	2018 Standard Bronze (AV of 63.92% for 2018) Minimal changes in **BOLD FONT** to comply w/ AV for 2019 estimated at 64.60% AV Plan design changes are estimated to result in a rate increase of +0.7% compared to 2018		2019 New Alternative 1 AV estimate: 64.60% Plan design changes are estimated to result in a rate decrease ranging from -3% to -5% compared to 2018		2019 New Alternative 2 AV estimate: 61.88% Plan design changes are estimated to result in a rate decrease ranging from -4% to -10% compared to 2018	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible: Individual (medical & Rx)	$6,000	$12,000	$6,000	$10,000	$6,500	$10,000
Deductible: Family (medical & Rx)	$12,000	$24,000	$12,000	$20,000	$13,000	$20,000
Out-of-Pocket Maximum: Individual	**$7,350 --> $7,900 for 2019**	**$14,700 --> $15,800 for 2019**	$7,900	$15,000	$7,900	$15,000
Out-of-Pocket Maximum: Family	**$14,700 --> $15,800 for 2019**	**$29,400 --> $31,600 for 2019**	$15,800	$30,000	$15,800	$30,000
Provider Office Visits						
Preventive Visit (Adult/Child)	$0	50% coinsurance	$0	50% coinsurance per visit after OON deductible	$0	50% coinsurance per visit after OON deductible
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	$40 copayment per visit	50% coinsurance per visit after OON deductible	$40 copayment per visit	50% coinsurance per visit after OON deductible	$40 copayment per visit	50% coinsurance per visit after OON deductible
Specialist Office Visits	$50 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible	$50 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible	$50 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible
Outpatient Diagnostic Services						
Advanced Radiology (CT/PET Scan, MRI)	$75 copay per service after INET deductible up to a combined annual maximum of $375 for MRI and CT scans; $400 for PET scans	50% coinsurance per service after OON deductible	40% coinsurance per service after INET deductible	50% coinsurance per service after OON deductible	50% coinsurance per service after INET deductible	50% coinsurance per service after OON deductible
Laboratory Services	$10 copayment per service after INET deductible	50% coinsurance per service after OON deductible	$10 copayment per service after INET deductible	50% coinsurance per service after OON deductible	50% coinsurance per service after INET deductible	50% coinsurance per service after OON deductible
Non-Advanced Radiology (X-ray, Diagnostic)	$40 copayment per service after INET deductible	50% coinsurance per service after OON deductible	$40 copayment per service after INET deductible	50% coinsurance per service after OON deductible	50% coinsurance per service after INET deductible	50% coinsurance per service after OON deductible
Mammography Ultrasound	$20 copayment per service after INET deductible	50% coinsurance per service after OON deductible	$20 copayment per service after INET deductible	50% coinsurance per service after OON deductible	50% coinsurance per service after INET deductible	50% coinsurance per service after OON deductible

	2018 Standard Bronze (AV of 63.92% for 2018) Minimal changes in **BOLD FONT** to comply w/ AV for 2019 estimated at 64.60% AV Plan design changes are estimated to result in a rate increase of +0.7% compared to 2018		2019 New Alternative 1 AV estimate: 64.60% Plan design changes are estimated to result in a rate decrease ranging from -3% to -5% compared to 2018		2019 New Alternative 2 AV estimate: 61.88% Plan design changes are estimated to result in a rate decrease ranging from -4% to -10% compared to 2018	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Prescription Drugs - Retail Pharmacy (up to 30 day supply per prescription)						
Tier 1	$5 copayment per prescription	50% coinsurance per prescription after OON deductible	$5 copayment per prescription	50% coinsurance per prescription after OON deductible	$5 copayment per prescription after INET deductible	50% coinsurance per prescription after OON deductible
Tier 2	50% coinsurance per prescription after INET deductible	50% coinsurance per prescription after OON deductible	50% coinsurance per prescription after INET deductible	50% coinsurance per prescription after OON deductible	50% coinsurance per prescription after INET deductible	50% coinsurance per prescription after OON deductible
Tier 3	50% coinsurance per prescription after INET deductible	50% coinsurance per prescription after OON deductible	50% coinsurance per prescription after INET deductible	50% coinsurance per prescription after OON deductible	50% coinsurance per prescription after INET deductible	50% coinsurance per prescription after OON deductible
Tier 4	50% coinsurance up to a maximum of $500 per prescription after INET deductible	50% coinsurance per prescription after OON deductible	50% coinsurance up to a maximum of $500 per prescription after INET deductible	50% coinsurance per prescription after OON deductible	50% coinsurance up to a maximum of $500 per prescription after INET deductible	50% coinsurance per prescription after OON deductible
Outpatient Rehabilitative and Habilitative Services						
Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT)	$30 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible	$50 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible	$50 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible
Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT)	$30 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible	$30 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible	$30 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible
Other Services						
Chiropractic Services (up to 20 visits per calendar year)	$50 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible	$50 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible	$50 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible
Diabetic Supplies & Equipment	40% coinsurance per equipment/supply after INET deductible	50% coinsurance per equipment / supply after OON deductible	50% coinsurance per equipment/supply after INET deductible	50% coinsurance per equipment / supply after OON deductible	50% coinsurance per equipment/supply after INET deductible	50% coinsurance per equipment / supply after OON deductible
Durable Medical Equipment	40% coinsurance per equipment/supply after INET deductible	50% coinsurance per equipment / supply after OON deductible	50% coinsurance per equipment/supply after INET deductible	50% coinsurance per equipment / supply after OON deductible	50% coinsurance per equipment/supply after INET deductible	50% coinsurance per equipment / supply after OON deductible
Home Health Care Services (up to 100 visits per calendar year)	25% coinsurance per visit after separate $50 deductible	25% coinsurance per visit after separate $50 deductible	25% coinsurance per visit	25% coinsurance per visit	25% coinsurance per visit	25% coinsurance per visit
Outpatient Services (in a hospital or ambulatory facility)	$500 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible	40% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible

	2018 Standard Bronze (AV of 63.92% for 2018) Minimal changes in **BOLD FONT** to comply w/ AV for 2019 estimated at 64.60% AV Plan design changes are estimated to result in a rate increase of +0.7% compared to 2018		2019 New Alternative 1 AV estimate: 64.60% Plan design changes are estimated to result in a rate decrease ranging from -3% to -5% compared to 2018		2019 New Alternative 2 AV estimate: 61.88% Plan design changes are estimated to result in a rate decrease ranging from -4% to -10% compared to 2018	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Hospital Services						
Inpatient Hospital Services (including MH, SA, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year)	$500 copayment per day to a maximum of $1,000 per admission after INET deductible	50% coinsurance per admission after OON deductible	40% coinsurance per admission after INET deductible	50% coinsurance per admission after OON deductible	50% coinsurance per admission after INET deductible	50% coinsurance per admission after OON deductible
Emergency and Urgent Care						
Ambulance Services	$0 copay after INET deductible	$0 copay after INET deductible	40% coinsurance per service after INET deductible	40% coinsurance per service after INET deductible	50% coinsurance per service after INET deductible	50% coinsurance per service after INET deductible
Emergency Room	$200 copayment per visit after INET deductible	$200 copayment per visit after INET deductible	40% coinsurance per visit after INET deductible	40% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible
Urgent Care Center or Facility	$75 copayment per visit	50% coinsurance per visit after OON deductible	$75 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible
Pediatric Dental Care (for children under age 19)						
Diagnostic & Preventive	$0 copay	50% coinsurance per visit after OON deductible	$0 copay	50% coinsurance per visit after OON deductible	$0 copay	50% coinsurance per visit after OON deductible
Basic Services	45% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible
Major Services	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible
Orthodontia Services (medically necessary only)	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible
Pediatric Vision Care (for children under age 19)						
Prescription Eye Glasses (one pair of frames & lenses per calendar year)	$0 copay for Lenses; $0 copay for Collection frame; Substantially equal credit for non-collection frame selection	Not Covered	$0 copayment per service after INET deductible	Not Covered	$0 copayment per service after INET deductible	Not Covered
Routine Eye Exam by Specialist (one exam per calendar year)	$50 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible	$50 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible	$50 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible

	2018 Standard Silver (AV of 71.5% for 2018) Minimal changes in **BOLD FONT** to comply w/ AV for 2019 estimated at 71.9% AV Plan design changes are estimated to result in a rate increase of +0.4% compared to 2018		2019 Coinsurance Alternative AV estimate: 70.11% - 70.89% Plan design changes are estimated to result in a rate decrease ranging from -2% to -8% compared to 2018	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible: Individual (medical)	**$3,700 --> $4,300 for 2019**	**$7,400 --> $8,600 for 2019**	$3,500	$7,400
Deductible: Family (medical)	**$7,400 --> $8,600 for 2019**	**$14,800 --> $17,200 for 2019**	$7,000	$14,800
Deductible: Individual (prescription)	$250	$500	$250	$500
Deductible: Family (prescription)	$500	$1,000	$500	$1,000
Out-of-Pocket Maximum: Individual	**$7,350 --> $7,900 for 2019**	**$14,700 --> $15,800 for 2019**	$7,900	$15,800
Out-of-Pocket Maximum: Family	**$14,700 --> $15,800 for 2019**	**$29,400 --> $31,600 for 2019**	$15,800	$31,600
Provider Office Visits				
Preventive Visit (Adult/Child)	$0	40% coinsurance	$0	40% coinsurance
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	$40 copayment per visit	40% coinsurance per visit after OON medical deductible	30% coinsurance	40% coinsurance per visit after OON medical deductible
Specialist Office Visits	$50 copayment per visit	40% coinsurance per visit after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible

	2018 Standard Silver (AV of 71.5% for 2018) Minimal changes in **BOLD FONT** to comply w/ AV for 2019 estimated at 71.9% AV Plan design changes are estimated to result in a rate increase of +0.4% compared to 2018		2019 Coinsurance Alternative AV estimate: 70.11% - 70.89% Plan design changes are estimated to result in a rate decrease ranging from -2% to -8% compared to 2018	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Diagnostic Services				
Advanced Radiology (CT/PET Scan, MRI)	$75 copayment per service up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	40% coinsurance per service after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per service after OON medical deductible
Laboratory Services	$10 copayment per service after INET deductible	40% coinsurance per service after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per service after OON medical deductible
Non-Advanced Radiology (X-ray, Diagnostic)	$40 copayment per service after INET deductible	40% coinsurance per service after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per service after OON medical deductible
Mammography Ultrasound	$20 copayment per service	40% coinsurance per service after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per service after OON medical deductible
Prescription Drugs - Retail Pharmacy (up to 30 day supply per prescription)				
Tier 1	$5 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible	$5 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible
Tier 2	$35 copayment per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible	30% coinsurance per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible
Tier 3	$60 copayment per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible	30% coinsurance per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible
Tier 4	20% coinsurance up to a maximum of $200 per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible	30% coinsurance up to a maximum of $200 per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible

	2018 Standard Silver (AV of 71.5% for 2018) Minimal changes in **BOLD FONT** to comply w/ AV for 2019 estimated at 71.9% AV Plan design changes are estimated to result in a rate increase of +0.4% compared to 2018		2019 Coinsurance Alternative AV estimate: 70.11% - 70.89% Plan design changes are estimated to result in a rate decrease ranging from -2% to -8% compared to 2018	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Rehabilitative and Habilitative Services				
Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT)	$30 copayment per visit	40% coinsurance per visit after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible
Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT)	$30 copayment per visit	40% coinsurance per visit after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible
Other Services				
Chiropractic Services (up to 20 visits per calendar year)	$50 copayment per visit	40% coinsurance per visit after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible
Diabetic Supplies & Equipment	40% coinsurance per equipment / supply	40% coinsurance per equipment / supply after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per equipment / supply after OON medical deductible
Durable Medical Equipment	40% coinsurance per equipment / supply	40% coinsurance per equipment / supply after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per equipment / supply after OON medical deductible
Home Health Care Services (up to 100 visits per calendar year)	$0 copay	25% coinsurance per visit after separate $50 deductible	25% coinsurance per visit after separate $50 deductible	25% coinsurance per visit after separate $50 deductible
Outpatient Services (in a hospital or ambulatory facility)	$500 copayment per visit after INET plan deductible	40% coinsurance per visit after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible
Hospital Services				
Inpatient Hospital Services (including MH, SA, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year)	$500 copayment per day to a maximum of $2,000 per admission after INET plan deductible	40% coinsurance per visit after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible

	2018 Standard Silver (AV of 71.5% for 2018) Minimal changes in **BOLD FONT** to comply w/ AV for 2019 estimated at 71.9% AV Plan design changes are estimated to result in a rate increase of +0.4% compared to 2018		2019 Coinsurance Alternative AV estimate: 70.11% - 70.89% Plan design changes are estimated to result in a rate decrease ranging from -2% to -8% compared to 2018	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Emergency and Urgent Care				
Ambulance Services	$0 copay	$0 copay	30% coinsurance after INET medical deductible	30% coinsurance after INET medical deductible
Emergency Room	$200 copayment per visit after INET medical deductible	$200 copayment per visit after INET medical deductible	30% coinsurance after INET medical deductible	30% coinsurance after INET medical deductible
Urgent Care Center or Facility	$75 copayment per visit	40% coinsurance per visit after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible
Pediatric Dental Care (for children under age 19)				
Diagnostic & Preventive	$0 copay	50% coinsurance per visit after OON medical deductible	0% coinsurance	50% coinsurance per visit after OON medical deductible
Basic Services	40% coinsurance per visit	50% coinsurance per visit after OON medical deductible	30% coinsurance per visit after INET medical deductible	50% coinsurance per visit after OON medical deductible
Major Services	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible	40% coinsurance per visit after INET medical deductible	50% coinsurance per visit after OON medical deductible
Orthodontia Services (medically necessary only)	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible	50% coinsurance per visit after INET medical deductible	50% coinsurance per visit after OON medical deductible
Pediatric Vision Care (for children under age 19)				
Prescription Eye Glasses (one pair of frames & lenses per calendar year)	$0 copay for Lenses; $0 copay for Collection frame; Substantially equal credit for non-collection frame selection	Not Covered	30% coinsurance after INET medical deductible	Not Covered
Routine Eye Exam by Specialist (one exam per calendar year)	$50 copayment per visit	40% coinsurance per visit after OON medical deductible	30% coinsurance per visit after INET medical deductible	50% coinsurance per visit after OON medical deductible

	2018 Standard Silver (AV of 71.53% for 2018) Minimal changes in **BOLD FONT** to comply w/ AV for 2019 estimated at 71.90% AV Plan design changes are estimated to result in a rate increase of +0.4% compared to 2018		2019 Minimal Changes Alternative: 73% Cost Sharing Reduction Plan (AV of 73.62% for 2018) Minimal changes in BOLD FONT to comply w/ AV for 2019 AV estimate: 73.90%	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible: Individual (medical)	**$3,700 --> $4,300 for 2019**	**$7,400 --> $8,600 for 2019**	**$3,350 --> $3,900 for 2019**	**$7,400 --> $8,600 for 2019**
Deductible: Family (medical)	**$7,400 --> $8,600 for 2019**	**$14,800 --> $17,200 for 2019**	**$6,700 --> $7,800 for 2019**	**$14,800 --> $17,200 for 2019**
Deductible: Individual (prescription)	$250	$500	$250	$500
Deductible: Family (prescription)	$500	$1,000	$500	$1,000
Out-of-Pocket Maximum: Individual	**$7,350 --> $7,900 for 2019**	**$14,700 --> $15,800 for 2019**	**$5,850 --> $6,300 for 2019**	**$14,700 --> $15,800 for 2019**
Out-of-Pocket Maximum: Family	**$14,700 --> $15,800 for 2019**	**$29,400 --> $31,600 for 2019**	**$11,700 --> $12,600 for 2019**	**$29,400 --> $31,600 for 2019**
Provider Office Visits				
Preventive Visit (Adult/Child)	$0	40% coinsurance	$0	40% coinsurance
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	$40 copayment per visit	40% coinsurance per visit after OON medical deductible	$40 copayment per visit	40% coinsurance per visit after OON medical deductible
Specialist Office Visits	$50 copayment per visit	40% coinsurance per visit after OON medical deductible	$50 copayment per visit	40% coinsurance per visit after OON medical deductible

	2018 Standard Silver (AV of 71.53% for 2018) Minimal changes in **BOLD FONT** to comply w/ AV for 2019 estimated at 71.90% AV Plan design changes are estimated to result in a rate increase of +0.4% compared to 2018		2019 Minimal Changes Alternative: 73% Cost Sharing Reduction Plan (AV of 73.62% for 2018) Minimal changes in BOLD FONT to comply w/ AV for 2019 AV estimate: 73.90%	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Diagnostic Services				
Advanced Radiology (CT/PET Scan, MRI)	$75 copayment per service up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	40% coinsurance per service after OON medical deductible	$75 copayment per service up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	40% coinsurance per service after OON medical deductible
Laboratory Services	$10 copayment per service after INET deductible	40% coinsurance per service after OON medical deductible	$10 copayment per service after INET deductible	40% coinsurance per service after OON medical deductible
Non-Advanced Radiology (X-ray, Diagnostic)	$40 copayment per service after INET deductible	40% coinsurance per service after OON medical deductible	$40 copayment per service after INET deductible	40% coinsurance per service after OON medical deductible
Mammography Ultrasound	$20 copayment per service	40% coinsurance per service after OON medical deductible	$20 copayment per service	40% coinsurance per service after OON medical deductible
Prescription Drugs - Retail Pharmacy (up to 30 day supply per prescription)				
Tier 1	$5 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible	$5 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible
Tier 2	$35 copayment per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible	$35 copayment per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible
Tier 3	$60 copayment per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible	$60 copayment per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible
Tier 4	20% coinsurance up to a maximum of $200 per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible	20% coinsurance up to a maximum of $100 per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible

	2018 Standard Silver (AV of 71.53% for 2018) Minimal changes in **BOLD FONT** to comply w/ AV for 2019 estimated at 71.90% AV Plan design changes are estimated to result in a rate increase of +0.4% compared to 2018		2019 Minimal Changes Alternative: 73% Cost Sharing Reduction Plan (AV of 73.62% for 2018) Minimal changes in BOLD FONT to comply w/ AV for 2019 AV estimate: 73.90%	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Rehabilitative and Habilitative Services				
Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT)	$30 copayment per visit	40% coinsurance per visit after OON medical deductible	$30 copayment per visit	40% coinsurance per visit after OON medical deductible
Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT)	$30 copayment per visit	40% coinsurance per visit after OON medical deductible	$30 copayment per visit	40% coinsurance per visit after OON medical deductible
Other Services				
Chiropractic Services (up to 20 visits per calendar year)	$50 copayment per visit	40% coinsurance per visit after OON medical deductible	$50 copayment per visit	40% coinsurance per visit after OON medical deductible
Diabetic Supplies & Equipment	40% coinsurance per equipment / supply	40% coinsurance per equipment / supply after OON medical deductible	40% coinsurance per equipment / supply	40% coinsurance per equipment / supply after OON medical deductible
Durable Medical Equipment	40% coinsurance per equipment / supply	40% coinsurance per equipment / supply after OON medical deductible	40% coinsurance per equipment / supply	40% coinsurance per equipment / supply after OON medical deductible
Home Health Care Services (up to 100 visits per calendar year)	$0 copay	25% coinsurance per visit after separate $50 deductible	$0 copay	25% coinsurance per visit after separate $50 deductible
Outpatient Services (in a hospital or ambulatory facility)	$500 copayment per visit after INET plan deductible	40% coinsurance per visit after OON medical deductible	$500 copayment per visit after INET plan deductible	40% coinsurance per visit after OON medical deductible

	2018 Standard Silver (AV of 71.53% for 2018) Minimal changes in **BOLD FONT** to comply w/ AV for 2019 estimated at 71.90% AV Plan design changes are estimated to result in a rate increase of +0.4% compared to 2018		2019 Minimal Changes Alternative: 73% Cost Sharing Reduction Plan (AV of 73.62% for 2018) Minimal changes in BOLD FONT to comply w/ AV for 2019 AV estimate: 73.90%	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Hospital Services				
Inpatient Hospital Services (including MH, SA, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year)	$500 copayment per day to a maximum of $2,000 per admission after INET plan deductible	40% coinsurance per visit after OON medical deductible	$500 copayment per day to a maximum of $2,000 per admission after INET plan deductible	40% coinsurance per visit after OON medical deductible
Emergency and Urgent Care				
Ambulance Services	$0 copay	$0 copay	$0 copay	$0 copay
Emergency Room	$200 copayment per visit after INET medical deductible	$200 copayment per visit after INET medical deductible	$200 copayment per visit after INET medical deductible	$200 copayment per visit after INET medical deductible
Urgent Care Center or Facility	$75 copayment per visit	40% coinsurance per visit after OON medical deductible	$75 copayment per visit	40% coinsurance per visit after OON medical deductible
Pediatric Dental Care (for children under age 19)				
Diagnostic & Preventive	$0 copay	50% coinsurance per visit after OON medical deductible	$0 copay	50% coinsurance per visit after OON medical deductible
Basic Services	40% coinsurance per visit	50% coinsurance per visit after OON medical deductible	40% coinsurance per visit	50% coinsurance per visit after OON medical deductible
Major Services	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible
Orthodontia Services (medically necessary only)	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible

	2018 Standard Silver (AV of 71.53% for 2018) Minimal changes in **BOLD FONT** to comply w/ AV for 2019 estimated at 71.90% AV Plan design changes are estimated to result in a rate increase of +0.4% compared to 2018		2019 Minimal Changes Alternative: 73% Cost Sharing Reduction Plan (AV of 73.62% for 2018) Minimal changes in BOLD FONT to comply w/ AV for 2019 AV estimate: 73.90%	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Pediatric Vision Care (for children under age 19)				
Prescription Eye Glasses (one pair of frames & lenses per calendar year)	$0 copay for Lenses; $0 copay for Collection frame; Substantially equal credit for non-collection frame selection	Not Covered	$0 copay for Lenses; $0 copay for Collection frame; Substantially equal credit for non-collection frame selection	Not Covered
Routine Eye Exam by Specialist (one exam per calendar year)	$50 copayment per visit	40% coinsurance per visit after OON medical deductible	$50 copayment per visit	40% coinsurance per visit after OON medical deductible

	2019 Minimal Changes Alternative: 87% Cost Sharing Reduction Plan (AV of 87.85% for 2018) Minimal changes in BOLD FONT to comply w/ AV for 2019 AV estimate: 87.90%		2019 Minimal Changes Alternative: 94% Cost Sharing Reduction Plan (AV of 94.86% for 2018) Minimal changes in BOLD FONT to comply w/ AV for 2019 AV estimate: 94.70%	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible: Individual (medical)	$600	**$7,400 --> $8,600 for 2019**	$0	**$7,400 --> $8,600 for 2019**
Deductible: Family (medical)	$1,200	**$14,800 --> $17,200 for 2019**	$0	**$14,800 --> $17,200 for 2019**
Deductible: Individual (prescription)	$50	$500	$0	$500
Deductible: Family (prescription)	$100	$1,000	$0	$1,000
Out-of-Pocket Maximum: Individual	**$2,000 --> $2,300 for 2019**	**$14,700 --> $15,800 for 2019**	**$750 --> $900 for 2019**	**$14,700 --> $15,800 for 2019**
Out-of-Pocket Maximum: Family	**$4,000 --> $4,600 for 2019**	**$29,400 --> $31,600 for 2019**	**$1,500 --> $1,800 for 2019**	**$29,400 --> $31,600 for 2019**
Preventive Visit (Adult/Child)	$0	40% coinsurance	$0	40% coinsurance
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	$20 copayment per visit	40% coinsurance per visit after OON medical deductible	$10 copayment per visit	40% coinsurance per visit after OON medical deductible
Specialist Office Visits	$35 copayment per visit	40% coinsurance per visit after OON medical deductible	$30 copayment per visit	40% coinsurance per visit after OON medical deductible

Plan Overview	2019 Minimal Changes Alternative: 87% Cost Sharing Reduction Plan (AV of 87.85% for 2018) Minimal changes in BOLD FONT to comply w/ AV for 2019 AV estimate: 87.90%		2019 Minimal Changes Alternative: 94% Cost Sharing Reduction Plan (AV of 94.86% for 2018) Minimal changes in BOLD FONT to comply w/ AV for 2019 AV estimate: 94.70%	
	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Advanced Radiology (CT/PET Scan, MRI)	$60 copayment per service up to a combined annual maximum of $360 for MRI and CAT scans; $400 for PET scans	40% coinsurance per service after OON medical deductible	$50 copayment per service up to a combined annual maximum of $350 for MRI and CAT scans; $400 for PET scans	40% coinsurance per service after OON medical deductible
Laboratory Services	$10 copayment per service after INET deductible	40% coinsurance per service after OON medical deductible	$10 copayment per service	40% coinsurance per service after OON medical deductible
Non-Advanced Radiology (X-ray, Diagnostic)	$30 copayment per service after INET deductible	40% coinsurance per service after OON medical deductible	$25 copayment per service	40% coinsurance per service after OON medical deductible
Mammography Ultrasound	$20 copayment per service	40% coinsurance per service after OON medical deductible	$20 copayment per service	40% coinsurance per service after OON medical deductible
Prescription Drugs -				
Tier 1	$5 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible	$5 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible
Tier 2	$20 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible	$10 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible
Tier 3	$35 copayment per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible	$30 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible
Tier 4	20% coinsurance up to a maximum of $60 per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible	20% coinsurance up to a maximum of $60 per prescription	40% coinsurance per prescription after OON prescription drug deductible

Plan Overview	2019 Minimal Changes Alternative: 87% Cost Sharing Reduction Plan (AV of 87.85% for 2018) Minimal changes in BOLD FONT to comply w/ AV for 2019 AV estimate: 87.90%		2019 Minimal Changes Alternative: 94% Cost Sharing Reduction Plan (AV of 94.86% for 2018) Minimal changes in BOLD FONT to comply w/ AV for 2019 AV estimate: 94.70%	
	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatie				
Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT)	$20 copayment per visit	40% coinsurance per visit after OON medical deductible	$20 copayment per visit	40% coinsurance per visit after OON medical deductible
Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT)	$20 copayment per visit	40% coinsurance per visit after OON medical deductible	$20 copayment per visit	40% coinsurance per visit after OON medical deductible
Chiropractic Services (up to 20 visits per calendar year)	$35 copayment per visit	40% coinsurance per visit after OON medical deductible	$30 copayment per visit	40% coinsurance per visit after OON medical deductible
Diabetic Supplies & Equipment	40% coinsurance per equipment / supply	40% coinsurance per equipment / supply after OON medical deductible	40% coinsurance per equipment / supply	40% coinsurance per equipment / supply after OON medical deductible
Durable Medical Equipment	40% coinsurance per equipment / supply	40% coinsurance per equipment / supply after OON medical deductible	40% coinsurance per equipment / supply	40% coinsurance per equipment / supply after OON medical deductible
Home Health Care Services (up to 100 visits per calendar year)	$0 copay	25% coinsurance per visit after separate $50 deductible	$0 copay	25% coinsurance per visit after separate $50 deductible
Outpatient Services (in a hospital or ambulatory facility)	$100 copayment per visit after INET plan deductible	40% coinsurance per visit after OON medical deductible	$75 copayment per visit	40% coinsurance per visit after OON medical deductible

	2019 Minimal Changes Alternative: 87% Cost Sharing Reduction Plan (AV of 87.85% for 2018) Minimal changes in BOLD FONT to comply w/ AV for 2019 AV estimate: 87.90%		2019 Minimal Changes Alternative: 94% Cost Sharing Reduction Plan (AV of 94.86% for 2018) Minimal changes in BOLD FONT to comply w/ AV for 2019 AV estimate: 94.70%	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Inpatient Hospital Services (including MH, SA, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year)	$100 copayment per day to a maximum of $400 per admission after INET plan deductible	40% coinsurance per visit after OON medical deductible	$75 copayment per day to a maximum of $300 per admission	40% coinsurance per visit after OON medical deductible
Ambulance Services	$0 copay	$0 copay	$0 copay	$0 copay
Emergency Room	$75 copayment per visit after INET medical deductible	$75 copayment per visit after INET medical deductible	$50 copayment per visit	$50 copayment per visit
Urgent Care Center or Facility	$35 copayment per visit	40% coinsurance per visit after OON medical deductible	$25 copayment per visit	40% coinsurance per visit after OON medical deductible
Pediatr				
Diagnostic & Preventive	$0 copay	50% coinsurance per visit after OON medical deductible	$0 copay	50% coinsurance per visit after OON medical deductible
Basic Services	40% coinsurance per visit	50% coinsurance per visit after OON medical deductible	40% coinsurance per visit	50% coinsurance per visit after OON medical deductible
Major Services	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible
Orthodontia Services (medically necessary only)	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible

Plan Overview	2019 Minimal Changes Alternative: 87% Cost Sharing Reduction Plan (AV of 87.85% for 2018) Minimal changes in BOLD FONT to comply w/ AV for 2019 AV estimate: 87.90%		2019 Minimal Changes Alternative: 94% Cost Sharing Reduction Plan (AV of 94.86% for 2018) Minimal changes in BOLD FONT to comply w/ AV for 2019 AV estimate: 94.70%	
	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Pediatı				
Prescription Eye Glasses (one pair of frames & lenses per calendar year)	$0 copay for Lenses; $0 copay for Collection frame; Substantially equal credit for non-collection frame selection	Not Covered	$0 copay for Lenses; $0 copay for Collection frame; Substantially equal credit for non-collection frame selection	Not Covered
Routine Eye Exam by Specialist (one exam per calendar year)	$35 copayment per visit	40% coinsurance per visit after OON medical deductible	$30 copayment per visit	40% coinsurance per visit after OON medical deductible

	2019 Coinsurance Alternative AV estimate: 70.11% - 70.89% Plan design changes are estimated to result in a rate decrease ranging from -2% to -8% compared to 2018		2019 Coinsurance Alternative: 73% Cost Sharing Reduction Plan AV estimate: 73.52%	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible: Individual (medical)	$3,500	$7,400	$2,600	$7,400
Deductible: Family (medical)	$7,000	$14,800	$5,200	$14,800
Deductible: Individual (prescription)	$250	$500	$250	$500
Deductible: Family (prescription)	$500	$1,000	$500	$1,000
Out-of-Pocket Maximum: Individual	$7,900	$15,800	$6,300	$15,800
Out-of-Pocket Maximum: Family	$15,800	$31,600	$12,600	$31,600
Provider Office Visits				
Preventive Visit (Adult/Child)	$0	40% coinsurance	$0	40% coinsurance
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	30% coinsurance	40% coinsurance per visit after OON medical deductible	30% coinsurance	40% coinsurance per visit after OON medical deductible
Specialist Office Visits	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible

	2019 Coinsurance Alternative AV estimate: 70.11% - 70.89% Plan design changes are estimated to result in a rate decrease ranging from -2% to -8% compared to 2018		2019 Coinsurance Alternative: 73% Cost Sharing Reduction Plan AV estimate: 73.52%	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Diagnostic Services				
Advanced Radiology (CT/PET Scan, MRI)	30% coinsurance after INET medical deductible	40% coinsurance per service after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per service after OON medical deductible
Laboratory Services	30% coinsurance after INET medical deductible	40% coinsurance per service after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per service after OON medical deductible
Non-Advanced Radiology (X-ray, Diagnostic)	30% coinsurance after INET medical deductible	40% coinsurance per service after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per service after OON medical deductible
Mammography Ultrasound	30% coinsurance after INET medical deductible	40% coinsurance per service after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per service after OON medical deductible
Prescription Drugs - Retail Pharmacy (up to 30 day supply per prescription)				
Tier 1	$5 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible	$5 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible
Tier 2	30% coinsurance per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible	30% coinsurance per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible
Tier 3	30% coinsurance per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible	30% coinsurance per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible
Tier 4	30% coinsurance up to a maximum of $200 per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible	30% coinsurance up to a maximum of $100 per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible

	2019 Coinsurance Alternative AV estimate: 70.11% - 70.89% Plan design changes are estimated to result in a rate decrease ranging from -2% to -8% compared to 2018		2019 Coinsurance Alternative: 73% Cost Sharing Reduction Plan AV estimate: 73.52%	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Rehabilitative and Habilitative Services				
Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT)	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible
Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT)	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible
Other Services				
Chiropractic Services (up to 20 visits per calendar year)	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible
Diabetic Supplies & Equipment	30% coinsurance after INET medical deductible	40% coinsurance per equipment / supply after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per equipment / supply after OON medical deductible
Durable Medical Equipment	30% coinsurance after INET medical deductible	40% coinsurance per equipment / supply after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per equipment / supply after OON medical deductible
Home Health Care Services (up to 100 visits per calendar year)	25% coinsurance per visit after separate $50 deductible	25% coinsurance per visit after separate $50 deductible	25% coinsurance per visit after separate $50 deductible	25% coinsurance per visit after separate $50 deductible
Outpatient Services (in a hospital or ambulatory facility)	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible

	2019 Coinsurance Alternative AV estimate: 70.11% - 70.89% Plan design changes are estimated to result in a rate decrease ranging from -2% to -8% compared to 2018		2019 Coinsurance Alternative: 73% Cost Sharing Reduction Plan AV estimate: 73.52%	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Hospital Services				
Inpatient Hospital Services (including MH, SA, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year)	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible
Emergency and Urgent Care				
Ambulance Services	30% coinsurance after INET medical deductible	30% coinsurance after INET medical deductible	30% coinsurance after INET medical deductible	30% coinsurance after INET medical deductible
Emergency Room	30% coinsurance after INET medical deductible	30% coinsurance after INET medical deductible	30% coinsurance after INET medical deductible	30% coinsurance after INET medical deductible
Urgent Care Center or Facility	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible	30% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible
Pediatric Dental Care (for children under age 19)				
Diagnostic & Preventive	0% coinsurance	50% coinsurance per visit after OON medical deductible	0% coinsurance	50% coinsurance per visit after OON medical deductible
Basic Services	30% coinsurance per visit after INET medical deductible	50% coinsurance per visit after OON medical deductible	30% coinsurance per visit after INET medical deductible	50% coinsurance per visit after OON medical deductible
Major Services	40% coinsurance per visit after INET medical deductible	50% coinsurance per visit after OON medical deductible	40% coinsurance per visit after INET medical deductible	50% coinsurance per visit after OON medical deductible
Orthodontia Services (medically necessary only)	50% coinsurance per visit after INET medical deductible	50% coinsurance per visit after OON medical deductible	50% coinsurance per visit after INET medical deductible	50% coinsurance per visit after OON medical deductible

	2019 Coinsurance Alternative AV estimate: 70.11% - 70.89% Plan design changes are estimated to result in a rate decrease ranging from -2% to -8% compared to 2018		2019 Coinsurance Alternative: 73% Cost Sharing Reduction Plan AV estimate: 73.52%	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Pediatric Vision Care (for children under age 19)				
Prescription Eye Glasses (one pair of frames & lenses per calendar year)	30% coinsurance after INET medical deductible	Not Covered	30% coinsurance after INET medical deductible	Not Covered
Routine Eye Exam by Specialist (one exam per calendar year)	30% coinsurance per visit after INET medical deductible	50% coinsurance per visit after OON medical deductible	30% coinsurance per visit after INET medical deductible	50% coinsurance per visit after OON medical deductible

	2019 Coinsurance Alternative: 87% Cost Sharing Reduction Plan AV estimate: 87.52%		2019 Coinsurance Alternative: 94% Cost Sharing Reduction Plan AV estimate: 94.76%	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible: Individual (medical)	$500	$7,400	$0	$7,400
Deductible: Family (medical)	$1,000	$14,800	$0	$14,800
Deductible: Individual (prescription)	$50	$500	$0	$500
Deductible: Family (prescription)	$100	$1,000	$0	$1,000
Out-of-Pocket Maximum: Individual	$2,300	$15,800	$750	$15,800
Out-of-Pocket Maximum: Family	$4,600	$31,600	$1,500	$31,600
Preventive Visit (Adult/Child)	$0	40% coinsurance	$0	40% coinsurance
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	20% coinsurance	40% coinsurance per visit after OON medical deductible	20% coinsurance	40% coinsurance per visit after OON medical deductible
Specialist Office Visits	20% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible	20% coinsurance	40% coinsurance per visit after OON medical deductible

	2019 Coinsurance Alternative: 87% Cost Sharing Reduction Plan AV estimate: 87.52%		2019 Coinsurance Alternative: 94% Cost Sharing Reduction Plan AV estimate: 94.76%	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Advanced Radiology (CT/PET Scan, MRI)	20% coinsurance after INET medical deductible	40% coinsurance per service after OON medical deductible	20% coinsurance	40% coinsurance per service after OON medical deductible
Laboratory Services	20% coinsurance after INET medical deductible	40% coinsurance per service after OON medical deductible	20% coinsurance	40% coinsurance per service after OON medical deductible
Non-Advanced Radiology (X-ray, Diagnostic)	20% coinsurance after INET medical deductible	40% coinsurance per service after OON medical deductible	20% coinsurance	40% coinsurance per service after OON medical deductible
Mammography Ultrasound	20% coinsurance after INET medical deductible	40% coinsurance per service after OON medical deductible	20% coinsurance	40% coinsurance per service after OON medical deductible
Prescription Drugs -				
Tier 1	$5 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible	$5 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible
Tier 2	20% coinsurance per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible	20% coinsurance per prescription	40% coinsurance per prescription after OON prescription drug deductible
Tier 3	20% coinsurance per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible	20% coinsurance per prescription	40% coinsurance per prescription after OON prescription drug deductible
Tier 4	20% coinsurance up to a maximum of $60 per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible	20% coinsurance up to a maximum of $60 per prescription	40% coinsurance per prescription after OON prescription drug deductible

	2019 Coinsurance Alternative: 87% Cost Sharing Reduction Plan AV estimate: 87.52%		2019 Coinsurance Alternative: 94% Cost Sharing Reduction Plan AV estimate: 94.76%	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpati				
Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT)	20% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible	20% coinsurance	40% coinsurance per visit after OON medical deductible
Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT)	20% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible	20% coinsurance	40% coinsurance per visit after OON medical deductible
Chiropractic Services (up to 20 visits per calendar year)	20% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible	20% coinsurance	40% coinsurance per visit after OON medical deductible
Diabetic Supplies & Equipment	20% coinsurance after INET medical deductible	40% coinsurance per equipment / supply after OON medical deductible	20% coinsurance	40% coinsurance per equipment / supply after OON medical deductible
Durable Medical Equipment	20% coinsurance after INET medical deductible	40% coinsurance per equipment / supply after OON medical deductible	20% coinsurance	40% coinsurance per equipment / supply after OON medical deductible
Home Health Care Services (up to 100 visits per calendar year)	25% coinsurance per visit after separate $50 deductible	25% coinsurance per visit after separate $50 deductible	25% coinsurance per visit after separate $50 deductible	25% coinsurance per visit after separate $50 deductible
Outpatient Services (in a hospital or ambulatory facility)	20% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible	20% coinsurance	40% coinsurance per visit after OON medical deductible

	2019 Coinsurance Alternative: 87% Cost Sharing Reduction Plan AV estimate: 87.52%		2019 Coinsurance Alternative: 94% Cost Sharing Reduction Plan AV estimate: 94.76%	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Inpatient Hospital Services (including MH, SA, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year)	20% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible	20% coinsurance	40% coinsurance per visit after OON medical deductible
Ambulance Services	20% coinsurance after INET medical deductible	20% coinsurance after INET medical deductible	20% coinsurance	20% coinsurance
Emergency Room	20% coinsurance after INET medical deductible	20% coinsurance after INET medical deductible	20% coinsurance	20% coinsurance
Urgent Care Center or Facility	20% coinsurance after INET medical deductible	40% coinsurance per visit after OON medical deductible	20% coinsurance	40% coinsurance per visit after OON medical deductible
Pediat				
Diagnostic & Preventive	0% coinsurance	50% coinsurance per visit after OON medical deductible	0% coinsurance	50% coinsurance per visit after OON medical deductible
Basic Services	30% coinsurance per visit after INET medical deductible	50% coinsurance per visit after OON medical deductible	30% coinsurance per visit	50% coinsurance per visit after OON medical deductible
Major Services	40% coinsurance per visit after INET medical deductible	50% coinsurance per visit after OON medical deductible	40% coinsurance per visit	50% coinsurance per visit after OON medical deductible
Orthodontia Services (medically necessary only)	50% coinsurance per visit after INET medical deductible	50% coinsurance per visit after OON medical deductible	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible

	2019 Coinsurance Alternative: 87% Cost Sharing Reduction Plan AV estimate: 87.52%		2019 Coinsurance Alternative: 94% Cost Sharing Reduction Plan AV estimate: 94.76%	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Pediat				
Prescription Eye Glasses (one pair of frames & lenses per calendar year)	20% coinsurance after INET medical deductible	Not Covered	20% coinsurance	Not Covered
Routine Eye Exam by Specialist (one exam per calendar year)	20% coinsurance per visit after INET medical deductible	50% coinsurance per visit after OON medical deductible	20% coinsurance per visit	50% coinsurance per visit after OON medical deductible