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.**

****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 3		2021 Standard Bronze Copay Plan Alt 4	
2021 Actuarial Value		66.48%		64.96%		64.84%	
Individual Overall Deductible		$8,000		$8,350		$8,200	
Other Individual Deductibles for Specific Services							
Medical		$7,250		$7,500		$7,350	
Prescription Drugs		$750		$850		$850	
Dental		$0		$0		$0	
Individual Out-of-Pocket Maximum		$8,000		$8,550		$8,550	
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		$60		$65	
	Specialist Visit	$100		$125		$130	
	Preventive Care/Screening/Immunization	$0		$0		$0	
Tests	Laboratory Tests	$55	X	$55	X	$55	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	40%	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	40%	X	40%	X
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	40%	X	40%	X	40%	X
	Emergency Medical Transportation	40%	X	40%	X	40%	X
	Urgent Care	$100		$100		$100	
Hospital Stay	Facility Fee (e.g. Hospital Room)	40%	X	40%	X	40%	X
	Physician/Surgeon Fee						
Mental/Behavioral Health	Office Visits	$55		$60		$65	
	Outpatient Services	$0		$0		$0	
	Inpatient Services	40%	X	40%	X	40%	X
Substance Abuse Needs	Office Visits	$55		$60		$65	
	Outpatient Services	$0		$0		$0	
	Inpatient Services	40%	X	40%	X	40%	X
Pregnancy	Prenatal Care And Preconception Services	$0		$0		$0	
	Delivery And All Inpatient Services - Hospital	40%	X	40%	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	40%	X	40%	X
	Durable Medical Equipment	40%	X	40%	X	40%	X
	Hospice Services	40%	X	40%	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.**

****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 Alt 5		2021 Standard Bronze Copay Alt 6	
2021 Actuarial Value		66.48%		64.98%		64.91%	
Individual Overall Deductible		$8,000		$6,000		$6,000	
Other Individual Deductibles for Specific Services				Integrated Medical and Drug Deductible		Integrated Medical and Drug Deductible	
Medical		$7,250					
Prescription Drugs		$750					
Dental		$0					
Individual Out-of-Pocket Maximum		$8,000		$8,300		$8,550	
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		$40		55 (first 3 visits), 40% after	
	Specialist Visit	$100		$50	X	40%	X
	Preventive Care/Screening/Immunization	$0		$0		$0	
Tests	Laboratory Tests	$55	X	$55	X	40%	X
	X-Rays And Diagnostic Imaging	$80	X	$80	X	40%	X
	Imaging (CT/PET scans, MRIs)	$500	X	$500	X	40%	X
Drugs to Treat Illness or Condition***	Generic	$25		$20	X	$25	
	Preferred Brand	$75	X	$50	X	40%	X
	Non-Preferred Brand	$100	X	$70	X	50%	X
	Specialty	$150	X	$150	X	50%, max $150	X
Outpatient Surgery	Facility Fee (e.g. Hospital Room)	40%	X	$300	X	40%	X
	Physician/Surgeon Fee			$100			
Outpatient Non-Surgical Clinic Visit*	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	40%	X	$100	X	40%	X
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	40%	X	40%	X	40%	X
	Emergency Medical Transportation	40%	X	$50	X	40%	X
	Urgent Care	$100		$70		40%	
Hospital Stay	Facility Fee (e.g. Hospital Room)	40%	X	40%	X	40%	X
	Physician/Surgeon Fee						
Mental/Behavioral Health	Office Visits	$55		$40		40%	
	Outpatient Services	$0		$40		40%	
	Inpatient Services	40%	X	40%	X	40%	X
Substance Abuse Needs	Office Visits	$55		$40		40%	
	Outpatient Services	$0		$40		40%	
	Inpatient Services	40%	X	40%	X	40%	X
Pregnancy	Prenatal Care And Preconception Services	$0		$0		$0	
	Delivery And All Inpatient Services - Hospital	40%	X	40%	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	$0		40%	X
	Outpatient Rehabilitation Services	$50	X	$50	X	40%	X
	Outpatient Habilitation Services	$50	X	$50	X	40%	X
	Skilled Nursing Care	40%	X	$100 (per admit)	X	40%	X
	Durable Medical Equipment	40%	X	40%	X	40%	X
	Hospice Services	40%	X	$0		40%	X
Child Eye Care	Eye Exam (OD)	$50		$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	$41		20%	X	$41	
Child Dental Major Services	Root Canal - Molar	$512		20%		$512	
	Gingivectomy - Per Quad	$279		50%		$279	
	Extraction - Single Tooth Exposed Root	$69		50%		$69	
	Extraction - Complete Bony	$241		50%		$241	
	Porcelain With Metal Crown	$523		50%		$523	
Child Orthodontics	Medically Necessary Orthodontics	$3,422		50%		$3,422	

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