	2040 51-	dand Cald	2040 All	amatica 1	2040 414-	matica 2
		idard Gold		ernative 1	2019 Alte	
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)	\$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 Serv	rices				
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

	2018 Stan	dard Gold	2019 Alte	rnative 1	2019 Alte	ernative 2
	In-Network (INET) Member	Out-of-Network (OON)	In-Network (INET) Member	Out-of-Network (OON)	In-Network (INET) Member	Out-of-Network (OON)
Plan Overview	Pays	Member Pays	Pays	Member Pays	Pays	Member Pays
Prescription Drugs -	- Retail Pharmacy (up to 30 da	,				,
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
Outpat	tient Rehabilitative and Habili	tative 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

2018 Standard Gold		2019 Alte	ernative 1	2019 Alternative 2		
Plan Overview	In-Network (INET) Member	Out-of-Network (OON)	In-Network (INET) Member	Out-of-Network (OON)	In-Network (INET) Member	Out-of-Network (OON)
Plan Overview	Pays	Member Pays	Pays	Member Pays	Pays	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 Ca	are				
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
Pedia	tric Dental Care (for children u	· ,				
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
Pedia	tric Vision Care (for children u	nder 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

2018 Standard Silver 70%		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)	\$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 Serv	vices				
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

2018 Standard Silver 70%		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 da		Tays	Wiember rays	Tuys	Wiemberruys
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
Outpat	ient Rehabilitative and Habili	tative 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

	2018 Standar	rd Silver 70%	2019 Alte	ernative 1	2019 Alte	ernative 2
Plan Overview	In-Network (INET) Member	Out-of-Network (OON)	In-Network (INET) Member	Out-of-Network (OON)	In-Network (INET) Member	Out-of-Network (OON)
	Pays Hospital Services	Member Pays	Pays	Member Pays	Pays	Member Pays
Inpatient Hospital Services (including	nospitai services					
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 Ca	re				
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
Pedia	tric Dental Care (for children u	• '				
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
Pedia	tric Vision Care (for children u	nder 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			
Plan Overview	In-Network (INET) Member	Out-of-Network (OON)		
Plan Overview	Pays	Member Pays		
Deductible: Individual (medical & Rx)	\$6,000	\$12,000		
Deductible: Family (medical & Rx)	\$12,000	\$24,000		
Out-of-Pocket Maximum: Individual	\$7,350	\$14,700		
Out-of-Pocket Maximum: Family	\$14,700	\$29,400		
	Provider Office Visits			
Preventive Visit (Adult/Child)	\$0	50% coinsurance		
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	\$40 copayment per visit	50% coinsurance per visit after OON deductible		
Specialist Office	\$50 copayment per visit	50% coinsurance per visit		
Visits	after INET deductible	after OON deductible		
	Outpatient Diagnostic Serv	vices		
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		
Laboratory Services	\$10 copayment 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		
Mammography Ultrasound	\$20 copayment per service after INET deductible	50% coinsurance per service after OON deductible		

2019 Alternative 1				
In-Network (INET) Member	Out-of-Network (OON)			
Pays	Member Pays			
\$7,000	\$15,000			
\$14,000	\$30,000			
\$7,350	\$20,000			
\$14,700	\$40,000			
\$0	50% coinsurance			
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 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			
50% 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			

	ernative 2
In-Network (INET) Member	Out-of-Network (OON)
Pays	Member Pays
\$6,000	Not Covered
\$12,000	Not Covered
\$7,900	Not Covered
\$15,800	Not Covered
\$0	Not Covered
\$40 copayment per visit	Not Covered
\$50 copayment per visit after INET deductible	Not Covered
40% coinsurance per service after INET deductible	Not Covered
40% coinsurance per service after INET deductible	Not Covered
40% coinsurance per service after INET deductible	Not Covered
40% coinsurance per service after INET deductible	Not Covered

	2018 Standard Bronze				
Dian Oversion	In-Network (INET) Member	Out-of-Network (OON)			
Plan Overview	Pays	Member Pays			
Prescription Drugs	- Retail Pharmacy (up to 30 da	y supply per prescription)			
	\$5 copayment per	50% coinsurance per			
Tier 1	prescription	prescription after OON			
	prescription	deductible			
	50% coinsurance per	50% coinsurance per			
Tier 2	prescription after INET	prescription after OON			
	deductible	deductible			
	50% coinsurance per	50% coinsurance per			
Tier 3	prescription after INET	prescription after OON			
	deductible	deductible			
	50% coinsurance up to a				
	maximum of \$500 per	50% coinsurance per			
Tier 4	prescription after INET	prescription after OON			
	deductible	deductible			
Outpat	ient Rehabilitative and Habilit	ative Services			
-	icht Kenasintative and Habilit	active Del Vices			
Speech Therapy					
(40 visits per	\$30 copayment per visit	50% coinsurance per visit			
calendar year limit	after INET deductible	after OON deductible			
combined for	arter mer deduction	arter con academore			
PT/ST/OT)					
Physical and					
Occupational					
Therapy					
(40 visits per	\$30 copayment per visit	50% coinsurance per visit			
calendar year limit	after INET deductible	after OON deductible			
combined for					
PT/ST/OT)					
	Other Services				
Chiropractic Services					
(up to 20 visits per	\$50 copayment per visit	50% coinsurance per visit			
calendar year)	after INET deductible	after OON deductible			
caleffual year)					
Diabetic Supplies &	40% coinsurance per	50% coinsurance per			
Equipment	equipment/supply after INET	equipment / supply after			
Lyuipinient	deductible	OON deductible			
Durable Medical	40% coinsurance per	50% coinsurance per			
Equipment	equipment/supply after INET	equipment / supply after			
	deductible	OON deductible			
Home Health Care	25% coinsurance per visit	25% coinsurance per visit			
Services	after separate \$50	after separate \$50			
(up to 100 visits per	deductible	deductible			
calendar year)	acaactible	acaactible			
Outpatient Services					
(in a hospital or	\$500 copayment per visit	50% coinsurance per visit			
ambulatory facility)	after INET deductible	after OON deductible			

2019 Alte	ernative 1
In-Network (INET) Member	Out-of-Network (OON)
Pays	Member Pays
50% coinsurance per	50% coinsurance per
prescription after INET	prescription after OON
deductible	deductible
50% coinsurance per	50% coinsurance per
prescription after INET	prescription after OON
deductible	deductible
50% coinsurance per	50% coinsurance per
prescription after INET	prescription after OON
deductible	deductible
50% coinsurance per	50% coinsurance per
prescription after INET	prescription after OON
deductible	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
50% coinsurance per visit	50% coinsurance per visit
after INET deductible	after OON deductible
FOO/ paingurance v = "	FOO/ painsurance :
50% coinsurance per equipment/supply after INET	50% coinsurance per
	equipment / supply after
deductible 50% coinsurance per	OON deductible 50% coinsurance per
•	•
equipment/supply after INET	equipment / supply after
deductible	OON deductible
25% coinsurance per visit	25% coinsurance per visit after separate \$50 deductible
50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible

2019 Alte	rnativo 2
	Out-of-Network (OON)
Pays	Member Pays
rays	Welliber Fays
\$5 copayment per	
prescription	Not Covered
50% coinsurance per	
prescription after INET	Not Covered
deductible	
50% coinsurance per	
prescription after INET	Not Covered
deductible	
50% coinsurance per	
prescription after INET	Not Covered
deductible	
deddonore	
\$30 copayment per visit	
after INET deductible	Not Covered
\$30 copayment per visit	Not Covered
after INET deductible	Not Covered
Ć50	
\$50 copayment per visit after INET deductible	Not Covered
after INET deductible	
40% coinsurance per	
equipment/supply after INET	Not Covered
deductible	
40% coinsurance per	
equipment/supply after INET	Not Covered
deductible	
25% coinsurance per visit	
after separate \$50	Not Covered
deductible	1100 0010100
acaactoic	
40% coinsurance per visit	
after INET deductible	Not Covered
arter int i deductible	

Plan Overview Inpatient Hospital Services (including MH, SA, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year)	2018 Stand		2019 Alte	ernative 1		ernative 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	·			-	
Services (including MH, SA, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited	\$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 Ca	re				
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
Pedia	tric Dental Care (for children u	nder 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
Pedia	tric Vision Care (for children u	nder 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

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.