	Minimal changes in BOLD FO estimated a Plan design changes are estimat	(AV of 63.92% for 2018) NT to comply w/ AV for 2019 t 64.60% AV eed to result in a rate increase of ared 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	Out-of-Network (OON) Member Pays	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Network (INET) Member	Out-of-Network (OON) Member Pays
Deductible: Individual (medical & Rx)	Pays \$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			<u> </u>		L	
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	\$50 copayment per visit	50% coinsurance per visit	\$50 copayment per visit after	50% coinsurance per visit	\$50 copayment per visit after	50% coinsurance per visit
Visits	after INET deductible Outpatient Diagnostic Serv	after OON deductible	INET deductible	after OON deductible	INET deductible	after OON deductible
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 (Minimal changes in BOLD FO) estimated at Plan design changes are estimat +0.7% compa	NT to comply w/ AV for 2019 t 64.60% AV ed to result in a rate increase of	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 de 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 da	y supply per prescription)			<u> </u>	
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
Outpa	tient Rehabilitative and Habilit	ative 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 (Minimal changes in BOLD FO estimated at Plan design changes are estimat +0.7% compa	NT to comply w/ AV for 2019 64.60% AV ed to result in a rate increase of ired to 2018	2019 New A AV estima Plan design changes are estima ranging from -3% to -1	te: 64.60% ted to result in a rate decrease 5% compared to 2018	2018 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
culendur yeury	Emergency and Urgent Ca	re				
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
Pediat	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	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
Pediat	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 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

SILVER 70 PLANS

	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 deci ranging from -2% to -8% compared to 2018	
Plan Overview	In-Network (INET) Member	Out-of-Network (OON)	In-Network (INET) Member	Out-of-Network (OON)
Deductible: Individual (medical)	Pays \$3,700> \$4,300 for 2019	Member Pays	Pays \$3,500	Member Pays \$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 Coinsura AV estimate: 7 Plan design changes are estima ranging from -2% to -	0.11% - 70.89% Ited to result in a rate decrease
Plan Overview	In-Network (INET) Member	Out-of-Network (OON)		In-Network (INET) Member	Out-of-Network (OON)
Than Overview	Pays	Member Pays		Pays	Member Pays
	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		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 da	ay 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	Out-of-Network (OON)	In-Network (INET) Member	Out-of-Network (OON)
	Pays	Member Pays	Pays	Member Pays
	ient Rehabilitative and Habilit	ative 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		-	AV estimate: 7 n changes are estima	nce Alternative 0.11% - 70.89% ated to result in a rate decrease 8% compared to 2018
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	In-Networ	k (INET) Member Pays	Out-of-Network (OON) Member Pays
	Emergency and Urgent Ca	ire			
Ambulance Services	\$0 сорау	\$0 copay		urance after INET al 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		urance after INET al deductible	30% coinsurance after INET medical deductible
Urgent Care Center or Facility	\$75 copayment per visit	40% coinsurance per visit after OON medical deductible		urance after INET al deductible	40% coinsurance per visit after OON medical deductible
Pedia	tric Dental Care (for children u	nder age 19)			
Diagnostic & Preventive	\$0 copay	50% coinsurance per visit after OON medical deductible	0% c	oinsurance	50% coinsurance per visit after OON medical deductible
Basic Services	40% coinsurance per visit	50% coinsurance per visit after OON medical deductible	after I	surance per visit NET medical eductible	50% coinsurance per visit after OON medical deductible
Major Services	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible	after I	surance per visit NET medical eductible	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	after I	surance per visit NET medical eductible	50% coinsurance per visit after OON medical deductible
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		urance after INET al 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	after I	surance per visit NET medical eductible	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 Red Plan (AV of 73.62% for 2018) Minimal changes in BOLD FONT to comply w/ AV for 2 AV estimate: 73.90%	
Plan Overview	In-Network (INET) Member	Out-of-Network (OON)	In-Network (INET)	Out-of-Network (OON)
Deductible: Individual (medical)	Pays \$3,700> \$4,300 for 2019	Member Pays \$7,400> \$8,600 for 2019	Member Pays	Member Pays \$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 (A Minimal changes in BOLD FOI estimated at Plan design changes are estimate +0.4% compa	NT to comply w/ AV for 2019 71.90% AV ed to result in a rate increase of	2	Plan (AV of 73 Minimal changes in BOLD FC	ive: 73% Cost Sharing Reduction 8.62% for 2018) NT to comply w/ AV for 2019 ite: 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 Servi	ces		4	
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	y 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 R Plan (AV of 73.62% for 2018) Minimal changes in BOLD FONT to comply w/ AV fo 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
Outpatie	ent Rehabilitative and Habilit		Ι Γ		
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 сорау	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 (A\ Minimal changes in BOLD FON estimated at Plan design changes are estimate +0.4% compa	IT to comply w/ AV for 2019 71.90% AV d to result in a rate increase of	Plan (AV of 75 Minimal changes in BOLD FC	tive: 73% Cost Sharing Reduction 3.62% for 2018) DNT to comply w/ AV for 2019 ate: 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 Car	e		
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
Pediatr	ic Dental Care (for children ur	nder 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

	Minimal changes in BOLD FON estimated at Plan design changes are estimate	2018 Standard Silver (AV of 71.53% for 2018) finimal changes in BOLD FONT to comply w/ AV for 2019 estimated at 71.90% AV design changes are estimated to result in a rate increase of +0.4% compared to 2018		tive: 73% Cost Sharing Reduction 3.62% for 2018) DNT to comply w/ AV for 2019 ate: 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
Pediat	ric Vision Care (for children un	der 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 Alternativ Plan (AV of 87. Minimal changes in BOLD FON AV estimate	85% for 2018) NT to comply w/ AV for 2019	2019 Minimal Changes Alternati Plan (AV of 94 Minimal changes in BOLD FO AV estima	.86% for 2018) NT to comply w/ AV for 2019
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	\$1,500> \$1,800 for 2019	\$29,400> \$31,600 for
ividXIIIIUIII. Faililly	+ , + ,	2019	+=,====	2019
Preventive Visit (Adult/Child)	\$0	2019 40% coinsurance	\$0	2019 40% coinsurance
Preventive Visit				

	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 Alternativ Plan (AV of 94.8 Minimal changes in BOLD FON AV estimate	86% for 2018) IT to comply w/ AV for 2019
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)	\$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

	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
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 сорау	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 сорау	50% coinsurance per visit after OON medical deductible	\$0 сорау	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

	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
Pediati					
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: 7 AV estima	3% Cost Sharing Reduction Plan te: 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 Serv	vices			
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 da	ay 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	k	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	F	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	Ł	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 Reductio 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
Outpat	ient Rehabilitative and Habili	tative 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			'3% Cost Sharing Reduction Plan te: 73.52%
Plan Overview	In-Network (INET) Member	Out-of-Network (OON)	In-Network (INET) Member	Out-of-Network (OON)
	Pays Hospital Services	Member Pays	Pays	Member Pays
Inpatient Hospital	Hospital Services			
Services (including				
MH, SA, maternity,				
hospice and skilled		40% coinsurance per visit		40% coinsurance per visit
	30% coinsurance after INET	after OON medical	30% coinsurance after INET	after OON medical
nursing facility*) *(akillad pursing	medical deductible	deductible	medical deductible	deductible
*(skilled nursing facility stay is limited		deductible		deductible
to 90 days per				
calendar year)	Emergency and Urgent Ca			
	30% coinsurance after INET	30% coinsurance after INET	30% coinsurance after INET	30% coinsurance after INET
Ambulance Services	medical deductible	medical deductible	medical deductible	medical deductible
	30% coinsurance after INET	30% coinsurance after INET	30% coinsurance after INET	30% coinsurance after INET
Emergency Room	medical deductible	medical deductible	medical deductible	medical deductible
	inedical deductible	medical deddctible		
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
Pediat	ric Dental Care (for children ι	inder 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: 7 AV estima	3% Cost Sharing Reduction Plan te: 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
Pedia	tric Vision Care (for children u	nder 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 Pla 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%			94% Cost Sharing Reduction Plan ate: 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	Out-of-Network (OON)	In-Network (INET) Member	Out-of-Network (OON)
	Pays	Member Pays	Pays	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