inpatient	10%	10%	20% after deductible	20% after deductible
Outpatient	$15	$15	$25	$25
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	None	None	None	None
Tier 1	$5	$10	$15	$15
Tier 2	$15	$25	$50	$50
Tier 3	$25	$40	$80	$80
Tier 4	10% up to $250	10% up to $250	20% up to $250	20% up to $250
Pediatric Dental & Vision Coverage[5]				
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	No copayment	No copayment	No copayment

[1] No benefits for Non-Network services, except for emergency health and urgent care services. Members must obtain an electronic referral from their primary care physician before seeing another network physician.
[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.
[3] Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Maximum.
[4] No copayment applies to physician office visits for prenatal care.
[5] One routine vision exam and one pair of glasses per calendar year for children under age 19.

Navigate State Plans

	Prior to Jan. 1, 2021	Effective Jan. 1, 2021	Prior to Jan. 1, 2021	Effective Jan. 1, 2021
Metallic Level	**Silver**		**Bronze**	
EPO Plan	**50/2250/20%**	**50/2250/30%**	**65/6300/40%**	**65/6300/40%**
Network	**Network[1]**	**Network[1]**	**Network[1]**	**Network[1]**
Annual Deductible[2] (individual/family)	$2,250/$4,500	$2,250/$4,500	$6,300/$12,600	$6,300/$12,000
Annual Out-of-Pocket Maximum[3] (individual/family)	$7,800/$15,600	$8,200/$16,400	$7,800/$15,600	$8,200/$16,400
Professional Services				
Office Visits – PCP	$50	$50	$65 for first 3 visits, then deductible applies	$65 for first 3 visits, then deductible applies
Office Visits – Specialist	$85	$85	$95 for first 3 visits, then deductible applies	$95 for first 3 visits, then deductible applies
Laboratory (standard)	$40	$50	$40	$40
Radiology (standard)	$85	$85	40% after deductible	40% after deductible
Maternity Care[4]	$50	$50	$65	$65
Preventive Care Services	No copayment	No copayment	No copayment	No copayment
Hospitalization Services				
Inpatient Hospital Benefits	20% after deductible	30% after deductible	40% after deductible	40% after deductible
Inpatient Physician Care	20% after deductible	30% after deductible	40% after deductible	40% after deductible
Skilled Nursing Facility Care (100 days per benefit period)	20% after deductible	30% after deductible	40% after deductible	40% after deductible
Emergency Health Coverage				
Emergency Services	$400 after deductible	30% after deductible	40% after deductible	40% after deductible
Urgent Care Services	$50	$50	$65 for first 3 visits, then deductible applies	$65 for first 3 visits, then deductible applies
Ambulance Services	$250 after deductible	30% after deductible	40% after deductible	40% after deductible
Outpatient Services				
Outpatient Surgery	20%	30% after deductible	40% after deductible	40% after deductible
Durable Medical Equipment	20%	30%	40% after deductible	40% after deductible
Home Health Services (up to 100 visits per calendar year)	20%	30%	40% after deductible	40% after deductible
Infertility Services (benefits limited to $2,000 per lifetime)	20%	30%	40% after deductible	40% after deductible
Injections Received in a Physician's Office	$50	$50	$65	$65
Mental Health & Substance Use Disorder Services				
Inpatient	20% after deductible	30% after deductible	40% after deductible	40% after deductible
Outpatient	$50	$50	No copayment	No copayment
Outpatient Prescription Drug Coverage				
Calendar Year Deductible (individual/family)	$300/$600	$300/$600 does not apply to Tier 1	$500/$1,000	$500/$1,000
Tier 1	$17	$17	$18	$18
Tier 2	$65	$70	40% up to $500	40% up to $500
Tier 3	$90	$100	40% up to $500	40% up to $500
Tier 4	20% up to $250	30% up to $250	40% up to $500	40% up to $500
Pediatric Dental & Vision Coverage[5]				
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	No copayment	40%	40%

[1] No benefits for Non-Network services, except for emergency health and urgent care services. Members must obtain an electronic referral from their primary care physician before seeing another network physician.
[2] When a member of a family unit satisfies the individual Deductible amount for the calendar year, no further deductible will be required for him or her for that calendar year.
[3] Member cost share, including office visits, annual deductible, coinsurance and pharmacy, apply to the Out-of-Pocket Maximum.
[4] No copayment applies to physician office visits for prenatal care.
[5] One routine vision exam and one pair of glasses per calendar year for children under age 19.

Questions? Contact your UnitedHealthcare representative for more information.

United Healthcare

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