

PLAN PROVISION		BASIC PLAN		PLUS PLAN		ULTRA PLAN		BRONZE PLAN		SILVER PLAN	
		<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Deductible (<i>Individual</i> <i>Family</i>)		\$5,000 \$10,000	\$10,000 \$20,000	\$1,200 \$2,400	\$2,400 \$4,800	\$500 \$1,000	\$1,000 \$2,000	\$2,000 \$4,000	\$4,000 \$8,000	\$500 \$1,000	\$1,000 \$2,000
Coinsurance (<i>Plan Pays</i>)		100%	100%	80%	20%	80%	20%	80%	60%	80%	60%
Maximum Out of Pocket (<i>Ind</i> <i>Fam</i>)		\$5,000 \$10,000	\$10,000 \$20,000	\$6,000 \$12,000	\$12,000 \$24,000	\$4,500 \$9,000	\$9,000 \$18,000	\$3,000 \$6,000	\$6,000 \$12,000	\$2,000 \$4,000	\$4,000 \$8,000
PREVENTIVE CARE SERVICES											
ACA Preventive Services Schedule		\$0 Copay	100% after ded.	\$0 Copay	20% after ded.	\$0 Copay	20% after ded.	\$0 Copay	60% after ded.	\$0 Copay	60% after ded.
Adult Routine Physical Exam, Mammogram, GYN Exam and PSA		\$0 Copay	100% after ded.	\$0 Copay	20% after ded.	\$0 Copay	20% after ded.	\$0 Copay	Not Covered	\$0 Copay	Not Covered
PHYSICIAN SERVICES											
Primary Care Office Visit		\$15 Copay <i>(3 visits per year)</i>	100% after ded.	\$35 Copay	20% after ded.	\$25 Copay	20% after ded.	80% after ded.	60% after ded.	\$20 Copay	60% after ded.
Specialist Visit		\$15 Copay <i>(3 visits per year)</i>	100% after ded.	\$65 Copay	20% after ded.	\$50 Copay	20% after ded.	80% after ded.	60% after ded.	\$20 Copay	60% after ded.
Urgent Care Visit		\$50 Copay <i>(3 visits per year)</i>	100% after ded.	\$40 Copay	20% after ded.	\$40 Copay	20% after ded.	80% after ded.	60% after ded.	80% after ded.	60% after ded.
Telemedicine Vendor Services		\$0 Copay	Not Applicable	\$0 Copay	Not Applicable	\$0 Copay	Not Applicable	\$0 Copay	Not Applicable	\$0 Copay	Not Applicable
HOSPITAL/FACILITY SERVICES (<i>Subject to Reference Based Pricing</i>)											
Inpatient Hospital Services (RBP)		100% covered after deductible		80% after deductible		80% after deductible		80% after deductible		80% after deductible	
Outpatient Hospital/ Freestanding Surgery (RBP)		100% covered after deductible		80% after deductible		80% after deductible		80% after deductible		80% after deductible	
Anesthesia (RBP)		100% covered after deductible		80% after deductible		80% after deductible		80% after deductible		80% after deductible	
Emergency Room (RBP)		\$1,000 Copay (<i>Hospital charges subject to ded. and coinsurance</i>)		\$500 Copay		\$500 Copay		80% after deductible		80% after deductible	
OUTPATIENT DIAGNOSTIC SERVICES (<i>Non-Hospital Based</i>)											
Lab/X-Ray		100% after ded.	100% after ded.	80% after ded.	20% after ded.	80% after ded.	20% after ded.	80% after ded.	60% after ded.	80% after ded.	60% after ded.
Complex Medical Imaging (RBP)		100% covered after deductible		80% after deductible		80% after deductible		80% after deductible		80% after deductible	
PREGNANCY BENEFITS											
Professional Services		100% after ded.	100% after ded.	80% after ded.	20% after ded.	80% after ded.	20% after ded.	80% after ded.	60% after ded.	80% after ded.	60% after ded.
Maternity/Childbirth/Delivery		100% covered after deductible		80% after deductible		80% after deductible		80% after deductible		80% after deductible	
PRESCRIPTION DRUG PLAN											
Prescriptions ACA Preventive Drugs Non-Preventive Generic Drugs Preferred Brand Drugs Non-Preferred Brand Drugs Specialty Drugs		\$0 Copay \$5 Copay Not Covered Not Covered Not Covered		\$0 Copay \$5 Copay 80% 70% after deductible Managed		\$0 Copay \$5 Copay 80% 70% after deductible Managed		\$0 Copay \$15 Copay, after ded. \$50 Copay, after ded. \$70 Copay, after ded. Managed		\$0 Copay \$10 Copay, after ded. \$40 Copay, after ded. \$80 Copay, after ded. Managed	
Automated Diabetic Supplies		80%		80%		80%		80%		80%	
VISION BENEFITS											
In-Office Comprehensive Vision Exams		\$0 Copay	Up to \$35 benefit	\$0 Copay	Up to \$35 benefit	\$0 Copay	Up to \$35 benefit	\$0 Copay	Up to \$35 benefit	\$0 Copay	Up to \$35 benefit
Eyewear Allowance for frames or contacts		\$150 every two (2) years		\$150 every two (2) years		\$150 every two (2) years		\$150 every two (2) years		\$150 every two (2) years	