

Standard Platinum Plan

2020 Standard Plan AV:

89.59%

		2021 Standard Platinum Plan	
2021 Actuarial Value		88.99%	
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	
	Physician/Surgeon Fee	(Up To 5 Days)	
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	
	Delivery And All Inpatient Services - Prof	(Up To 5 Days)	
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

2020 Standard Plan AV:

81.94%

		2021 Standard Gold Plan		2021 Standard Gold Plan Alt 1		2021 Standard Gold Plan Alt 2		2021 Standard Gold Plan Alt 3	
2021 Actuarial Value		82.41%		81.95%		81.95%		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		\$4,650		\$4,950		\$4,650		\$4,800	
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		\$25	
	Specialist Visit	\$50		\$50		\$50		\$50	
	Preventive Care/Screening/Immunization	\$0		\$0		\$0		\$0	
Tests	Laboratory Tests	\$30		\$30		\$40		\$35	
	X-Rays And Diagnostic Imaging	\$50		\$50		\$55		\$50	
	Imaging (CT/PET scans, MRIs)	\$250		\$250		\$300		\$300	
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)	\$600		\$600		\$600		\$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		\$75		\$75		\$75	
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	\$300		\$300		\$350		\$300	
	Emergency Medical Transportation	\$300		\$300		\$300		\$300	
	Urgent Care	\$60		\$60		\$60		\$60	
Hospital Stay	Facility Fee (e.g. Hospital Room)	\$600 Per Day (Up To 5 Days)		\$600 Per Day (Up To 5 Days)		\$600 Per Day (Up To 5 Days)		\$600 Per Day (Up To 5 Days)	
	Physician/Surgeon Fee		X		X		X		X
Mental/Behavioral Health	Office Visits	\$25		\$25		\$25		\$25	
	Outpatient Services	\$25		\$25		\$25		\$25	
	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		\$25	
	Outpatient Services	\$25		\$25		\$25		\$25	
	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	\$600 Per Day (Up To 5 Days)		\$600 Per Day (Up To 5 Days)		\$600 Per Day (Up To 5 Days)		\$600 Per Day (Up To 5 Days)	
	Delivery And All Inpatient Services - Prof		X		X		X		X
Help Recovering or Other Special Health Needs	Home Health Care	\$30		\$30		\$30		\$30	
	Outpatient Rehabilitation Services	\$30		\$30		\$40		\$35	
	Outpatient Habilitation Services	\$30		\$30		\$40		\$35	
	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	
	Root Canal - Molar	\$300		\$300		\$300		\$300	
Child Dental Major Services	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

2020 Standard Plan AV:

71.95%

		2021 Standard Silver Plan		2021 Standard Silver Plan Alt 1		2021 Standard Silver Plan Alt 2	
2021 Actuarial Value		72.16%		71.96%		71.94%	
Individual Overall Deductible		\$4,250		\$4,250		\$4,350	
Other Individual Deductibles for Specific Services							
Medical		\$4,000		\$4,000		\$4,100	
Prescription Drugs		\$250		\$250		\$250	
Dental		\$0		\$0		\$0	
Individual Out-of-Pocket Maximum		\$8,000		\$8,250		\$8,150	
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	\$60		\$60		\$60	
	X-Rays And Diagnostic Imaging	\$80		\$80		\$80	
	Imaging (CT/PET scans, MRIs)	\$300		\$300		\$300	
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	\$0		\$0		\$0	
	Inpatient Services	20%	X	20%	X	20%	X
Substance Abuse Needs	Office Visits	\$40		\$40		\$40	
	Outpatient Services	\$0		\$0		\$0	
	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	\$65		\$65		\$65	
	Outpatient Habilitation Services	\$65		\$65		\$65	
	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 Bronze Copay Plan

2020 Standard Plan AV:

64.96%

		2021 Standard Bronze Copay Plan		2021 Standard Bronze Copay Plan Alt 1		2021 Standard Bronze Copay Plan Alt 2	
2021 Actuarial Value		66.48%		64.97%		65.00%	
Individual Overall Deductible		\$8,000		\$8,350		\$8,350	
Other Individual Deductibles for Specific Services							
Medical		\$7,250		\$7,500		\$7,450	
Prescription Drugs		\$750		\$850		\$900	
Dental		\$0		\$0		\$0	
Individual Out-of-Pocket Maximum		\$8,000		\$8,350		\$8,350	
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	\$55		\$65		\$65	
	Specialist Visit	\$100		\$130		\$130	
	Preventive Care/Screening/Immunization	\$0		\$0		\$0	
Tests	Laboratory Tests	\$55	X	\$55	X	\$60	X
	X-Rays And Diagnostic Imaging	\$80	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)	40%	X	50%	X	40%	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	40%	X	50%	X	40%	X
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	40%	X	50%	X	40%	X
	Emergency Medical Transportation	40%	X	50%	X	40%	X
	Urgent Care	\$100		\$100		\$100	
Hospital Stay	Facility Fee (e.g. Hospital Room)	40%	X	50%	X	40%	X
	Physician/Surgeon Fee						
Mental/Behavioral Health	Office Visits	\$55		\$65		\$65	
	Outpatient Services	\$0		\$0		\$0	
	Inpatient Services	40%	X	50%	X	40%	X
Substance Abuse Needs	Office Visits	\$55		\$65		\$65	
	Outpatient Services	\$0		\$0		\$0	
	Inpatient Services	40%	X	50%	X	40%	X
Pregnancy	Prenatal Care And Preconception Services	\$0		\$0		\$0	
	Delivery And All Inpatient Services - Hospital	40%	X	50%	X	40%	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	40%	X	50%	X	40%	X
	Durable Medical Equipment	40%	X	50%	X	40%	X
	Hospice Services	40%	X	50%	X	40%	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.

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Standard Bronze HDHP Plan

2020 Standard Plan AV:

63.13%

		2021 Standard Bronze HDHP Plan		2021 Standard Bronze HDHP Plan Alt 1		2021 Standard Bronze HDHP Plan Alt 2	
2021 Actuarial Value		65.72%		64.99%		64.98%	
Individual Overall Deductible		\$6,200		\$6,350		\$6,250	
Other Individual Deductibles for Specific Services							
Medical		\$6,200		\$6,350		\$6,250	
Prescription Drugs		Integrated with Medical		Integrated with Medical		Integrated with Medical	
Dental		\$0		\$0		\$0	
Individual Out-of-Pocket Maximum		\$6,550		\$6,900		\$6,900	
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	20%	X	20%	X	30%	X
	Specialist Visit	20%	X	20%	X	30%	X
	Preventive Care/Screening/Immunization	\$0		\$0		\$0	
Tests	Laboratory Tests	20%	X	20%	X	30%	X
	X-Rays And Diagnostic Imaging	20%	X	20%	X	30%	X
	Imaging (CT/PET scans, MRIs)	20%	X	20%	X	30%	X
Drugs to Treat Illness or Condition***	Generic	20%	X	20%	X	30%	X
	Preferred Brand	20%	X	20%	X	30%	X
	Non-Preferred Brand	20%	X	20%	X	30%	X
	Specialty	20%	X	20%	X	30%	X
Outpatient Surgery	Facility Fee (e.g. Hospital Room)	20%	X	20%	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	20%	X	20%	X	30%	X
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	20%	X	20%	X	30%	X
	Emergency Medical Transportation	20%	X	20%	X	30%	X
	Urgent Care	20%	X	20%	X	30%	X
Hospital Stay	Facility Fee (e.g. Hospital Room)	20%	X	20%	X	30%	X
	Physician/Surgeon Fee						
Mental/Behavioral Health	Office Visits	20%	X	20%	X	30%	X
	Outpatient Services	20%	X	20%	X	30%	X
	Inpatient Services	20%	X	20%	X	30%	X
Substance Abuse Needs	Office Visits	20%	X	20%	X	30%	X
	Outpatient Services	20%	X	20%	X	30%	X
	Inpatient Services	20%	X	20%	X	30%	X
Pregnancy	Prenatal Care And Preconception Services	\$0		\$0		\$0	
	Delivery And All Inpatient Services - Hospital	20%	X	20%	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)	20%	X	20%	X	30%	X
	Outpatient Rehabilitation Services	20%	X	20%	X	30%	X
	Outpatient Habilitation Services	20%	X	20%	X	30%	X
	Skilled Nursing Care	20%	X	20%	X	30%	X
	Durable Medical Equipment	20%	X	20%	X	30%	X
	Hospice Services	20%	X	20%	X	30%	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.

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