# Standard Platinum Plan

2019 Standard Plan AV: 88.92%

| | 2019 Standard Platinum Plan |
|---|---|
| **2020 Actuarial Value** | 89.59% |
| **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

2019 Standard Plan AV: 81.94%

| | | 2019 Standard Gold Plan | | 2020 Standard Gold Plan Alt 1 | | 2020 Standard Gold Plan Alt 2 | | 2020 Standard Gold Plan Alt 3 | |
|---|---|---|---|---|---|---|---|---|---|
| **2020 Actuarial Value** | | 83.01% | | 81.94% | | 82.00% | | 81.96% | |
| **Individual Overall Deductible** | | $500 | | $500 | | $500 | | $500 | |
| **Other Individual Deductibles for Specific Services** | | | | | | | | | |
| **Medical** | | $500 | | $500 | | $500 | | $500 | |
| **Prescription Drugs** | | $0 | | $0 | | $0 | | $0 | |
| **Dental** | | $0 | | $0 | | $0 | | $0 | |
| **Individual Out-of-Pocket Maximum** | | $4,000 | | $4,650 | | $4,300 | | $4,250 | |
| **Common Medical Event** | **Service Type** | **Member Cost Share** | **Deductible Applies**** | **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 | $25 | | $25 | | $25 | | $30 | |
| | Specialist Visit | $50 | | $50 | | $50 | | $60 | |
| | Preventive Care/Screening/Immunization | $0 | | $0 | | $0 | | $0 | |
| **Tests** | Laboratory Tests | $30 | | $30 | | $45 | | $30 | |
| | X-Rays And Diagnostic Imaging | $50 | | $50 | | $65 | | $60 | |
| | Imaging (CT/PET scans, MRIs) | $250 | | $250 | | $250 | | $250 | |
| **Drugs to Treat Illness or Condition***** | Generic | $15 | | $15 | | $15 | | $15 | |
| | Preferred Brand | $50 | | $50 | | $50 | | $50 | |
| | Non-Preferred Brand | $70 | | $70 | | $70 | | $70 | |
| | Specialty | $150 | | $150 | | $150 | | $150 | |
| **Outpatient Surgery** | Facility Fee (e.g. Hospital Room)<br>Physician/Surgeon Fee | $600 | | $600 | | $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 | | $75 | | $75 | |
| **Need Immediate Attention** | Emergency Room Services (Waived If Admitted) | $300 | | $300 | | $300 | | $300 | |
| | Emergency Medical Transportation | $300 | | $300 | | $300 | | $300 | |
| | Urgent Care | $60 | | $60 | | $60 | | $60 | |
| **Hospital Stay** | Facility Fee (e.g. Hospital Room)<br>Physician/Surgeon Fee | $600 Per Day (Up To 5 Days) | X | $600 Per Day (Up To 5 Days) | X | $600 Per Day (Up To 5 Days) | X | $600 Per Day (Up To 5 Days) | X |
| **Mental/Behavioral Health** | Office Visits | $25 | | $25 | | $25 | | $30 | |
| | Outpatient Services | $25 | | $25 | | $25 | | $30 | |
| | Inpatient Services | $600 Per Day (Up To 5 Days) | X | $600 Per Day (Up To 5 Days) | X | $600 Per Day (Up To 5 Days) | X | $600 Per Day (Up To 5 Days) | X |
| **Substance Abuse Needs** | Office Visits | $25 | | $25 | | $25 | | $30 | |
| | Outpatient Services | $25 | | $25 | | $25 | | $30 | |
| | Inpatient Services | $600 Per Day (Up To 5 Days) | X | $600 Per Day (Up To 5 Days) | X | $600 Per Day (Up To 5 Days) | X | $600 Per Day (Up To 5 Days) | X |
| **Pregnancy** | Prenatal Care And Preconception Services | $0 | | $0 | | $0 | | $0 | |
| | Delivery And All Inpatient Services - Hospital<br>Delivery And All Inpatient Services - Prof | $600 Per Day (Up To 5 Days) | X | $600 Per Day (Up To 5 Days) | X | $600 Per Day (Up To 5 Days) | X | $600 Per Day (Up To 5 Days) | X |
| **Help Recovering or Other Special Health Needs** | Home Health Care | $30 | | $30 | | $30 | | $30 | |
| | Outpatient Rehabilitation Services | $30 | | $30 | | $60 | | $40 | |
| | Outpatient Habilitation Services | $30 | | $30 | | $60 | | $40 | |
| | Skilled Nursing Care | $300 Per Day (Up To 5 Days) | | $300 Per Day (Up To 5 Days) | | $300 Per Day (Up To 5 Days) | | $300 Per Day (Up To 5 Days) | |
| | Durable Medical Equipment | 20% | | 20% | | 20% | | 20% | |
| | Hospice Services | $0 | | $0 | | $0 | | $0 | |
| **Child Eye Care** | Eye Exam | $0 | | $0 | | $0 | | $0 | |
| | 1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses) | $0 | | $0 | | $0 | | $0 | |
| **Child Dental Diagnostic and Preventive** | Oral Exam | $0 | | $0 | | $0 | | $0 | |
| | Preventive - Cleaning | $0 | | $0 | | $0 | | $0 | |
| | Preventive - X-Ray | $0 | | $0 | | $0 | | $0 | |
| | Sealants - Per Tooth | $0 | | $0 | | $0 | | $0 | |
| | Topical Fluoride Application | $0 | | $0 | | $0 | | $0 | |
| | Space Maintainers - Fixed | $0 | | $0 | | $0 | | $0 | |
| **Child Dental Basic Services** | Amalgam Fill - 1 Surface | $25 | | $25 | | $25 | | $25 | |
| **Child Dental Major Services** | Root Canal - Molar | $300 | | $300 | | $300 | | $300 | |
| | Gingivectomy - Per Quad | $150 | | $150 | | $150 | | $150 | |
| | Extraction - Single Tooth Exposed Root | $65 | | $65 | | $65 | | $65 | |
| | Extraction - Complete Bony | $160 | | $160 | | $160 | | $160 | |
| | Porcelain With Metal Crown | $300 | | $300 | | $300 | | $300 | |
| **Child Orthodontics** | Medically Necessary Orthodontics | $1,000 | | $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

2019 Standard Plan AV: 71.90%

| | | 2019 Standard Silver Plan | | 2020 Standard Silver Plan Alt 1 | | 2020 Standard Silver Plan Alt 2 | | 2020 Standard Silver Plan Alt 3 | |
|---|---|---|---|---|---|---|---|---|---|
| **2020 Actuarial Value** | | 73.16% | | 71.99% | | 71.97% | | 71.99% | |
| **Individual Overall Deductible** | | $3,750 | | $3,750 | | $4,150 | | $4,250 | |
| **Other Individual Deductibles for Specific Services** | | | | | | | | | |
| **Medical** | | $3,500 | | $3,500 | | $3,850 | | $4,000 | |
| **Prescription Drugs** | | $250 | | $250 | | $300 | | $250 | |
| **Dental** | | $0 | | $0 | | $0 | | $0 | |
| **Individual Out-of-Pocket Maximum** | | $7,600 | | $8,000 | | $8,000 | | $8,000 | |
| **Common Medical Event** | **Service Type** | **Member Cost Share** | **Deductible Applies**** | **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 | | $45 | | $40 | | $40 | |
| | Specialist Visit | $80 | | $90 | | $80 | | $80 | |
| | Preventive Care/Screening/Immunization | $0 | | $0 | | $0 | | $0 | |
| **Tests** | Laboratory Tests | $50 | | $65 | | $60 | | $65 | |
| | X-Rays And Diagnostic Imaging | $70 | | $90 | | $80 | | $85 | |
| | Imaging (CT/PET scans, MRIs) | $250 | | $300 | | $300 | | $250 | |
| **Drugs to Treat Illness or Condition***** | Generic | $15 | | $15 | | $15 | | $15 | |
| | Preferred Brand | $50 | X | $50 | X | $50 | X | $50 | X |
| | Non-Preferred Brand | $70 | X | $70 | X | $70 | X | $70 | X |
| | Specialty | $150 | X | $150 | X | $150 | X | $150 | X |
| **Outpatient Surgery** | Facility Fee (e.g. Hospital Room) | 20% | X | 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 | 20% | X |
| **Need Immediate Attention** | Emergency Room Services (Waived If Admitted) | $350 | X | $350 | X | $350 | X | $350 | X |
| | Emergency Medical Transportation | $350 | X | $350 | X | $350 | X | $350 | X |
| | Urgent Care | $90 | | $100 | | $90 | | $90 | |
| **Hospital Stay** | Facility Fee (e.g. Hospital Room) | 20% | X | 20% | X | 20% | X | 20% | X |
| | Physician/Surgeon Fee | | | | | | | | |
| **Mental/Behavioral Health** | Office Visits | $40 | | $45 | | $40 | | $40 | |
| | Outpatient Services | 5% | | $0 | | $0 | | $0 | |
| | Inpatient Services | 20% | X | 20% | X | 20% | X | 20% | X |
| **Substance Abuse Needs** | Office Visits | $40 | | $45 | | $40 | | $40 | |
| | Outpatient Services | 5% | | $0 | | $0 | | $0 | |
| | Inpatient Services | 20% | X | 20% | X | 20% | X | 20% | X |
| **Pregnancy** | Prenatal Care And Preconception Services | $0 | | $0 | | $0 | | $0 | |
| | Delivery And All Inpatient Services - Hospital | 20% | X | 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 | | $50 | |
| | Outpatient Rehabilitation Services | $50 | | $90 | | $80 | | $65 | |
| | Outpatient Habilitation Services | $50 | | $90 | | $80 | | $65 | |
| | Skilled Nursing Care | 20% | X | 20% | X | 20% | X | 20% | X |
| | Durable Medical Equipment | 20% | | 20% | | 20% | | 20% | |
| | Hospice Services | $0 | | $0 | | $0 | | $0 | |
| **Child Eye Care** | Eye Exam | $0 | | $0 | | $0 | | $0 | |
| | 1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses) | $0 | | $0 | | $0 | | $0 | |
| **Child Dental Diagnostic and Preventive** | Oral Exam | $0 | | $0 | | $0 | | $0 | |
| | Preventive - Cleaning | $0 | | $0 | | $0 | | $0 | |
| | Preventive - X-Ray | $0 | | $0 | | $0 | | $0 | |
| | Sealants - Per Tooth | $0 | | $0 | | $0 | | $0 | |
| | Topical Fluoride Application | $0 | | $0 | | $0 | | $0 | |
| | Space Maintainers - Fixed | $0 | | $0 | | $0 | | $0 | |
| **Child Dental Basic Services** | Amalgam Fill - 1 Surface | $25 | | $25 | | $25 | | $25 | |
| **Child Dental Major Services** | Root Canal - Molar | $300 | | $300 | | $300 | | $300 | |
| | Gingivectomy - Per Quad | $150 | | $150 | | $150 | | $150 | |
| | Extraction - Single Tooth Exposed Root | $65 | | $65 | | $65 | | $65 | |
| | Extraction - Complete Bony | $160 | | $160 | | $160 | | $160 | |
| | Porcelain With Metal Crown | $300 | | $300 | | $300 | | $300 | |
| **Child Orthodontics** | Medically Necessary Orthodontics | $1,000 | | $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

2019 Standard Plan AV: 71.90%

| | | 2019 Standard Silver Plan | | 2020 Standard Silver Plan Alt 4 | | 2020 Standard Silver Plan Alt 5 | | 2020 Standard Silver Plan Alt 6 | |
|---|---|---|---|---|---|---|---|---|---|
| **2020 Actuarial Value** | | 73.16% | | 71.84% | | 71.95% | | 71.95% | |
| **Individual Overall Deductible** | | $3,750 | | $4,300 | | $4,200 | | $4,250 | |
| **Other Individual Deductibles for Specific Services** | | | | | | | | | |
| **Medical** | | $3,500 | | $4,000 | | $3,900 | | $4,000 | |
| **Prescription Drugs** | | $250 | | $300 | | $300 | | $250 | |
| **Dental** | | $0 | | $0 | | $0 | | $0 | |
| **Individual Out-of-Pocket Maximum** | | $7,600 | | $8,000 | | $8,000 | | $8,000 | |
| **Common Medical Event** | **Service Type** | **Member Cost Share** | **Deductible Applies**** | **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 | | $40 | |
| | Specialist Visit | $80 | | $80 | | $80 | | $80 | |
| | Preventive Care/Screening/Immunization | $0 | | $0 | | $0 | | $0 | |
| **Tests** | Laboratory Tests | $50 | | $60 | | $60 | | $60 | |
| | X-Rays And Diagnostic Imaging | $70 | | $80 | | $80 | | $80 | |
| | Imaging (CT/PET scans, MRIs) | $250 | | $300 | | $300 | | $300 | |
| **Drugs to Treat Illness or Condition***** | Generic | $15 | | $15 | | $15 | | $15 | |
| | Preferred Brand | $50 | X | $50 | X | $50 | X | $50 | X |
| | Non-Preferred Brand | $70 | X | $70 | X | $70 | X | $70 | X |
| | Specialty | $150 | X | $150 | X | $150 | X | $150 | X |
| **Outpatient Surgery** | Facility Fee (e.g. Hospital Room) | 20% | X | 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 | 20% | X |
| **Need Immediate Attention** | Emergency Room Services (Waived If Admitted) | $350 | X | $350 | X | $350 | X | $350 | X |
| | Emergency Medical Transportation | $350 | X | $350 | X | $350 | X | $350 | X |
| | Urgent Care | $90 | | $90 | | $90 | | $90 | |
| **Hospital Stay** | Facility Fee (e.g. Hospital Room) | 20% | X | 20% | X | 20% | X | 20% | X |
| | Physician/Surgeon Fee | | | | | | | | |
| **Mental/Behavioral Health** | Office Visits | $40 | | $40 | | $40 | | $40 | |
| | Outpatient Services | 5% | | $0 | | $0 | | $0 | |
| | Inpatient Services | 20% | X | 20% | X | 20% | X | 20% | X |
| **Substance Abuse Needs** | Office Visits | $40 | | $40 | | $40 | | $40 | |
| | Outpatient Services | 5% | | $0 | | $0 | | $0 | |
| | Inpatient Services | 20% | X | 20% | X | 20% | X | 20% | X |
| **Pregnancy** | Prenatal Care And Preconception Services | $0 | | $0 | | $0 | | $0 | |
| | Delivery And All Inpatient Services - Hospital | 20% | X | 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 | | $50 | |
| | Outpatient Rehabilitation Services | $50 | | $65 | | $65 | | $65 | |
| | Outpatient Habilitation Services | $50 | | $65 | | $65 | | $65 | |
| | Skilled Nursing Care | 20% | X | 20% | X | 20% | X | 20% | X |
| | Durable Medical Equipment | 20% | | 20% | | 20% | | 20% | |
| | Hospice Services | $0 | | $0 | | $0 | | $0 | |
| **Child Eye Care** | Eye Exam | $0 | | $0 | | $0 | | $0 | |
| | 1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses) | $0 | | $0 | | $0 | | $0 | |
| **Child Dental Diagnostic and Preventive** | Oral Exam | $0 | | $0 | | $0 | | $0 | |
| | Preventive - Cleaning | $0 | | $0 | | $0 | | $0 | |
| | Preventive - X-Ray | $0 | | $0 | | $0 | | $0 | |
| | Sealants - Per Tooth | $0 | | $0 | | $0 | | $0 | |
| | Topical Fluoride Application | $0 | | $0 | | $0 | | $0 | |
| | Space Maintainers - Fixed | $0 | | $0 | | $0 | | $0 | |
| **Child Dental Basic Services** | Amalgam Fill - 1 Surface | $25 | | $25 | | $25 | | $25 | |
| **Child Dental Major Services** | Root Canal - Molar | $300 | | $300 | | $300 | | $300 | |
| | Gingivectomy - Per Quad | $150 | | $150 | | $150 | | $150 | |
| | Extraction - Single Tooth Exposed Root | $65 | | $65 | | $65 | | $65 | |
| | Extraction - Complete Bony | $160 | | $160 | | $160 | | $160 | |
| | Porcelain With Metal Crown | $300 | | $300 | | $300 | | $300 | |
| **Child Orthodontics** | Medically Necessary Orthodontics | $1,000 | | $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 Bronze Copay Plan

2019 Standard Plan AV: 64.88%

| | | 2019 Standard Bronze Copay Plan | | 2020 Standard Bronze Copay Plan Alt 1 | | 2020 Standard Bronze Copay Plan Alt 2 | | 2020 Standard Bronze Copay Plan Alt 3 | |
|---|---|---|---|---|---|---|---|---|---|
| **2020 Actuarial Value** | | 66.24% | | 64.94% | | 64.96% | | 64.96% | |
| **Individual Overall Deductible** | | $7,250 | | $8,000 | | $8,000 | | $8,000 | |
| **Other Individual Deductibles for Specific Services** | | | | | | | | | |
| **Medical** | | $6,650 | | $7,250 | | $7,250 | | $7,150 | |
| **Prescription Drugs** | | $600 | | $750 | | $750 | | $850 | |
| **Dental** | | $0 | | $0 | | $0 | | $0 | |
| **Individual Out-of-Pocket Maximum** | | $7,900 | | $8,000 | | $8,000 | | $8,000 | |
| **Common Medical Event** | **Service Type** | **Member Cost Share** | **Deductible Applies**** | **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 | | $60 | | $55 | | $55 | |
| | Specialist Visit | $80 | | $100 | | $100 | | $100 | |
| | Preventive Care/Screening/Immunization | $0 | | $0 | | $0 | | $0 | |
| **Tests** | Laboratory Tests | $55 | X | $65 | X | $55 | X | $55 | X |
| | X-Rays And Diagnostic Imaging | $80 | X | $90 | X | $80 | X | $80 | X |
| | Imaging (CT/PET scans, MRIs) | $500 | X | $500 | X | $500 | X | $500 | X |
| **Drugs to Treat Illness or Condition***** | Generic | $25 | | $25 | | $25 | | $25 | |
| | Preferred Brand | $75 | X | $75 | X | $75 | X | $75 | X |
| | Non-Preferred Brand | $100 | X | $100 | X | $100 | X | $100 | X |
| | Specialty | $150 | X | $150 | X | $150 | X | $150 | X |
| **Outpatient Surgery** | Facility Fee (e.g. Hospital Room) | 25% | X | 25% | X | 40% | X | 30% | 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 | 40% | X | 30% | X |
| **Need Immediate Attention** | Emergency Room Services (Waived If Admitted) | 25% | X | 25% | X | 40% | X | 30% | X |
| | Emergency Medical Transportation | 25% | X | 25% | X | 40% | X | 30% | X |
| | Urgent Care | $100 | | $100 | | $100 | | $100 | |
| **Hospital Stay** | Facility Fee (e.g. Hospital Room) | 25% | X | 25% | X | 40% | X | 30% | X |
| | Physician/Surgeon Fee | | | | | | | | |
| **Mental/Behavioral Health** | Office Visits | $50 | | $60 | | $55 | | $55 | |
| | Outpatient Services | 10% | | $0 | | $0 | | $0 | |
| | Inpatient Services | 25% | X | 25% | X | 40% | X | 30% | X |
| **Substance Abuse Needs** | Office Visits | $50 | | $60 | | $55 | | $55 | |
| | Outpatient Services | 10% | | $0 | | $0 | | $0 | |
| | Inpatient Services | 25% | X | 25% | X | 40% | X | 30% | X |
| **Pregnancy** | Prenatal Care And Preconception Services | $0 | | $0 | | $0 | | $0 | |
| | Delivery And All Inpatient Services - Hospital | 25% | X | 25% | X | 40% | X | 30% | 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 | $50 | X |
| | Outpatient Rehabilitation Services | $50 | X | $50 | X | $50 | X | $50 | X |
| | Outpatient Habilitation Services | $50 | X | $50 | X | $50 | X | $50 | X |
| | Skilled Nursing Care | 25% | X | 25% | X | 40% | X | 30% | X |
| | Durable Medical Equipment | 25% | X | 25% | X | 40% | X | 30% | X |
| | Hospice Services | 25% | X | 25% | X | 40% | X | 30% | X |
| **Child Eye Care** | Eye Exam (OD) | $50 | | $50 | | $50 | | $50 | |
| | 1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses) | $0 | | $0 | | $0 | | $0 | |
| **Child Dental Diagnostic and Preventive** | Oral Exam | $0 | | $0 | | $0 | | $0 | |
| | Preventive - Cleaning | $0 | | $0 | | $0 | | $0 | |
| | Preventive - X-Ray | $0 | | $0 | | $0 | | $0 | |
| | Sealants - Per Tooth | $0 | | $0 | | $0 | | $0 | |
| | Topical Fluoride Application | $0 | | $0 | | $0 | | $0 | |
| | Space Maintainers - Fixed | $0 | | $0 | | $0 | | $0 | |
| **Child Dental Basic Services** | Amalgam Fill - 1 Surface | $41 | | $41 | | $41 | | $41 | |
| **Child Dental Major Services** | Root Canal - Molar | $512 | | $512 | | $512 | | $512 | |
| | Gingivectomy - Per Quad | $279 | | $279 | | $279 | | $279 | |
| | Extraction - Single Tooth Exposed Root | $69 | | $69 | | $69 | | $69 | |
| | Extraction - Complete Bony | $241 | | $241 | | $241 | | $241 | |
| | Porcelain With Metal Crown | $523 | | $523 | | $523 | | $523 | |
| **Child Orthodontics** | Medically Necessary Orthodontics | $3,422 | | $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 Copay Plan

2019 Standard Plan AV: 64.88%

| | | 2019 Standard Bronze Copay Plan | | 2020 Standard Bronze Copay Plan Alt 4 | |
|---|---|---|---|---|---|
| **2020 Actuarial Value** | | 66.24% | | 64.96% | |
| **Individual Overall Deductible** | | $7,250 | | $7,800 | |
| **Other Individual Deductibles for Specific Services** | | | | | |
| **Medical** | | $6,650 | | $7,150 | |
| **Prescription Drugs** | | $600 | | $650 | |
| **Dental** | | $0 | | $0 | |
| **Individual Out-of-Pocket Maximum** | | $7,900 | | $8,200 | |
| **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 | | $55 | |
| | Specialist Visit | $80 | | $100 | |
| | Preventive Care/Screening/Immunization | $0 | | $0 | |
| **Tests** | Laboratory Tests | $55 | X | $55 | X |
| | X-Rays And Diagnostic Imaging | $80 | X | $80 | 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) | 25% | X | 30% | 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 | 30% | X |
| **Need Immediate Attention** | Emergency Room Services (Waived If Admitted) | 25% | X | 30% | X |
| | Emergency Medical Transportation | 25% | X | 30% | X |
| | Urgent Care | $100 | | $100 | |
| **Hospital Stay** | Facility Fee (e.g. Hospital Room) | 25% | X | 30% | X |
| | Physician/Surgeon Fee | | | | |
| **Mental/Behavioral Health** | Office Visits | $50 | | $55 | |
| | Outpatient Services | 10% | | $0 | |
| | Inpatient Services | 25% | X | 30% | X |
| **Substance Abuse Needs** | Office Visits | $50 | | $55 | |
| | Outpatient Services | 10% | | $0 | |
| | Inpatient Services | 25% | X | 30% | X |
| **Pregnancy** | Prenatal Care And Preconception Services | $0 | | $0 | |
| | Delivery And All Inpatient Services - Hospital | 25% | X | 30% | 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 | 30% | X |
| | Durable Medical Equipment | 25% | X | 30% | X |
| | Hospice Services | 25% | X | 30% | 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 HDHP Plan

2019 Standard Plan AV: 61.82%

| | 2019 Standard Bronze HDHP Plan |
|---|---|
| **2020 Actuarial Value** | 63.13% |
| **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 Cost Share" is applied**

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