

## Standard Platinum Plan

2019 Standard Plan AV:

88.92%

		2019 Standard Platinum Plan	
<b>2020 Actuarial Value</b>		89.59%	
<b>Individual Overall Deductible</b>		\$0	
<b>Other Individual Deductibles for Specific Services</b>			
<b>Medical</b>		\$0	
<b>Prescription Drugs</b>		\$0	
<b>Dental</b>		\$0	
<b>Individual Out-of-Pocket Maximum</b>		\$2,000	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies**
<b>Health Care Provider's Office or Clinic visit</b>	Primary Care Visit Or Non-Specialist Practitioner Visit to Treat an Injury or Illness	\$20	
	Specialist Visit	\$40	
	Preventive Care/Screening/Immunization	\$0	
<b>Tests</b>	Laboratory Tests	\$20	
	X-Rays And Diagnostic Imaging	\$40	
	Imaging (CT/PET scans, MRIs)	\$150	
<b>Drugs to Treat Illness or Condition***</b>	Generic	\$5	
	Preferred Brand	\$15	
	Non-Preferred Brand	\$25	
	Specialty	\$100	
<b>Outpatient Surgery</b>	Facility Fee (e.g. Hospital Room)	\$250	
	Physician/Surgeon Fee		
<b>Outpatient Non-Surgical Clinic Visit*</b>	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	\$75	
<b>Need Immediate Attention</b>	Emergency Room Services (Waived If Admitted)	\$150	
	Emergency Medical Transportation	\$150	
	Urgent Care	\$40	
<b>Hospital Stay</b>	Facility Fee (e.g. Hospital Room)	\$250 Per Day	
	Physician/Surgeon Fee	(Up To 5 Days)	
<b>Mental/Behavioral Health</b>	Office Visits	\$20	
	Outpatient Services	\$20	
	Inpatient Services	\$250 Per Day (Up To 5 Days)	
<b>Substance Abuse Needs</b>	Office Visits	\$20	
	Outpatient Services	\$20	
	Inpatient Services	\$250 Per Day (Up To 5 Days)	
<b>Pregnancy</b>	Prenatal Care And Preconception Services	\$0	
	Delivery And All Inpatient Services - Hospital	\$250 Per Day	
	Delivery And All Inpatient Services - Prof	(Up To 5 Days)	
<b>Help Recovering or Other Special Health Needs</b>	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	
<b>Child Eye Care</b>	Eye Exam	\$0	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	\$0	
<b>Child Dental Diagnostic and Preventive</b>	Oral Exam	\$0	
	Preventive - Cleaning	\$0	
	Preventive - X-Ray	\$0	
	Sealants - Per Tooth	\$0	
	Topical Fluoride Application	\$0	
	Space Maintainers - Fixed	\$0	
<b>Child Dental Basic Services</b>	Amalgam Fill - 1 Surface	\$25	
<b>Child Dental Major Services</b>	Root Canal - Molar	\$300	
	Gingivectomy - Per Quad	\$150	
	Extraction - Single Tooth Exposed Root	\$65	
	Extraction - Complete Bony	\$160	
	Porcelain With Metal Crown	\$300	
<b>Child Orthodontics</b>	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**

2019 Standard Plan AV:

81.94%

2020 Actuarial Value		2019 Standard Gold Plan		2020 Standard Gold Plan Alt 1	
Individual Overall Deductible		\$500		\$500	
Other Individual Deductibles for Specific Services					
Medical		\$500		\$500	
Prescription Drugs		\$0		\$0	
Dental		\$0		\$0	
Individual Out-of-Pocket Maximum		\$4,000		\$4,650	
Common Medical Event	Service Type	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	\$25		\$25	
	Specialist Visit	\$50		\$50	
	Preventive Care/Screening/Immunization	\$0		\$0	
Tests	Laboratory Tests	\$30		\$30	
	X-Rays And Diagnostic Imaging	\$50		\$50	
	Imaging (CT/PET scans, MRIs)	\$250		\$250	
Drugs to Treat Illness or Condition***	Generic	\$15		\$15	
	Preferred Brand	\$50		\$50	
	Non-Preferred Brand	\$70		\$70	
	Specialty	\$150		\$150	
Outpatient Surgery	Facility Fee (e.g. Hospital Room)				
	Physician/Surgeon Fee	\$600		\$600	
Outpatient Non-Surgical Clinic Visit*	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	\$75		\$75	
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	\$300		\$300	
	Emergency Medical Transportation	\$300		\$300	
	Urgent Care	\$60		\$60	
Hospital Stay	Facility Fee (e.g. Hospital Room)				
	Physician/Surgeon Fee	\$600 Per Day (Up To 5 Days)	X	\$600 Per Day (Up To 5 Days)	X
Mental/Behavioral Health	Office Visits	\$25		\$25	
	Outpatient Services	\$25		\$25	
	Inpatient Services	\$600 Per Day (Up To 5 Days)	X	\$600 Per Day (Up To 5 Days)	X
Substance Abuse Needs	Office Visits	\$25		\$25	
	Outpatient Services	\$25		\$25	
	Inpatient Services	\$600 Per Day (Up To 5 Days)	X	\$600 Per Day (Up To 5 Days)	X
Pregnancy	Prenatal Care And Preconception Services	\$0		\$0	
	Delivery And All Inpatient Services - Hospital	\$600 Per Day (Up To 5 Days)	X	\$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		\$30	
	Outpatient Rehabilitation Services	\$30		\$30	
	Outpatient Habilitation Services	\$30		\$30	
	Skilled Nursing Care	\$300 Per Day (Up To 5 Days)		\$300 Per Day (Up To 5 Days)	
	Durable Medical Equipment	20%		20%	
	Hospice Services	\$0		\$0	
Child Eye Care	Eye Exam	\$0		\$0	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	\$0		\$0	
Child Dental Diagnostic and Preventive	Oral Exam	\$0		\$0	
	Preventive - Cleaning	\$0		\$0	
	Preventive - X-Ray	\$0		\$0	
	Sealants - Per Tooth	\$0		\$0	
	Topical Fluoride Application	\$0		\$0	
	Space Maintainers - Fixed	\$0		\$0	
Child Dental Basic Services	Amalgam Fill - 1 Surface	\$25		\$25	
	Root Canal - Molar	\$300		\$300	
Child Dental Major Services	Gingivectomy - Per Quad	\$150		\$150	
	Extraction - Single Tooth Exposed Root	\$65		\$65	
	Extraction - Complete Bony	\$160		\$160	
	Porcelain With Metal Crown	\$300		\$300	
Child Orthodontics	Medically Necessary Orthodontics	\$1,000		\$1,000	

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\*\*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**

2019 Standard Plan AV:

81.94%

2020 Actuarial Value		2019 Standard Gold Plan		2020 Standard Gold Plan Alt 2	
Individual Overall Deductible		83.01%		82.00%	
Other Individual Deductibles for Specific Services		\$500		\$500	
Medical		\$500		\$500	
Prescription Drugs		\$0		\$0	
Dental		\$0		\$0	
Individual Out-of-Pocket Maximum		\$4,000		\$4,300	
Common Medical Event	Service Type	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	\$25		\$25	
	Specialist Visit	\$50		\$50	
	Preventive Care/Screening/Immunization	\$0		\$0	
Tests	Laboratory Tests	\$30		\$45	
	X-Rays And Diagnostic Imaging	\$50		\$65	
	Imaging (CT/PET scans, MRIs)	\$250		\$250	
Drugs to Treat Illness or Condition***	Generic	\$15		\$15	
	Preferred Brand	\$50		\$50	
	Non-Preferred Brand	\$70		\$70	
	Specialty	\$150		\$150	
Outpatient Surgery	Facility Fee (e.g. Hospital Room)				
	Physician/Surgeon Fee	\$600		\$600	
Outpatient Non-Surgical Clinic Visit*	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	\$75		\$75	
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	\$300		\$300	
	Emergency Medical Transportation	\$300		\$300	
	Urgent Care	\$60		\$60	
Hospital Stay	Facility Fee (e.g. Hospital Room)				
	Physician/Surgeon Fee	\$600 Per Day (Up To 5 Days)	X	\$600 Per Day (Up To 5 Days)	X
Mental/Behavioral Health	Office Visits	\$25		\$25	
	Outpatient Services	\$25		\$25	
	Inpatient Services	\$600 Per Day (Up To 5 Days)	X	\$600 Per Day (Up To 5 Days)	X
Substance Abuse Needs	Office Visits	\$25		\$25	
	Outpatient Services	\$25		\$25	
	Inpatient Services	\$600 Per Day (Up To 5 Days)	X	\$600 Per Day (Up To 5 Days)	X
Pregnancy	Prenatal Care And Preconception Services	\$0		\$0	
	Delivery And All Inpatient Services - Hospital	\$600 Per Day (Up To 5 Days)	X	\$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		\$30	
	Outpatient Rehabilitation Services	\$30		\$60	
	Outpatient Habilitation Services	\$30		\$60	
	Skilled Nursing Care	\$300 Per Day (Up To 5 Days)		\$300 Per Day (Up To 5 Days)	
	Durable Medical Equipment	20%		20%	
	Hospice Services	\$0		\$0	
Child Eye Care	Eye Exam	\$0		\$0	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	\$0		\$0	
Child Dental Diagnostic and Preventive	Oral Exam	\$0		\$0	
	Preventive - Cleaning	\$0		\$0	
	Preventive - X-Ray	\$0		\$0	
	Sealants - Per Tooth	\$0		\$0	
	Topical Fluoride Application	\$0		\$0	
	Space Maintainers - Fixed	\$0		\$0	
Child Dental Basic Services	Amalgam Fill - 1 Surface	\$25		\$25	
	Root Canal - Molar	\$300		\$300	
Child Dental Major Services	Gingivectomy - Per Quad	\$150		\$150	
	Extraction - Single Tooth Exposed Root	\$65		\$65	
	Extraction - Complete Bony	\$160		\$160	
	Porcelain With Metal Crown	\$300		\$300	
Child Orthodontics	Medically Necessary Orthodontics	\$1,000		\$1,000	

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

**Standard Gold Plan**

2019 Standard Plan AV:

81.94%

2020 Actuarial Value		2019 Standard Gold Plan		2020 Standard Gold Plan Alt 3	
<b>Individual Overall Deductible</b>		83.01%		81.96%	
<b>Other Individual Deductibles for Specific Services</b>		\$500		\$500	
<b>Medical</b>		\$500		\$500	
<b>Prescription Drugs</b>		\$0		\$0	
<b>Dental</b>		\$0		\$0	
<b>Individual Out-of-Pocket Maximum</b>		\$4,000		\$4,250	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies**	Member Cost Share	Deductible Applies**
<b>Health Care Provider's Office or Clinic visit</b>	Primary Care Visit Or Non-Specialist Practitioner Visit to Treat an Injury or Illness	\$25		\$30	
	Specialist Visit	\$50		\$60	
	Preventive Care/Screening/Immunization	\$0		\$0	
<b>Tests</b>	Laboratory Tests	\$30		\$30	
	X-Rays And Diagnostic Imaging	\$50		\$60	
	Imaging (CT/PET scans, MRIs)	\$250		\$250	
<b>Drugs to Treat Illness or Condition***</b>	Generic	\$15		\$15	
	Preferred Brand	\$50		\$50	
	Non-Preferred Brand	\$70		\$70	
	Specialty	\$150		\$150	
<b>Outpatient Surgery</b>	Facility Fee (e.g. Hospital Room)				
	Physician/Surgeon Fee	\$600		\$600	
<b>Outpatient Non-Surgical Clinic Visit*</b>	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	\$75		\$75	
<b>Need Immediate Attention</b>	Emergency Room Services (Waived If Admitted)	\$300		\$300	
	Emergency Medical Transportation	\$300		\$300	
	Urgent Care	\$60		\$60	
<b>Hospital Stay</b>	Facility Fee (e.g. Hospital Room)	\$600 Per Day		\$600 Per Day	
	Physician/Surgeon Fee	(Up To 5 Days)	X	(Up To 5 Days)	X
<b>Mental/Behavioral Health</b>	Office Visits	\$25		\$30	
	Outpatient Services	\$25		\$30	
	Inpatient Services	\$600 Per Day (Up To 5 Days)	X	\$600 Per Day (Up To 5 Days)	X
<b>Substance Abuse Needs</b>	Office Visits	\$25		\$30	
	Outpatient Services	\$25		\$30	
	Inpatient Services	\$600 Per Day (Up To 5 Days)	X	\$600 Per Day (Up To 5 Days)	X
<b>Pregnancy</b>	Prenatal Care And Preconception Services	\$0		\$0	
	Delivery And All Inpatient Services - Hospital	\$600 Per Day		\$600 Per Day	
	Delivery And All Inpatient Services - Prof	(Up To 5 Days)	X	(Up To 5 Days)	X
<b>Help Recovering or Other Special Health Needs</b>	Home Health Care	\$30		\$30	
	Outpatient Rehabilitation Services	\$30		\$40	
	Outpatient Habilitation Services	\$30		\$40	
	Skilled Nursing Care	\$300 Per Day (Up To 5 Days)		\$300 Per Day (Up To 5 Days)	
	Durable Medical Equipment	20%		20%	
	Hospice Services	\$0		\$0	
<b>Child Eye Care</b>	Eye Exam	\$0		\$0	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	\$0		\$0	
<b>Child Dental Diagnostic and Preventive</b>	Oral Exam	\$0		\$0	
	Preventive - Cleaning	\$0		\$0	
	Preventive - X-Ray	\$0		\$0	
	Sealants - Per Tooth	\$0		\$0	
	Topical Fluoride Application	\$0		\$0	
	Space Maintainers - Fixed	\$0		\$0	
<b>Child Dental Basic Services</b>	Amalgam Fill - 1 Surface	\$25		\$25	
	Root Canal - Molar	\$300		\$300	
<b>Child Dental Major Services</b>	Gingivectomy - Per Quad	\$150		\$150	
	Extraction - Single Tooth Exposed Root	\$65		\$65	
	Extraction - Complete Bony	\$160		\$160	
	Porcelain With Metal Crown	\$300		\$300	
	Medically Necessary Orthodontics	\$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

2019 Standard Plan AV:

71.90%

		2019 Standard Silver Plan		2020 Standard Silver Plan Alt 1	
<b>2020 Actuarial Value</b>		73.16%		71.99%	
<b>Individual Overall Deductible</b>		\$3,750		\$3,750	
<b>Other Individual Deductibles for Specific Services</b>					
<b>Medical</b>		\$3,500		\$3,500	
<b>Prescription Drugs</b>		\$250		\$250	
<b>Dental</b>		\$0		\$0	
<b>Individual Out-of-Pocket Maximum</b>		\$7,600		\$8,000	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies**	Member Cost Share	Deductible Applies**
<b>Health Care Provider's Office or Clinic visit</b>	Primary Care Visit Or Non-Specialist Practitioner Visit to Treat an Injury or Illness	\$40		\$45	
	Specialist Visit	\$80		\$90	
	Preventive Care/Screening/Immunization	\$0		\$0	
<b>Tests</b>	Laboratory Tests	\$50		\$65	
	X-Rays And Diagnostic Imaging	\$70		\$90	
	Imaging (CT/PET scans, MRIs)	\$250		\$300	
<b>Drugs to Treat Illness or Condition***</b>	Generic	\$15		\$15	
	Preferred Brand	\$50	X	\$50	X
	Non-Preferred Brand	\$70	X	\$70	X
	Specialty	\$150	X	\$150	X
<b>Outpatient Surgery</b>	Facility Fee (e.g. Hospital Room)				
	Physician/Surgeon Fee	20%	X	20%	X
<b>Outpatient Non-Surgical Clinic Visit*</b>	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	20%	X	20%	X
<b>Need Immediate Attention</b>	Emergency Room Services (Waived If Admitted)	\$350	X	\$350	X
	Emergency Medical Transportation	\$350	X	\$350	X
	Urgent Care	\$90		\$100	
<b>Hospital Stay</b>	Facility Fee (e.g. Hospital Room)				
	Physician/Surgeon Fee	20%	X	20%	X
<b>Mental/Behavioral Health</b>	Office Visits	\$40		\$45	
	Outpatient Services	5%		\$0	
	Inpatient Services	20%	X	20%	X
<b>Substance Abuse Needs</b>	Office Visits	\$40		\$45	
	Outpatient Services	5%		\$0	
	Inpatient Services	20%	X	20%	X
<b>Pregnancy</b>	Prenatal Care And Preconception Services	\$0		\$0	
	Delivery And All Inpatient Services - Hospital				
	Delivery And All Inpatient Services - Prof	20%	X	20%	X
<b>Help Recovering or Other Special Health Needs</b>	Home Health Care	\$50		\$50	
	Outpatient Rehabilitation Services	\$50		\$90	
	Outpatient Habilitation Services	\$50		\$90	
	Skilled Nursing Care	20%	X	20%	X
	Durable Medical Equipment	20%		20%	
	Hospice Services	\$0		\$0	
<b>Child Eye Care</b>	Eye Exam	\$0		\$0	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	\$0		\$0	
<b>Child Dental Diagnostic and Preventive</b>	Oral Exam	\$0		\$0	
	Preventive - Cleaning	\$0		\$0	
	Preventive - X-Ray	\$0		\$0	
	Sealants - Per Tooth	\$0		\$0	
	Topical Fluoride Application	\$0		\$0	
	Space Maintainers - Fixed	\$0		\$0	
<b>Child Dental Basic Services</b>	Amalgam Fill - 1 Surface	\$25		\$25	
	Root Canal - Molar	\$300		\$300	
<b>Child Dental Major Services</b>	Gingivectomy - Per Quad	\$150		\$150	
	Extraction - Single Tooth Exposed Root	\$65		\$65	
	Extraction - Complete Bony	\$160		\$160	
	Porcelain With Metal Crown	\$300		\$300	
	Medically Necessary Orthodontics	\$1,000		\$1,000	

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

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## Standard Silver Plan

2019 Standard Plan AV:

71.90%

		2019 Standard Silver Plan	2020 Standard Silver Plan Alt 2		
<b>2020 Actuarial Value</b>		73.16%	71.97%		
<b>Individual Overall Deductible</b>		\$3,750	\$3,750		
<b>Other Individual Deductibles for Specific Services</b>					
<b>Medical</b>		\$3,500	\$3,850		
<b>Prescription Drugs</b>		\$250	\$300		
<b>Dental</b>		\$0	\$0		
<b>Individual Out-of-Pocket Maximum</b>		\$7,600	\$8,000		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies**	Member Cost Share	Deductible Applies**
<b>Health Care Provider's Office or Clinic visit</b>	Primary Care Visit Or Non-Specialist Practitioner Visit to Treat an Injury or Illness	\$40		\$40	
	Specialist Visit	\$80		\$80	
	Preventive Care/Screening/Immunization	\$0		\$0	
<b>Tests</b>	Laboratory Tests	\$50		\$60	
	X-Rays And Diagnostic Imaging	\$70		\$80	
	Imaging (CT/PET scans, MRIs)	\$250		\$300	
<b>Drugs to Treat Illness or Condition***</b>	Generic	\$15		\$15	
	Preferred Brand	\$50	X	\$50	X
	Non-Preferred Brand	\$70	X	\$70	X
	Specialty	\$150	X	\$150	X
<b>Outpatient Surgery</b>	Facility Fee (e.g. Hospital Room)				
	Physician/Surgeon Fee	20%	X	20%	X
<b>Outpatient Non-Surgical Clinic Visit*</b>	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	20%	X	20%	X
<b>Need Immediate Attention</b>	Emergency Room Services (Waived If Admitted)	\$350	X	\$350	X
	Emergency Medical Transportation	\$350	X	\$350	X
	Urgent Care	\$90		\$90	
<b>Hospital Stay</b>	Facility Fee (e.g. Hospital Room)				
	Physician/Surgeon Fee	20%	X	20%	X
<b>Mental/Behavioral Health</b>	Office Visits	\$40		\$40	
	Outpatient Services	5%		\$0	
	Inpatient Services	20%	X	20%	X
<b>Substance Abuse Needs</b>	Office Visits	\$40		\$40	
	Outpatient Services	5%		\$0	
	Inpatient Services	20%	X	20%	X
<b>Pregnancy</b>	Prenatal Care And Preconception Services	\$0		\$0	
	Delivery And All Inpatient Services - Hospital				
	Delivery And All Inpatient Services - Prof	20%	X	20%	X
<b>Help Recovering or Other Special Health Needs</b>	Home Health Care	\$50		\$50	
	Outpatient Rehabilitation Services	\$50		\$80	
	Outpatient Habilitation Services	\$50		\$80	
	Skilled Nursing Care	20%	X	20%	X
	Durable Medical Equipment	20%		20%	
	Hospice Services	\$0		\$0	
<b>Child Eye Care</b>	Eye Exam	\$0		\$0	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	\$0		\$0	
<b>Child Dental Diagnostic and Preventive</b>	Oral Exam	\$0		\$0	
	Preventive - Cleaning	\$0		\$0	
	Preventive - X-Ray	\$0		\$0	
	Sealants - Per Tooth	\$0		\$0	
	Topical Fluoride Application	\$0		\$0	
	Space Maintainers - Fixed	\$0		\$0	
	Amalgam Fill - 1 Surface	\$25		\$25	
<b>Child Dental Basic Services</b>	Root Canal - Molar	\$300		\$300	
	Gingivectomy - Per Quad	\$150		\$150	
	Extraction - Single Tooth Exposed Root	\$65		\$65	
	Extraction - Complete Bony	\$160		\$160	
	Porcelain With Metal Crown	\$300		\$300	
<b>Child Orthodontics</b>	Medically Necessary Orthodontics	\$1,000		\$1,000	

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## Standard Silver Plan

2019 Standard Plan AV:

71.90%

		2019 Standard Silver Plan		2020 Standard Silver Plan Alt 3	
<b>2020 Actuarial Value</b>		73.16%		71.99%	
<b>Individual Overall Deductible</b>		\$3,750		\$3,750	
<b>Other Individual Deductibles for Specific Services</b>					
<b>Medical</b>		\$3,500		\$4,000	
<b>Prescription Drugs</b>		\$250		\$250	
<b>Dental</b>		\$0		\$0	
<b>Individual Out-of-Pocket Maximum</b>		\$7,600		\$8,000	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies**	Member Cost Share	Deductible Applies**
<b>Health Care Provider's Office or Clinic visit</b>	Primary Care Visit Or Non-Specialist Practitioner Visit to Treat an Injury or Illness	\$40		\$40	
	Specialist Visit	\$80		\$80	
	Preventive Care/Screening/Immunization	\$0		\$0	
<b>Tests</b>	Laboratory Tests	\$50		\$65	
	X-Rays And Diagnostic Imaging	\$70		\$85	
	Imaging (CT/PET scans, MRIs)	\$250		\$250	
<b>Drugs to Treat Illness or Condition***</b>	Generic	\$15		\$15	
	Preferred Brand	\$50	X	\$50	X
	Non-Preferred Brand	\$70	X	\$70	X
	Specialty	\$150	X	\$150	X
<b>Outpatient Surgery</b>	Facility Fee (e.g. Hospital Room)				
	Physician/Surgeon Fee	20%	X	20%	X
<b>Outpatient Non-Surgical Clinic Visit*</b>	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	20%	X	20%	X
<b>Need Immediate Attention</b>	Emergency Room Services (Waived If Admitted)	\$350	X	\$350	X
	Emergency Medical Transportation	\$350	X	\$350	X
	Urgent Care	\$90		\$90	
<b>Hospital Stay</b>	Facility Fee (e.g. Hospital Room)				
	Physician/Surgeon Fee	20%	X	20%	X
<b>Mental/Behavioral Health</b>	Office Visits	\$40		\$40	
	Outpatient Services	5%		\$0	
	Inpatient Services	20%	X	20%	X
<b>Substance Abuse Needs</b>	Office Visits	\$40		\$40	
	Outpatient Services	5%		\$0	
	Inpatient Services	20%	X	20%	X
<b>Pregnancy</b>	Prenatal Care And Preconception Services	\$0		\$0	
	Delivery And All Inpatient Services - Hospital				
	Delivery And All Inpatient Services - Prof	20%	X	20%	X
<b>Help Recovering or Other Special Health Needs</b>	Home Health Care	\$50		\$50	
	Outpatient Rehabilitation Services	\$50		\$65	
	Outpatient Habilitation Services	\$50		\$65	
	Skilled Nursing Care	20%	X	20%	X
	Durable Medical Equipment	20%		20%	
	Hospice Services	\$0		\$0	
<b>Child Eye Care</b>	Eye Exam	\$0		\$0	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	\$0		\$0	
<b>Child Dental Diagnostic and Preventive</b>	Oral Exam	\$0		\$0	
	Preventive - Cleaning	\$0		\$0	
	Preventive - X-Ray	\$0		\$0	
	Sealants - Per Tooth	\$0		\$0	
	Topical Fluoride Application	\$0		\$0	
	Space Maintainers - Fixed	\$0		\$0	
<b>Child Dental Basic Services</b>	Amalgam Fill - 1 Surface	\$25		\$25	
<b>Child Dental Major Services</b>	Root Canal - Molar	\$300		\$300	
	Gingivectomy - Per Quad	\$150		\$150	
	Extraction - Single Tooth Exposed Root	\$65		\$65	
	Extraction - Complete Bony	\$160		\$160	
	Porcelain With Metal Crown	\$300		\$300	
<b>Child Orthodontics</b>	Medically Necessary Orthodontics	\$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 Bronze Copay Plan

2019 Standard Plan AV:

64.88%

2020 Actuarial Value		2019 Standard Bronze Copay Plan		2020 Standard Bronze Copay Plan Alt 1	
Individual Overall Deductible		66.24%		64.94%	
Other Individual Deductibles for Specific Services		\$7,250		\$7,250	
Medical		\$6,650		\$7,250	
Prescription Drugs		\$600		\$750	
Dental		\$0		\$0	
Individual Out-of-Pocket Maximum		\$7,900		\$8,000	
Common Medical Event	Service Type	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		\$60	
	Specialist Visit	\$80		\$100	
	Preventive Care/Screening/Immunization	\$0		\$0	
Tests	Laboratory Tests	\$55	X	\$65	X
	X-Rays And Diagnostic Imaging	\$80	X	\$90	X
	Imaging (CT/PET scans, MRIs)	\$500	X	\$500	X
Drugs to Treat Illness or Condition***	Generic	\$25		\$25	
	Preferred Brand	\$75	X	\$75	X
	Non-Preferred Brand	\$100	X	\$100	X
	Specialty	\$150	X	\$150	X
Outpatient Surgery	Facility Fee (e.g. Hospital Room)				
	Physician/Surgeon Fee	25%	X	25%	X
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
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	25%	X	25%	X
	Emergency Medical Transportation	25%	X	25%	X
	Urgent Care	\$100		\$100	
Hospital Stay	Facility Fee (e.g. Hospital Room)				
	Physician/Surgeon Fee	25%	X	25%	X
Mental/Behavioral Health	Office Visits	\$50		\$60	
	Outpatient Services	10%		\$0	
	Inpatient Services	25%	X	25%	X
Substance Abuse Needs	Office Visits	\$50		\$60	
	Outpatient Services	10%		\$0	
	Inpatient Services	25%	X	25%	X
Pregnancy	Prenatal Care And Preconception Services	\$0		\$0	
	Delivery And All Inpatient Services - Hospital	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
	Outpatient Rehabilitation Services	\$50	X	\$50	X
	Outpatient Habilitation Services	\$50	X	\$50	X
	Skilled Nursing Care	25%	X	25%	X
	Durable Medical Equipment	25%	X	25%	X
	Hospice Services	25%	X	25%	X
Child Eye Care	Eye Exam (OD)	\$50		\$50	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	\$0		\$0	
Child Dental Diagnostic and Preventive	Oral Exam	\$0		\$0	
	Preventive - Cleaning	\$0		\$0	
	Preventive - X-Ray	\$0		\$0	
	Sealants - Per Tooth	\$0		\$0	
	Topical Fluoride Application	\$0		\$0	
	Space Maintainers - Fixed	\$0		\$0	
Child Dental Basic Services	Amalgam Fill - 1 Surface	\$41		\$41	
Child Dental Major Services	Root Canal - Molar	\$512		\$512	
	Gingivectomy - Per Quad	\$279		\$279	
	Extraction - Single Tooth Exposed Root	\$69		\$69	
	Extraction - Complete Bony	\$241		\$241	
	Porcelain With Metal Crown	\$523		\$523	
Child Orthodontics	Medically Necessary Orthodontics	\$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 Copay Plan

2019 Standard Plan AV:

64.88%

		2019 Standard Bronze Copay Plan		2020 Standard Bronze Copay Plan Alt 2	
<b>2020 Actuarial Value</b>		66.24%		64.96%	
<b>Individual Overall Deductible</b>		\$7,250		\$7,250	
<b>Other Individual Deductibles for Specific Services</b>					
<b>Medical</b>		\$6,650		\$7,250	
<b>Prescription Drugs</b>		\$600		\$750	
<b>Dental</b>		\$0		\$0	
<b>Individual Out-of-Pocket Maximum</b>		\$7,900		\$8,000	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies**	Member Cost Share	Deductible Applies**
<b>Health Care Provider's Office or Clinic visit</b>	Primary Care Visit Or Non-Specialist Practitioner Visit to Treat an Injury or Illness	\$50		\$55	
	Specialist Visit	\$80		\$100	
	Preventive Care/Screening/Immunization	\$0		\$0	
<b>Tests</b>	Laboratory Tests	\$55	X	\$55	X
	X-Rays And Diagnostic Imaging	\$80	X	\$80	X
	Imaging (CT/PET scans, MRIs)	\$500	X	\$500	X
<b>Drugs to Treat Illness or Condition***</b>	Generic	\$25		\$25	
	Preferred Brand	\$75	X	\$75	X
	Non-Preferred Brand	\$100	X	\$100	X
	Specialty	\$150	X	\$150	X
<b>Outpatient Surgery</b>	Facility Fee (e.g. Hospital Room)				
	Physician/Surgeon Fee	25%	X	40%	X
<b>Outpatient Non-Surgical Clinic Visit*</b>	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	25%	X	40%	X
<b>Need Immediate Attention</b>	Emergency Room Services (Waived If Admitted)	25%	X	40%	X
	Emergency Medical Transportation	25%	X	40%	X
	Urgent Care	\$100		\$100	
<b>Hospital Stay</b>	Facility Fee (e.g. Hospital Room)				
	Physician/Surgeon Fee	25%	X	40%	X
<b>Mental/Behavioral Health</b>	Office Visits	\$50		\$55	
	Outpatient Services	10%		\$0	
	Inpatient Services	25%	X	40%	X
<b>Substance Abuse Needs</b>	Office Visits	\$50		\$55	
	Outpatient Services	10%		\$0	
	Inpatient Services	25%	X	40%	X
<b>Pregnancy</b>	Prenatal Care And Preconception Services	\$0		\$0	
	Delivery And All Inpatient Services - Hospital				
	Delivery And All Inpatient Services - Prof	25%	X	40%	X
<b>Help Recovering or Other Special Health Needs</b>	Home Health Care (Up to 90 Visits for 4 Hours per Calendar Yr)	\$50	X	\$50	X
	Outpatient Rehabilitation Services	\$50	X	\$50	X
	Outpatient Habilitation Services	\$50	X	\$50	X
	Skilled Nursing Care	25%	X	40%	X
	Durable Medical Equipment	25%	X	40%	X
	Hospice Services	25%	X	40%	X
<b>Child Eye Care</b>	Eye Exam (OD)	\$50		\$50	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	\$0		\$0	
<b>Child Dental Diagnostic and Preventive</b>	Oral Exam	\$0		\$0	
	Preventive - Cleaning	\$0		\$0	
	Preventive - X-Ray	\$0		\$0	
	Sealants - Per Tooth	\$0		\$0	
	Topical Fluoride Application	\$0		\$0	
	Space Maintainers - Fixed	\$0		\$0	
<b>Child Dental Basic Services</b>	Amalgam Fill - 1 Surface	\$41		\$41	
<b>Child Dental Major Services</b>	Root Canal - Molar	\$512		\$512	
	Gingivectomy - Per Quad	\$279		\$279	
	Extraction - Single Tooth Exposed Root	\$69		\$69	
	Extraction - Complete Bony	\$241		\$241	
	Porcelain With Metal Crown	\$523		\$523	
<b>Child Orthodontics</b>	Medically Necessary Orthodontics	\$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 Copay Plan

2019 Standard Plan AV:

64.88%

		2019 Standard Bronze Copay Plan		2020 Standard Bronze Copay Plan Alt 3	
<b>2020 Actuarial Value</b>		66.24%		64.96%	
<b>Individual Overall Deductible</b>		\$7,250		\$7,250	
<b>Other Individual Deductibles for Specific Services</b>					
<b>Medical</b>		\$6,650		\$7,150	
<b>Prescription Drugs</b>		\$600		\$850	
<b>Dental</b>		\$0		\$0	
<b>Individual Out-of-Pocket Maximum</b>		\$7,900		\$8,000	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies**	Member Cost Share	Deductible Applies**
<b>Health Care Provider's Office or Clinic visit</b>	Primary Care Visit Or Non-Specialist Practitioner Visit to Treat an Injury or Illness	\$50		\$55	
	Specialist Visit	\$80		\$100	
	Preventive Care/Screening/Immunization	\$0		\$0	
<b>Tests</b>	Laboratory Tests	\$55	X	\$55	X
	X-Rays And Diagnostic Imaging	\$80	X	\$80	X
	Imaging (CT/PET scans, MRIs)	\$500	X	\$500	X
<b>Drugs to Treat Illness or Condition***</b>	Generic	\$25		\$25	
	Preferred Brand	\$75	X	\$75	X
	Non-Preferred Brand	\$100	X	\$100	X
	Specialty	\$150	X	\$150	X
<b>Outpatient Surgery</b>	Facility Fee (e.g. Hospital Room)				
	Physician/Surgeon Fee	25%	X	30%	X
<b>Outpatient Non-Surgical Clinic Visit*</b>	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	25%	X	30%	X
<b>Need Immediate Attention</b>	Emergency Room Services (Waived If Admitted)	25%	X	30%	X
	Emergency Medical Transportation	25%	X	30%	X
	Urgent Care	\$100		\$100	
<b>Hospital Stay</b>	Facility Fee (e.g. Hospital Room)				
	Physician/Surgeon Fee	25%	X	30%	X
<b>Mental/Behavioral Health</b>	Office Visits	\$50		\$55	
	Outpatient Services	10%		\$0	
	Inpatient Services	25%	X	30%	X
<b>Substance Abuse Needs</b>	Office Visits	\$50		\$55	
	Outpatient Services	10%		\$0	
	Inpatient Services	25%	X	30%	X
<b>Pregnancy</b>	Prenatal Care And Preconception Services	\$0		\$0	
	Delivery And All Inpatient Services - Hospital				
	Delivery And All Inpatient Services - Prof	25%	X	30%	X
<b>Help Recovering or Other Special Health Needs</b>	Home Health Care (Up to 90 Visits for 4 Hours per Calendar Yr)	\$50	X	\$50	X
	Outpatient Rehabilitation Services	\$50	X	\$50	X
	Outpatient Habilitation Services	\$50	X	\$50	X
	Skilled Nursing Care	25%	X	30%	X
	Durable Medical Equipment	25%	X	30%	X
	Hospice Services	25%	X	30%	X
<b>Child Eye Care</b>	Eye Exam (OD)	\$50		\$50	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	\$0		\$0	
<b>Child Dental Diagnostic and Preventive</b>	Oral Exam	\$0		\$0	
	Preventive - Cleaning	\$0		\$0	
	Preventive - X-Ray	\$0		\$0	
	Sealants - Per Tooth	\$0		\$0	
	Topical Fluoride Application	\$0		\$0	
	Space Maintainers - Fixed	\$0		\$0	
<b>Child Dental Basic Services</b>	Amalgam Fill - 1 Surface	\$41		\$41	
<b>Child Dental Major Services</b>	Root Canal - Molar	\$512		\$512	
	Gingivectomy - Per Quad	\$279		\$279	
	Extraction - Single Tooth Exposed Root	\$69		\$69	
	Extraction - Complete Bony	\$241		\$241	
	Porcelain With Metal Crown	\$523		\$523	
	Medically Necessary Orthodontics	\$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 HDHP Plan

2019 Standard Plan AV:

61.82%

		2019 Standard Bronze HDHP Plan	
<b>2020 Actuarial Value</b>		63.13%	
<b>Individual Overall Deductible</b>		\$6,200	
<b>Other Individual Deductibles for Specific Services</b>			
<b>Medical</b>		\$6,200	
<b>Prescription Drugs</b>		Integrated with Medical	
<b>Dental</b>		\$0	
<b>Individual Out-of-Pocket Maximum</b>		\$6,550	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies**
<b>Health Care Provider's Office or Clinic visit</b>	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	
<b>Tests</b>	Laboratory Tests	20%	X
	X-Rays And Diagnostic Imaging	20%	X
	Imaging (CT/PET scans, MRIs)	20%	X
<b>Drugs to Treat Illness or Condition***</b>	Generic	20%	X
	Preferred Brand	20%	X
	Non-Preferred Brand	20%	X
	Specialty	20%	X
<b>Outpatient Surgery</b>	Facility Fee (e.g. Hospital Room)	20%	X
	Physician/Surgeon Fee		
<b>Outpatient Non-Surgical Clinic Visit*</b>	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	20%	X
<b>Need Immediate Attention</b>	Emergency Room Services (Waived If Admitted)	20%	X
	Emergency Medical Transportation	20%	X
	Urgent Care	20%	X
<b>Hospital Stay</b>	Facility Fee (e.g. Hospital Room)	20%	X
	Physician/Surgeon Fee		
<b>Mental/Behavioral Health</b>	Office Visits	20%	X
	Outpatient Services	20%	X
	Inpatient Services	20%	X
<b>Substance Abuse Needs</b>	Office Visits	20%	X
	Outpatient Services	20%	X
	Inpatient Services	20%	X
<b>Pregnancy</b>	Prenatal Care And Preconception Services	\$0	
	Delivery And All Inpatient Services - Hospital	20%	X
	Delivery And All Inpatient Services - Prof		
<b>Help Recovering or Other Special Health Needs</b>	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
<b>Child Eye Care</b>	Eye Exam (OD)	\$50	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	\$0	
<b>Child Dental Diagnostic and Preventive</b>	Oral Exam	\$0	
	Preventive - Cleaning	\$0	
	Preventive - X-Ray	\$0	
	Sealants - Per Tooth	\$0	
	Topical Fluoride Application	\$0	
	Space Maintainers - Fixed	\$0	
<b>Child Dental Basic Services</b>	Amalgam Fill - 1 Surface	\$41	
<b>Child Dental Major Services</b>	Root Canal - Molar	\$512	
	Gingivectomy - Per Quad	\$279	
	Extraction - Single Tooth Exposed Root	\$69	
	Extraction - Complete Bony	\$241	
	Porcelain With Metal Crown	\$523	
<b>Child Orthodontics</b>	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 Cost Share" is applied

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