Standard Platinum Plan

2018 Standard Plan AV: 88.20%

	2019 Standard Platinum Plan
2019 Actuarial Value	88.92%
Individual Overall Deductible	$0
Other Individual Deductibles for Specific Services	
Medical	$0
Prescription Drugs	$0
Dental	$0
Individual Out-of-Pocket Maximum	$2,000

Common Medical Event	Service Type	Member Cost Share	Deductible Applies**
Health Care Provider's Office or Clinic visit	Primary Care Visit Or Non-Specialist Practitioner Visit to Treat an Injury or Illness	$20	
	Specialist Visit	$40	
	Preventive Care/Screening/Immunization	$0	
Tests	Laboratory Tests	$20	
	X-Rays And Diagnostic Imaging	$40	
	Imaging (CT/PET scans, MRIs)	$150	
Drugs to Treat Illness or Condition* **	Generic	$5	
	Preferred Brand	$15	
	Non-Preferred Brand	$25	
	Specialty	$100	
Outpatient Surgery	Facility Fee (e.g. Hospital Room)	$250	
	Physician/Surgeon Fee		
Outpatient Non-Surgical Clinic Visit*	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	$75	
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	$150	
	Emergency Medical Transportation	$150	
	Urgent Care	$40	
Hospital Stay	Facility Fee (e.g. Hospital Room)	$250 Per Day (Up To 5 Days)	
	Physician/Surgeon Fee		
Mental/Behavioral Health	Office Visits	$20	
	Outpatient Services	$20	
	Inpatient Services	$250 Per Day (Up To 5 Days)	
Substance Abuse Needs	Office Visits	$20	
	Outpatient Services	$20	
	Inpatient Services	$250 Per Day (Up To 5 Days)	
Pregnancy	Prenatal Care And Preconception Services	$0	
	Delivery And All Inpatient Services - Hospital	$250 Per Day (Up To 5 Days)	
	Delivery And All Inpatient Services - Prof		
Help Recovering or Other Special Health Needs	Home Health Care	$20	
	Outpatient Rehabilitation Services	$20	
	Outpatient Habilitation Services	$20	
	Skilled Nursing Care	$150 Per Day (Up To 5 Days)	
	Durable Medical Equipment	10%	
	Hospice Services	$0	
Child Eye Care	Eye Exam	$0	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0	
	Preventive - Cleaning	$0	
	Preventive - X-Ray	$0	
	Sealants - Per Tooth	$0	
	Topical Fluoride Application	$0	
	Space Maintainers - Fixed	$0	
Child Dental Basic Services	Amalgam Fill - 1 Surface	$25	
Child Dental Major Services	Root Canal - Molar	$300	
	Gingivectomy - Per Quad	$150	
	Extraction - Single Tooth Exposed Root	$65	
	Extraction - Complete Bony	$160	
	Porcelain With Metal Crown	$300	
Child Orthodontics	Medically Necessary Orthodontics	$1,000	

***Copay may not apply in staff model HMO setting.**

****If deductible applies to benefit, member must first satisfy the deductible before "Member Cost Share" is applied**

***** Cost sharing capped at $150 per script for specialty drugs**

Standard Gold Plan

2018 Standard Plan AV: 81.91%

	2019 Standard Gold Plan
2019 Actuarial Value	81.94%
Individual Overall Deductible	$500
Other Individual Deductibles for Specific Services	
Medical	$500
Prescription Drugs	$0
Dental	$0
Individual Out-of-Pocket Maximum	$4,000

Common Medical Event	Service Type	Member Cost Share	Deductible Applies**
Health Care Provider's Office or Clinic visit	Primary Care Visit Or Non-Specialist Practitioner Visit to Treat an Injury or Illness	$25	
	Specialist Visit	$50	
	Preventive Care/Screening/Immunization	$0	
Tests	Laboratory Tests	$30	
	X-Rays And Diagnostic Imaging	$50	
	Imaging (CT/PET scans, MRIs)	$250	
Drugs to Treat Illness or Condition* **	Generic	$15	
	Preferred Brand	$50	
	Non-Preferred Brand	$70	
	Specialty	$150	
Outpatient Surgery	Facility Fee (e.g. Hospital Room)	$600	
	Physician/Surgeon Fee		
Outpatient Non-Surgical Clinic Visit*	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	$75	
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	$300	
	Emergency Medical Transportation	$300	
	Urgent Care	$60	
Hospital Stay	Facility Fee (e.g. Hospital Room)	$600 Per Day (Up To 5 Days)	X
	Physician/Surgeon Fee		
Mental/Behavioral Health	Office Visits	$25	
	Outpatient Services	$25	
	Inpatient Services	$600 Per Day (Up To 5 Days)	X
Substance Abuse Needs	Office Visits	$25	
	Outpatient Services	$25	
	Inpatient Services	$600 Per Day (Up To 5 Days)	X
Pregnancy	Prenatal Care And Preconception Services	$0	
	Delivery And All Inpatient Services - Hospital	$600 Per Day (Up To 5 Days)	X
	Delivery And All Inpatient Services - Prof		
Help Recovering or Other Special Health Needs	Home Health Care	$30	
	Outpatient Rehabilitation Services	$30	
	Outpatient Habilitation Services	$30	
	Skilled Nursing Care	$300 Per Day (Up To 5 Days)	
	Durable Medical Equipment	20%	
	Hospice Services	$0	
Child Eye Care	Eye Exam	$0	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0	
	Preventive - Cleaning	$0	
	Preventive - X-Ray	$0	
	Sealants - Per Tooth	$0	
	Topical Fluoride Application	$0	
	Space Maintainers - Fixed	$0	
Child Dental Basic Services	Amalgam Fill - 1 Surface	$25	
Child Dental Major Services	Root Canal - Molar	$300	
	Gingivectomy - Per Quad	$150	
	Extraction - Single Tooth Exposed Root	$65	
	Extraction - Complete Bony	$160	
	Porcelain With Metal Crown	$300	
Child Orthodontics	Medically Necessary Orthodontics	$1,000	

***Copay may not apply in staff model HMO setting.**

****If deductible applies to benefit, member must first satisfy the deductible before "Member Cost Share" is applied**

***** Cost sharing capped at $150 per script for specialty drugs**

Standard Silver Plan

2018 Standard Plan AV: 71.96%

		2018 Standard Silver Plan		2019 Silver Alt 1		2019 Silver Alt 2	
2019 Actuarial Value		73.22%		72.02%		71.98%	
Individual Overall Deductible		$3,750		$3,750		$3,750	
Other Individual Deductibles for Specific Services							
Medical		$3,500		$3,500		$3,500	
Prescription Drugs		$250		$250		$250	
Dental		$0		$0		$0	
Individual Out-of-Pocket Maximum		$6,250		$7,250		$7,300	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies****	**Member Cost Share**	**Deductible Applies****	**Member Cost Share**	**Deductible Applies****
Health Care Provider's Office or Clinic visit	Primary Care Visit Or Non-Specialist Practitioner Visit to Treat an Injury or Illness	$40		$40		$40	
	Specialist Visit	$80		$80		$80	
	Preventive Care/Screening/Immunization	$0		$0		$0	
Tests	Laboratory Tests	$50		$50		$50	
	X-Rays And Diagnostic Imaging	$70		$80		$80	
	Imaging (CT/PET scans, MRIs)	$250		$250		$250	
Drugs to Treat Illness or Condition***	Generic	$15		$15		$15	
	Preferred Brand	$50	X	$50	X	$50	X
	Non-Preferred Brand	$70	X	$70	X	$70	X
	Specialty	$150	X	$150	X	$150	X
Outpatient Surgery	Facility Fee (e.g. Hospital Room)	20%	X	20%	X	20%	X
	Physician/Surgeon Fee						
Outpatient Non-Surgical Clinic Visit*	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	20%	X	20%	X	20%	X
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	$250	X	$350	X	$350	X
	Emergency Medical Transportation	$250	X	$350	X	$350	X
	Urgent Care	$90		$90		$90	
Hospital Stay	Facility Fee (e.g. Hospital Room)	20%	X	20%	X	20%	X
	Physician/Surgeon Fee						
Mental/Behavioral Health	Office Visits	$40		$40		$40	
	Outpatient Services	5%		5%		5%	
	Inpatient Services	20%	X	20%	X	20%	X
Substance Abuse Needs	Office Visits	$40		$40		$40	
	Outpatient Services	5%		5%		5%	
	Inpatient Services	20%	X	20%	X	20%	X
Pregnancy	Prenatal Care And Preconception Services	$0		$0		$0	
	Delivery And All Inpatient Services - Hospital	20%	X	20%	X	20%	X
	Delivery And All Inpatient Services - Prof						
Help Recovering or Other Special Health Needs	Home Health Care	$50		$50		$50	
	Outpatient Rehabilitation Services	$50		$50		$50	
	Outpatient Habilitation Services	$50		$50		$50	
	Skilled Nursing Care	20%	X	20%	X	20%	X
	Durable Medical Equipment	20%		20%		20%	
	Hospice Services	$0		$0		$0	
Child Eye Care	Eye Exam	$0		$0		$0	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	$0		$0		$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0		$0		$0	
	Preventive - Cleaning	$0		$0		$0	
	Preventive - X-Ray	$0		$0		$0	
	Sealants - Per Tooth	$0		$0		$0	
	Topical Fluoride Application	$0		$0		$0	
	Space Maintainers - Fixed	$0		$0		$0	
Child Dental Basic Services	Amalgam Fill - 1 Surface	$25		$25		$25	
Child Dental Major Services	Root Canal - Molar	$300		$300		$300	
	Gingivectomy - Per Quad	$150		$150		$150	
	Extraction - Single Tooth Exposed Root	$65		$65		$65	
	Extraction - Complete Bony	$160		$160		$160	
	Porcelain With Metal Crown	$300		$300		$300	
Child Orthodontics	Medically Necessary Orthodontics	$1,000		$1,000		$1,000	

***Copay may not apply in staff model HMO setting.**

****If deductible applies to benefit, member must first satisfy the deductible before "Member Cost Share" is applied**

***** Cost sharing capped at $150 per script for specialty drugs**

Standard Silver Plan

2018 Standard Plan AV: 71.96%

		2019 Silver Alt 3		2019 Silver Alt 4		2019 Silver Alt 5	
2019 Actuarial Value		71.87%		71.79%		72.06%	
Individual Overall Deductible		$4,000		$4,000		$3,750	
Other Individual Deductibles for Specific Services							
Medical		$3,750		$3,750		$3,500	
Prescription Drugs		$250		$250		$250	
Dental		$0		$0		$0	
Individual Out-of-Pocket Maximum		$7,250		$7,250		$7,400	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies****	**Member Cost Share**	**Deductible Applies****	**Member Cost Share**	**Deductible Applies****
Health Care Provider's Office or Clinic visit	Primary Care Visit Or Non-Specialist Practitioner Visit to Treat an Injury or Illness	$40		$40		$40	
	Specialist Visit	$80		$80		$80	
	Preventive Care/Screening/Immunization	$0		$0		$0	
Tests	Laboratory Tests	$50		$50		$50	
	X-Rays And Diagnostic Imaging	$70		$75		$70	
	Imaging (CT/PET scans, MRIs)	$250		$250		$250	
Drugs to Treat Illness or Condition***	Generic	$15		$15		$15	
	Preferred Brand	$50	X	$50	X	$50	X
	Non-Preferred Brand	$70	X	$70	X	$70	X
	Specialty	$150	X	$150	X	$150	X
Outpatient Surgery	Facility Fee (e.g. Hospital Room)	20%	X	20%	X	20%	X
	Physician/Surgeon Fee						
Outpatient Non-Surgical Clinic Visit*	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	20%	X	20%	X	20%	X
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	$350	X	$350	X	$350	X
	Emergency Medical Transportation	$350	X	$350	X	$350	X
	Urgent Care	$90		$90		$90	
Hospital Stay	Facility Fee (e.g. Hospital Room)	20%	X	20%	X	20%	X
	Physician/Surgeon Fee						
Mental/Behavioral Health	Office Visits	$40		$40		$40	
	Outpatient Services	5%		5%		5%	
	Inpatient Services	20%	X	20%	X	20%	X
Substance Abuse Needs	Office Visits	$40		$40		$40	
	Outpatient Services	5%		5%		5%	
	Inpatient Services	20%	X	20%	X	20%	X
Pregnancy	Prenatal Care And Preconception Services	$0		$0		$0	
	Delivery And All Inpatient Services - Hospital	20%	X	20%	X	20%	X
	Delivery And All Inpatient Services - Prof						
Help Recovering or Other Special Health Needs	Home Health Care	$50		$50		$50	
	Outpatient Rehabilitation Services	$50		$50		$50	
	Outpatient Habilitation Services	$50		$50		$50	
	Skilled Nursing Care	20%	X	20%	X	20%	X
	Durable Medical Equipment	20%		20%		20%	
	Hospice Services	$0		$0		$0	
Child Eye Care	Eye Exam	$0		$0		$0	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	$0		$0		$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0		$0		$0	
	Preventive - Cleaning	$0		$0		$0	
	Preventive - X-Ray	$0		$0		$0	
	Sealants - Per Tooth	$0		$0		$0	
	Topical Fluoride Application	$0		$0		$0	
	Space Maintainers - Fixed	$0		$0		$0	
Child Dental Basic Services	Amalgam Fill - 1 Surface	$25		$25		$25	
Child Dental Major Services	Root Canal - Molar	$300		$300		$300	
	Gingivectomy - Per Quad	$150		$150		$150	
	Extraction - Single Tooth Exposed Root	$65		$65		$65	
	Extraction - Complete Bony	$160		$160		$160	
	Porcelain With Metal Crown	$300		$300		$300	
Child Orthodontics	Medically Necessary Orthodontics	$1,000		$1,000		$1,000	

***Copay may not apply in staff model HMO setting.**

****If deductible applies to benefit, member must first satisfy the deductible before "Member C**

***** Cost sharing capped at $150 per script for specialty drugs**

Standard Bronze Plan

2018 Standard Plan AV: 64.81%

		2018 Standard Bronze Copay Plan		2019 Standard Bronze Copay Plan Alt 1		2019 Standard Bronze Copay Plan Alt 2	
2019 Actuarial Value		66.20%		65.21%		64.99%	
Individual Overall Deductible		$6,600		$6,850		$7,100	
Other Individual Deductibles for Specific Services							
Medical		$6,000		$6,250		$6,500	
Prescription Drugs		$600		$600		$600	
Dental		$0		$0		$0	
Individual Out-of-Pocket Maximum		$7,350		$7,850		$7,900	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies****	**Member Cost Share**	**Deductible Applies****	**Member Cost Share**	**Deductible Applies****
Health Care Provider's Office or Clinic visit	Primary Care Visit Or Non-Specialist Practitioner Visit to Treat an Injury or Illness	$50		$50		$50	
	Specialist Visit	$75		$80		$80	
	Preventive Care/Screening/Immunization	$0		$0		$0	
Tests	Laboratory Tests	$55	X	$55	X	$55	X
	X-Rays And Diagnostic Imaging	$75	X	$80	X	$80	X
	Imaging (CT/PET scans, MRIs)	$500	X	$500	X	$500	X
Drugs to Treat Illness or Condition***	Generic	$25		$25		$25	
	Preferred Brand	$75	X	$75	X	$75	X
	Non-Preferred Brand	$100	X	$100	X	$100	X
	Specialty	$150	X	$150	X	$150	X
Outpatient Surgery	Facility Fee (e.g. Hospital Room)	25%	X	25%	X	25%	X
	Physician/Surgeon Fee						
Outpatient Non-Surgical Clinic Visit*	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	25%	X	25%	X	25%	X
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	25%	X	25%	X	25%	X
	Emergency Medical Transportation	25%	X	25%	X	25%	X
	Urgent Care	$100		$100		$100	
Hospital Stay	Facility Fee (e.g. Hospital Room)	25%	X	25%	X	25%	X
	Physician/Surgeon Fee						
Mental/Behavioral Health	Office Visits	$50		$50		$50	
	Outpatient Services	10%		10%		10%	
	Inpatient Services	25%	X	25%	X	25%	X
Substance Abuse Needs	Office Visits	$50		$50		$50	
	Outpatient Services	10%		10%		10%	
	Inpatient Services	25%	X	25%	X	25%	X
Pregnancy	Prenatal Care And Preconception Services	$0		$0		$0	
	Delivery And All Inpatient Services - Hospital	25%	X	25%	X	25%	X
	Delivery And All Inpatient Services - Prof						
Help Recovering or Other Special Health Needs	Home Health Care (Up to 90 Visits for 4 Hours per Calendar Yr)	$50	X	$50	X	$50	X
	Outpatient Rehabilitation Services	$50	X	$50	X	$50	X
	Outpatient Habilitation Services	$50	X	$50	X	$50	X
	Skilled Nursing Care	25%	X	25%	X	25%	X
	Durable Medical Equipment	25%	X	25%	X	25%	X
	Hospice Services	25%	X	25%	X	25%	X
Child Eye Care	Eye Exam (OD)	$50		$50		$50	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	$0		$0		$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0		$0		$0	
	Preventive - Cleaning	$0		$0		$0	
	Preventive - X-Ray	$0		$0		$0	
	Sealants - Per Tooth	$0		$0		$0	
	Topical Fluoride Application	$0		$0		$0	
	Space Maintainers - Fixed	$0		$0		$0	
Child Dental Basic Services	Amalgam Fill - 1 Surface	$41		$41		$41	
Child Dental Major Services	Root Canal - Molar	$512		$512		$512	
	Gingivectomy - Per Quad	$279		$279		$279	
	Extraction - Single Tooth Exposed Root	$69		$69		$69	
	Extraction - Complete Bony	$241		$241		$241	
	Porcelain With Metal Crown	$523		$523		$523	
Child Orthodontics	Medically Necessary Orthodontics	$3,422		$3,422		$3,422	

***Copay may not apply in staff model HMO setting.**

****If deductible applies to benefit, member must first satisfy the deductible before "Member Cost Share" is applied**

***** Cost sharing capped at $150 per script for specialty drugs**

Standard Bronze Plan

2018 Standard Plan AV: 60.61%

		2019 Standard Bronze HDHP Plan	
2019 Actuarial Value		61.82%	
Individual Overall Deductible		$6,200	
Other Individual Deductibles for Specific Services			
Medical		$6,200	
Prescription Drugs		Integrated with Medical	
Dental		$0	
Individual Out-of-Pocket Maximum		$6,550	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies****
Health Care Provider's Office or Clinic visit	Primary Care Visit Or Non-Specialist Practitioner Visit to Treat an Injury or Illness	20%	X
	Specialist Visit	20%	X
	Preventive Care/Screening/Immunization	$0	
Tests	Laboratory Tests	20%	X
	X-Rays And Diagnostic Imaging	20%	X
	Imaging (CT/PET scans, MRIs)	20%	X
Drugs to Treat Illness or Condition***	Generic	20%	X
	Preferred Brand	20%	X
	Non-Preferred Brand	20%	X
	Specialty	20%	X
Outpatient Surgery	Facility Fee (e.g. Hospital Room)	20%	X
	Physician/Surgeon Fee		
Outpatient Non-Surgical Clinic Visit*	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	20%	X
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	20%	X
	Emergency Medical Transportation	20%	X
	Urgent Care	20%	X
Hospital Stay	Facility Fee (e.g. Hospital Room)	20%	X
	Physician/Surgeon Fee		
Mental/Behavioral Health	Office Visits	20%	X
	Outpatient Services	20%	X
	Inpatient Services	20%	X
Substance Abuse Needs	Office Visits	20%	X
	Outpatient Services	20%	X
	Inpatient Services	20%	X
Pregnancy	Prenatal Care And Preconception Services	$0	
	Delivery And All Inpatient Services - Hospital	20%	X
	Delivery And All Inpatient Services - Prof		
Help Recovering or Other Special Health Needs	Home Health Care (Up to 90 Visits for 4 Hours per Calendar Yr)	20%	X
	Outpatient Rehabilitation Services	20%	X
	Outpatient Habilitation Services	20%	X
	Skilled Nursing Care	20%	X
	Durable Medical Equipment	20%	X
	Hospice Services	20%	X
Child Eye Care	Eye Exam (OD)	$50	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0	
	Preventive - Cleaning	$0	
	Preventive - X-Ray	$0	
	Sealants - Per Tooth	$0	
	Topical Fluoride Application	$0	
	Space Maintainers - Fixed	$0	
Child Dental Basic Services	Amalgam Fill - 1 Surface	$41	
Child Dental Major Services	Root Canal - Molar	$512	
	Gingivectomy - Per Quad	$279	
	Extraction - Single Tooth Exposed Root	$69	
	Extraction - Complete Bony	$241	
	Porcelain With Metal Crown	$523	
Child Orthodontics	Medically Necessary Orthodontics	$3,422	

***Copay may not apply in staff model HMO setting.**

****If deductible applies to benefit, member must first satisfy the deductible before "Member C**

***** Cost sharing capped at $150 per script for specialty drugs**