2020 - 2021 Medical Plan Descriptions

Benefits	Plan 3			Plan 4			Plan 6		
	Coordinated Care In-Network	Non-Coordinated Care In-Network	Out-of-Network	Coordinated Care In-Network	Non-Coordinated Care In-Network	Out-of-Network	Coordinated Care In-Network	Non-Coordinated Care In-Network	Out-of-Network
Plan Year Costs									
Deductible per person/family	$1,200/$3,900	$1,300/$3,900	$2,400/$7,200	$1,600/$5,100	$1,700/$5,100	$3,200/$9,600	$1,600/$3,400	$1,700.$3,400	$3,200/$6,400
Out-of-pocket max per person	$4,850	$5,250	$10,000	$6,700	$7,100	$13,700	$6,400	$6,750	$13,100
out-of-pocket max per family	$15,750	$15,750	$27,400	$15,800	$15,800	$27,400	$13,500	$13,500	$26,200
Max cost share per person (includes OOP & ACT)	$7,900	$7,900	N/A	$7,900	$7,900	N/A	N/A	N/A	N/A
Max cost share per family (includes OOP & ACT)	$15,800	$15,800	N/A	$15,800	$15,800	N/A	N/A	N/A	N/A
Preventive Care Services									
PCP360 wellness visit (ages 21 & over)	$0	$0	Not Covered	$0	$0	Not Covered	$0	$0	Not Covered
Routine adult, well-child, and women's exams; annual obesity screening & immunizatons	$0	$0	50%	$0	$0	50%	$0	$0	50%
Professional Services									
Primary care office visit	$25 copay	25%	50%	$25 copay	25%	50%	15%	20%	50%
Primary care office visit with a provider other than your PCP360	$50 copay	N/A	50%	$50 copay	N/A	50%	15%	N/A	50%
Specialist office visit	$50 copay	25%	50%	$50 copay	25%	50%	15%	20%	50%
Mental health office visit	$25 copay	$25 copay	50%	$25 copay	$25 copay	50%	15%	20%	50%
Chemical dependency services	$25 copay	$25 copay	50%	$25 copay	$25 copay	50%	15%	20%	50%
Virtual visits	$10 copay	$10 copay	N/A	$10 copay	$10 copay	N/A	$10 copay - after deductible met	$10 copay - after deductible met	N/A
Alternative Care Services ($2,000 plan year max)									
Acupuncture/chriopractic manipulation/ naturopathic remedies	$25 copay	25%	50%	$25 copay	25%	50%	20%	25%	50%
Maternity Care									
Physician or midwife services & hospital stay	25%	25%	50%	25%	25%	50%	20%	25%	50%
Outpaitent & Hospital Services									
Outpatient hospital/facility care	25%	25%	50%	25%	25%	50%	20%	25%	50%
Inpatient care/surgery	25%	25%	50%	25%	25%	50%	20%	25%	50%
Skilled nursing facility care (60 days per plan year)	25%	25%	50%	25%	25%	50%	20%	25%	50%
ACT 100: specified imaging (MRI, CT, PET) spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	$100 copay + 25%	$100 copay + 25%	$100 copay + 50%	$100 copay + 25%	$100 copay + 25%	$100 copay + 50%	20%	25%	50%
ACT 500: Spine surgery, knee & hip replacement, knee & shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 25%	$500 copay + 25%	$500 copay + 50%	$500 copay + 25%	$500 copay + 25%	$500 copay + 50%	20%	25%	50%
Bariatric surgery (Roux-en-Y & gastric sleeve)	$500 + 25%	$500 + 25%	$500 + 50%	$500 + 25%	$500 + 25%	$500 + 50%	$500 + 20%	$500 + 25%	Not Covered
Emergency Services									
Urgent care visit	$50 copay	25%	25%	$50 copay	25%	25%	15%	20%	20%
Emergency room (copay waived if admitted)	$100 copay + 25%	$100 copay + 25%	$100 copay + 25%	$100 copay + 25%	$100 copay + 25%	$100 copay + 25%	20%	25%	25%
Ambulance	25%	25%	25%	25%	25%	25%	20%	25%	25%
Other Covered Services									
Hearing aids and bone anchored hearing aids - $4,000 max every 48 months for adults	10%	10%	10%	10%	10%	10%	20%	25%	50%
Physical, occupational & speech therapy - 30 sessions per plan year 60 sessions per plan year for head or spinal injury	25%	25%	50%	25%	25%	50%	20%	25%	50%
Outpatient diagnostic lab & x-ray	25%	25%	50%	25%	25%	50%	20%	25%	50%
Durable medical equipment	25%	25%	50%	25%	25%	50%	20%	25%	50%

2020 - 2021 Dental Plan Descriptions

Benefits	Delta Dental Plan 5	Delta Dental Plan 6
Benefit maximum	$1,700	$1,200
Deductible	$50	$50
Preventive & Diagnostic Services - Deductible waived for preventive & diagnostic services		
Oral exams, x-rays, cleaning (prophlyaxis), flouride treatments, and space maintainers	70% - 100%	100%
Restorative Services		
Routine fillings, inlays and stainless steel crowns	70% - 100%	80%
Simple Extraction		
Simple tooth extractions	70% - 100%	80%
Oral Surgery		
Surgical tooth extractions, including diagnosis & evaluation	70% - 100%	80%
Periodontics		
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% -100%	80%
Endodontics		
Root canal and related therapy including diagnosis and evaluation	70% - 100%	80%
Major Restorative Services		
Gold or porcelain crowns and onlays	70%	50%
Implants	50%	50%
Other Covered Services		
Occlusal guards (night guards)	50% up to $250 max once every 5 years	50% up to $250 max once every 5 years
Athletic mouth guards	50%	50%
Nitrous Oxide	50%	50%
Fixed and Removable Prosthetic Services		
Full & partial dentures, relines, rebases	50%	50%
Bridge retainers & pontics	50%	50%
Orthodontics		
Orthodontic treatment	80% to $1,800 lifetime max	N/A

2020 - 2021 Vision Plan Descriptions

Benefits	Moda Opal	Moda Quartz
Benefit maximum	$600	$250
Routine Eye Exam		
Benefit	Plan pays 100% (up to plan max)	Plan pays 100% (up to plan max)
Frequency	Once per plan year	Once per plan year
Lenses/Contacts (Contacts in lieu of lenses)		
Basic lens benefit	Plan pays 100% (up to plan max)	Plan pays 100% (up to plan max)
Lens enhancements	Plan pays 100% (up to plan max)	Plan pays 100% (up to plan max)
Frequency	Once per plan year	Once per plan year
Frames		
Benefit	Plan pays 100% (up to plan max)	Plan pays 100% (up to plan max)
Frequency	Ages 0 - 16: Once per plan year Ages 17+: Once every two plan years	Ages 0 - 16: Once per plan year Ages 17+: Once every two plan years