Plan Overview	2018 Standard Gold In-Network (INET) Member Pays	2018 Standard Gold Out-of-Network (OON) Member Pays	2019 Alternative 1 In-Network (INET) Member Pays	2019 Alternative 1 Out-of-Network (OON) Member Pays	2019 Alternative 2 In-Network (INET) Member Pays	2019 Alternative 2 Out-of-Network (OON) Member Pays
Deductible: Individual (medical)	$1,250	$3,000	$2,000	$15,000	$1,500	Not Covered
Deductible: Family (medical)	$2,500	$6,000	$4,000	$30,000	$4,500	Not Covered
Deductible: Individual (prescription)	$50	$350	Included with Medical	Included with Medical	Included with Medical	Not Covered
Deductible: Family (prescription)	$100	$700	Included with Medical	Included with Medical	Included with Medical	Not Covered
Out-of-Pocket Maximum: Individual	$4,400	$8,800	$6,250	$20,000	$7,350	Not Covered
Out-of-Pocket Maximum: Family	$8,800	$17,600	$12,500	$40,000	$14,700	Not Covered
Provider Office Visits						
Preventive Visit (Adult/Child)	$0	30% coinsurance	$0	50% coinsurance	$0	Not Covered
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	$20 copayment per visit	30% coinsurance per visit after OON medical deductible	$30 copayment per visit	50% coinsurance per visit after OON deductible	$40 copayment per visit	Not Covered
Specialist Office Visits	$40 copayment per visit	30% coinsurance per visit after OON medical deductible	$50 copayment per visit	50% coinsurance per visit after OON deductible	$50 copayment per visit	Not Covered
Outpatient Diagnostic Services						
Advanced Radiology (CT/PET Scan, MRI)	$65 copayment per service up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	30% coinsurance per service after OON medical deductible	20% coinsurance per service after INET deductible	50% coinsurance per service after OON deductible	10% coinsurance per service after INET deductible	Not Covered
Laboratory Services	$10 copayment per service after INET medical deductible	30% coinsurance per service after OON medical deductible	20% coinsurance per service after INET deductible	50% coinsurance per service after OON deductible	10% coinsurance per service after INET deductible	Not Covered
Non-Advanced Radiology (X-ray, Diagnostic)	$40 copayment per service after INET medical deductible	30% coinsurance per service after OON medical deductible	20% coinsurance per service after INET deductible	50% coinsurance per service after OON deductible	10% coinsurance per service after INET deductible	Not Covered
Mammography Ultrasound	$20 copayment per service	30% coinsurance per service after OON medical deductible	20% coinsurance per service after INET deductible	50% coinsurance per service after OON plan deductible	10% coinsurance per service after INET deductible	Not Covered

Red font identifies information included in Actuarial Value Calculator

	2018 Standard Gold		2019 Alternative 1		2019 Alternative 2	
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	30% coinsurance per prescription after OON prescription drug deductible	$5 copayment per prescription	50% coinsurance per prescription after OON deductible	$5 copayment per prescription	Not Covered
Tier 2	$25 copayment per prescription	30% coinsurance per prescription after OON prescription drug deductible	$60 copayment per prescription	50% coinsurance per prescription after OON deductible	$60 copayment per prescription after deductible	Not Covered
Tier 3	$50 copayment per prescription	30% coinsurance per prescription after OON prescription drug deductible	50% coinsurance per prescription after INET deductible	50% coinsurance per prescription after OON deductible	50% coinsurance after INET deductible	Not Covered
Tier 4	20% coinsurance up to a maximum of $100 per prescription after INET prescription drug deductible	30% coinsurance per prescription after OON prescription drug deductible	50% coinsurance up to a maximum of $500 per prescription after INET deductible	50% coinsurance per prescription after OON deductible	50% coinsurance after INET deductible	Not Covered
Outpatient Rehabilitative and Habilitative Services						
Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT)	$20 copayment per visit	30% coinsurance per visit after OON medical deductible	$50 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible	0% coinsurance after INET deductible	Not Covered
Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT)	$20 copayment per visit	30% coinsurance per visit after OON medical deductible	$30 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible	0% coinsurance after INET deductible	Not Covered
Other Services						
Chiropractic Services (up to 20 visits per calendar year)	$40 copayment per visit	30% coinsurance per visit after OON medical deductible	$50 copayment per visit	50% coinsurance per visit after OON deductible	$50 copayment per visit	Not Covered
Diabetic Supplies & Equipment	30% coinsurance per equipment/supply	30% coinsurance per equipment / supply after OON medical deductible	20% coinsurance per equipment / supply after INET deductible	50% coinsurance per equipment / supply after OON deductible	10% coinsurance per equipment/supply after INET deductible	Not Covered
Durable Medical Equipment	30% coinsurance per equipment/supply	30% coinsurance per equipment / supply after OON medical deductible	20% coinsurance per equipment / supply after INET deductible	50% coinsurance per equipment / supply after OON deductible	10% coinsurance per equipment/supply after INET deductible	Not Covered
Home Health Care Services (up to 100 visits per calendar year)	$0 copay	25% coinsurance per visit after separate $50 deductible	20% coinsurance per visit	25% coinsurance per visit after separate $50 deductible	0% coinsurance per visit after separate $50 deductible	Not Covered
Outpatient Services (in a hospital or ambulatory facility)	$500 copayment after INET plan deductible	30% coinsurance per visit after OON medical deductible	20% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible	10% coinsurance after INET deductible	Not Covered

Red font identifies information included in Actuarial Value Calculator

Plan Overview	2018 Standard Gold In-Network (INET) Member Pays	2018 Standard Gold Out-of-Network (OON) Member Pays	2019 Alternative 1 In-Network (INET) Member Pays	2019 Alternative 1 Out-of-Network (OON) Member Pays	2019 Alternative 2 In-Network (INET) Member Pays	2019 Alternative 2 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 plan deductible	30% coinsurance per admission after OON medical deductible	20% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible	10% coinsurance after INET deductible	Not Covered
Emergency and Urgent Care						
Ambulance Services	$0 copay	$0 copay	20% coinsurance per service after INET deductible	20% coinsurance per service after INET deductible	0% coinsurance after INET deductible	0% coinsurance after INET deductible
Emergency Room	$200 copayment per visit	$200 copayment per visit	20% coinsurance per visit after INET deductible	20% coinsurance per visit after INET deductible	10% coinsurance per visit after INET deductible	10% coinsurance per visit after INET deductible
Urgent Care Center or Facility	$50 copayment per visit	30% coinsurance per visit after OON medical deductible	$75 copayment per visit	50% coinsurance per visit after OON deductible	$50 copayment per visit after INET deductible	Not Covered
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 deductible	$0 copay	Not Covered
Basic Services	20% coinsurance per visit	50% coinsurance per visit after OON medical deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible	20% coinsurance per visit	Not Covered
Major Services	40% coinsurance per visit	50% coinsurance per visit after OON medical deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible	40% coinsurance per visit	Not Covered
Orthodontia Services (medically necessary only)	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible	50% coinsurance per visit	Not Covered
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 after INET deductible for Lenses; $0 copay after INET deductible 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)	$40 copayment per visit	30% coinsurance per visit after OON medical deductible	$50 copayment per visit	50% coinsurance per visit after OON deductible	$50 copayment per visit	Not Covered

Red font identifies information included in Actuarial Value Calculator

Plan Overview	2018 Standard Silver 70% In-Network (INET) Member Pays	2018 Standard Silver 70% Out-of-Network (OON) Member Pays	2019 Alternative 1 In-Network (INET) Member Pays	2019 Alternative 1 Out-of-Network (OON) Member Pays	2019 Alternative 2 In-Network (INET) Member Pays	2019 Alternative 2 Out-of-Network (OON) Member Pays
Deductible: Individual (medical)	$3,700	$7,400	$5,500	$15,000	$3,700	Not Covered
Deductible: Family (medical)	$7,400	$14,800	$11,000	$30,000	$7,400	Not Covered
Deductible: Individual (prescription)	$250	$500	Included with Medical	Included with Medical	Included with Medical	Not Covered
Deductible: Family (prescription)	$500	$1,000	Included with Medical	Included with Medical	Included with Medical	Not Covered
Out-of-Pocket Maximum: Individual	$7,350	$14,700	$7,350	$20,000	$7,350	Not Covered
Out-of-Pocket Maximum: Family	$14,700	$29,400	$14,700	$40,000	$14,700	Not Covered
Provider Office Visits						
Preventive Visit (Adult/Child)	$0	40% coinsurance	$0	50% coinsurance	$0	Not Covered
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	50% coinsurance per visit after OON plan deductible	$40 copayment per visit	Not Covered
Specialist Office Visits	$50 copayment per visit	40% coinsurance per visit after OON medical deductible	$50 copayment per visit	50% coinsurance per visit after OON plan deductible	$50 copayment per visit	Not Covered
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	40% coinsurance per service after INET deductible	50% coinsurance per service after OON plan deductible	20% coinsurance after INET deductible	Not Covered
Laboratory Services	$10 copayment per service after INET deductible	40% coinsurance per service after OON medical deductible	40% coinsurance per service after INET deductible	50% coinsurance per service after OON plan deductible	$10 copayment per service after INET deductible	Not Covered
Non-Advanced Radiology (X-ray, Diagnostic)	$40 copayment per service after INET deductible	40% coinsurance per service after OON medical deductible	40% coinsurance per service after INET deductible	50% coinsurance per service after OON plan deductible	$40 copayment per service after INET deductible	Not Covered
Mammography Ultrasound	$20 copayment per service	40% coinsurance per service after OON medical deductible	40% coinsurance per service after INET deductible	50% coinsurance per service after OON plan deductible	$20 copayment per service after INET deductible	Not Covered

Red font identifies information included in Actuarial Value Calculator

Plan Overview	2018 Standard Silver 70% In-Network (INET) Member Pays	2018 Standard Silver 70% Out-of-Network (OON) Member Pays	2019 Alternative 1 In-Network (INET) Member Pays	2019 Alternative 1 Out-of-Network (OON) Member Pays	2019 Alternative 2 In-Network (INET) Member Pays	2019 Alternative 2 Out-of-Network (OON) Member Pays
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	50% coinsurance per prescription after OON deductible	$5 copayment per prescription	Not Covered
Tier 2	$35 copayment per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible	$60 copayment per prescription after INET deductible	50% coinsurance per prescription after OON deductible	$35 copayment per prescription after INET deductible	Not Covered
Tier 3	$60 copayment per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible	50% coinsurance per prescription after INET deductible	50% coinsurance per prescription after OON deductible	20% coinsurance per prescription after INET deductible	Not Covered
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	50% coinsurance up to a maximum of $500 per prescription after INET deductible	50% coinsurance per prescription after OON deductible	20% coinsurance per prescription after INET deductible	Not Covered
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	$50 copayment per visit after INET deductible	50% coinsurance per visit after OON plan deductible	$30 copayment per visit	Not Covered
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 after INET deductible	50% coinsurance per visit after OON plan deductible	$30 copayment per visit	Not Covered
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	50% coinsurance per visit after OON plan deductible	$50 copayment per visit	Not Covered
Diabetic Supplies & Equipment	40% coinsurance per equipment / supply	40% coinsurance per equipment / supply after OON medical deductible	40% coinsurance per equipment / supply after INET deductible	50% coinsurance per equipment / supply after OON plan deductible	40% coinsurance per equipment / supply	Not Covered
Durable Medical Equipment	40% coinsurance per equipment / supply	40% coinsurance per equipment / supply after OON medical deductible	40% coinsurance per equipment / supply after INET deductible	50% coinsurance per equipment / supply after OON plan deductible	40% coinsurance per equipment / supply	Not Covered
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	25% coinsurance per visit after separate $50 deductible	20% coinsurance per visit after separate $50 deductible	Not Covered
Outpatient Services (in a hospital or ambulatory facility)	$500 copayment per visit after INET plan deductible	40% coinsurance per visit after OON medical deductible	40% coinsurance per visit after INET plan deductible	50% coinsurance per visit after OON plan deductible	$500 copayment per visit after INET plan deductible	Not Covered

Red font identifies information included in Actuarial Value Calculator

Plan Overview	2018 Standard Silver 70% In-Network (INET) Member Pays	2018 Standard Silver 70% Out-of-Network (OON) Member Pays	2019 Alternative 1 In-Network (INET) Member Pays	2019 Alternative 1 Out-of-Network (OON) Member Pays	2019 Alternative 2 In-Network (INET) Member Pays	2019 Alternative 2 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	40% coinsurance per visit after INET plan deductible	50% coinsurance per visit after OON plan deductible	20% coinsurance after INET deductible	Not Covered
Emergency and Urgent Care						
Ambulance Services	$0 copay	$0 copay	40% coinsurance per service after INET plan deductible	40% coinsurance per service after INET plan deductible	0% coinsurance after INET plan deductible	0% coinsurance after INET plan deductible
Emergency Room	$200 copayment per visit after INET medical deductible	$200 copayment per visit after INET medical deductible	40% coinsurance per visit after INET plan deductible	40% coinsurance per visit after INET plan deductible	20% coinsurance after INET plan deductible	20% coinsurance after INET plan deductible
Urgent Care Center or Facility	$75 copayment per visit	40% coinsurance per visit after OON medical deductible	$75 copayment per visit	50% coinsurance per visit after OON plan deductible	$75 copayment per visit	Not Covered
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 plan deductible	$0 copay	Not Covered
Basic Services	40% coinsurance per visit	50% coinsurance per visit after OON medical deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON plan deductible	40% coinsurance per visit	Not Covered
Major Services	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON plan deductible	50% coinsurance per visit	Not Covered
Orthodontia Services (medically necessary only)	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON plan deductible	50% coinsurance per visit	Not Covered
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 after INET deductible for Lenses; $0 copay after INET deductible 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	50% coinsurance per visit after OON plan deductible	$50 copayment per visit	Not Covered

	2018 Standard Bronze		2019 Alternative 1		2019 Alternative 2	
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	$7,000	$15,000	$6,000	Not Covered
Deductible: Family (medical & Rx)	$12,000	$24,000	$14,000	$30,000	$12,000	Not Covered
Out-of-Pocket Maximum: Individual	$7,350	$14,700	$7,350	$20,000	$7,900	Not Covered
Out-of-Pocket Maximum: Family	$14,700	$29,400	$14,700	$40,000	$15,800	Not Covered
Provider Office Visits						
Preventive Visit (Adult/Child)	$0	50% coinsurance	$0	50% coinsurance	$0	Not Covered
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	$40 copayment per visit	50% coinsurance per visit after OON deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible	$40 copayment per visit	Not Covered
Specialist Office Visits	$50 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	$50 copayment per visit after INET deductible	Not Covered
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	50% coinsurance per service after INET deductible	50% coinsurance per service after OON deductible	40% coinsurance per service after INET deductible	Not Covered
Laboratory Services	$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	40% coinsurance per service after INET deductible	Not Covered
Non-Advanced Radiology (X-ray, Diagnostic)	$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	40% coinsurance per service after INET deductible	Not Covered
Mammography Ultrasound	$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	40% coinsurance per service after INET deductible	Not Covered

Red font identifies information included in Actuarial Value Calculator

	2018 Standard Bronze		2019 Alternative 1		2019 Alternative 2	
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	50% coinsurance per prescription after INET deductible	50% coinsurance per prescription after OON deductible	$5 copayment per prescription	Not Covered
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	Not Covered
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	Not Covered
Tier 4	50% coinsurance up to a maximum of $500 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	Not Covered
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% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible	$30 copayment per visit after INET deductible	Not Covered
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	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible	$30 copayment per visit after INET deductible	Not Covered
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% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible	$50 copayment per visit after INET deductible	Not Covered
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	40% coinsurance per equipment/supply after INET deductible	Not Covered
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	40% coinsurance per equipment/supply after INET deductible	Not Covered
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 after separate $50 deductible	25% coinsurance per visit after separate $50 deductible	Not Covered
Outpatient Services (in a hospital or ambulatory facility)	$500 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	40% coinsurance per visit after INET deductible	Not Covered

Red font identifies information included in Actuarial Value Calculator

	2018 Standard Bronze		2019 Alternative 1		2019 Alternative 2	
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	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible	40% coinsurance per visit after INET deductible	Not Covered
Emergency and Urgent Care						
Ambulance Services	$0 copay after INET deductible	$0 copay after INET deductible	50% coinsurance per service after INET deductible	50% coinsurance per service after INET deductible	0% coinsurance per service after INET deductible	0% coinsurance per service after INET deductible
Emergency Room	$200 copayment per visit after INET deductible	$200 copayment per visit after INET deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after INET deductible	40% coinsurance per service after INET deductible	40% coinsurance per service after INET deductible
Urgent Care Center or Facility	$75 copayment per visit	50% coinsurance per visit after OON deductible	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible	$75 copayment per visit	Not Covered
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	Not Covered
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	45% coinsurance per visit after INET deductible	Not Covered
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	Not Covered
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	Not Covered
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 after INET deductible for Lenses; $0 copay after INET deductible 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 after INET deductible	50% coinsurance per visit after OON deductible	50% coinsurance per visit	50% coinsurance per visit after OON deductible	$50 copayment per visit after INET deductible	Not Covered

Red font identifies information included in Actuarial Value Calculator

Metal Tier	2017	2018	Alternate Plan 1	Alternate Plan 2	Est. Premium Change*
Bronze	6000/12000	6000/10000	7000/15000	6000	(10-15%)
AV	62%	63.92%	58.58/59.81%	64.66/64.62%	
Silver	4000/6000	3700/7400	5500/15000	3700	(20-25%)
AV	72%	71.53%	66.59/67.86	70.25/69.13%	
Gold	1550/3000	1250/3000	2000/15000	1500	(20-25%)
AV	81.10%	81.66%	76.01/77.32%	79.07/78.78%	

NOTE: Actuarial values are based on the AV calculator that was in place at the time the plans were developed.

*Actual change in premium will vary by carrier due to pricing assumption differentials, networks, administrative expenses, etc.