



## January - August 2017 Summary of Benefits

	 Standard Platinum EPO	 Value Platinum EPO	 Freedom Platinum EPO 5/15
	In-Network	In-Network	In-Network
<b>Prescription Drugs</b>			
Drug Card	10/30/60	0/50/50%to \$500	5/30/60/100 ded T2-3
<b>Cost Share Information</b>			
Individual/Family Deductible	N/A	N/A	N/A
Individual/Family OOP Limit	\$2,000/\$4,000	\$3,000/\$6,000	\$3,000/\$6,000
Co-Insurance	0%	10%	0%
<b>Office Visits</b>			
Primary Care	\$15	\$20	\$5
Specialist	\$35	\$30	\$15
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Chiropractic Care	\$35	\$30	\$15
<b>Inpatient Services</b>			
Inpatient Hospital	\$500/admit	10%	\$200/admit
Mental Health Inpatient	\$500/admit	10%	\$200/admit
Substance Abuse Inpatient	\$500/admit	10%	Rehab-\$200/admit
<b>Outpatient Services</b>			
Outpatient Facility	\$100	10%	Hosp-\$100;FS-\$50
Lab/X-Ray	\$35	Lab-No charge; X-ray-\$40	Lab-No charge; X-ray-\$90
Advanced Radiology	\$35	\$100	Hosp-\$100;FS-No charge
Mental Health Outpatient	\$15	No charge	\$15
Substance Abuse Outpatient	\$15	No charge	Rehab-\$15
<b>Emergency Care</b>			
Emergency Room	\$100 (waived if admitted)	\$250 (waived if admitted)	\$200 (waived if admitted)
Ambulance	\$100	\$100	No charge
Urgent Care	\$55	\$75	\$50
<b>Recovery/Special Needs</b>			
Home Health Care	\$15; 40 visits/yr	\$30; 40 visits/yr	\$15; 40 visits/contr yr
Skilled Nursing	\$500/admit; 200 days/yr	10%; 200 days/yr	\$200/admit; 200 days/contr yr
Durable Medical Equipment	10%	10%	No charge

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

\*\*Gated plan which requires the selection of Primary Care Physician (PCP) and referrals to see specialists.



## January - August 2017 Summary of Benefits

	 <b>Tradition Gold Copay EPO</b>	 <b>Value Gold Copay EPO</b>	 <b>Freedom Gold EPO 15/30</b>
	<b>In-Network</b>	<b>In-Network</b>	<b>In-Network</b>
<b>Prescription Drugs</b>			
Drug Card	15/35/75/100 ded T2-3	0/50/50%to\$500 Int ded T3	15/35/75/100 ded T2-3
<b>Cost Share Information</b>			
Individual/Family Deductible	N/A	\$500/\$1,000	\$800/\$1,600
Individual/Family OOP Limit	\$7,150/\$14,300	\$3,750/\$7,500 (incl ded)	\$4,000/\$8,000 (incl ded)
Co-Insurance	0%	20%	10%
<b>Office Visits</b>			
Primary Care	\$30	\$20 ded waived	\$15 ded waived
Specialist	\$50	\$50 ded waived	\$30 ded waived
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Chiropractic Care	\$50	\$50 ded waived	\$30 ded waived
<b>Inpatient Services</b>			
Inpatient Hospital	\$500/day; \$1,500 max/admit	20% after ded	10% after ded
Mental Health Inpatient	\$500/day; \$1,500 max/admit	20% after ded	10% after ded
Substance Abuse Inpatient	\$500/day; \$1,500 max/admit	20% after ded	Rehab-10% after ded
<b>Outpatient Services</b>			
Outpatient Facility	\$300	20% after ded	Hosp-\$300 after ded; FS-\$150 after ded
Lab/X-Ray	\$30	Lab-\$40 ded waived; X-ray-\$60 ded waived	Lab-No charge; X-ray-\$80 after ded
Advanced Radiology	\$100	\$100 ded waived	\$150 after ded
Mental Health Outpatient	\$30	No charge	\$30 ded waived
Substance Abuse Outpatient	\$30	No charge	Rehab-\$30 ded waived
<b>Emergency Care</b>			
Emergency Room	\$350 (waived if admitted)	\$250 (waived if admitted) ded waived	\$400 (waived if admitted) ded waived
Ambulance	\$150	\$100 ded waived	No charge
Urgent Care	\$50	\$75 ded waived	\$75 ded waived
<b>Recovery/Special Needs</b>			
Home Health Care	\$30; 40 visits/yr	\$20 ded waived; 40 visits/yr	\$30 ded waived; 40 visits/contr yr
Skilled Nursing	\$500/day; \$1,500 max/admit; 200 days/yr	20% after ded; 200 days/yr	10% after ded; 200 days/contr yr
Durable Medical Equipment	No charge	20% after ded	10% after ded

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

\*\*Gated plan which requires the selection of Primary Care Physician (PCP) and referrals to see specialists.



## January - August 2017 Summary of Benefits

	 <b>Liberty Gold EPO 30/60**</b>	 <b>Metro Gold EPO 25/40 NG</b>	 <b>Metro Gold EPO 25/40**</b>
	<b>In-Network</b>	<b>In-Network</b>	<b>In-Network</b>
<b>Prescription Drugs</b>			
Drug Card	15/35/75/100 ded T2-3	10/65/90/100 ded T2-3	10/65/50%to \$800
<b>Cost Share Information</b>			
Individual/Family Deductible	\$1,000/\$2,000	\$1,250/\$2,500	\$1,250/\$2,500
Individual/Family OOP Limit	\$4,000/\$8,000 (incl ded)	\$5,000/\$10,000 (incl ded)	\$4,500/\$9,000 (incl ded)
Co-Insurance	0%	20%	20%
<b>Office Visits</b>			
Primary Care	\$30 ded waived	\$25 ded waived	\$25 ded waived
Specialist	\$60 ded waived	\$40 ded waived	\$40 ded waived
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Chiropractic Care	\$60 ded waived	\$40 ded waived	\$40 ded waived
<b>Inpatient Services</b>			
Inpatient Hospital	\$500/day after ded; \$2,000 max/admit	20% after ded	20% after ded
Mental Health Inpatient	\$500/day after ded; \$2,000 max/admit	20% after ded	20% after ded
Substance Abuse Inpatient	Rehab-\$500/day after ded; \$2,000 max/admit	Rehab-20% after ded	Rehab-20% after ded
<b>Outpatient Services</b>			
Outpatient Facility	Hosp-\$250 after ded; FS-\$150 after ded	Hosp-\$500 after ded; FS-\$200 after ded	Hosp-\$500 after ded; FS-\$200 after ded
Lab/X-Ray	Lab-No charge; X-ray-\$35 after ded	Lab-No charge; X-ray-\$50 after ded	Lab-No charge; X-ray-\$50 after ded
Advanced Radiology	\$100 after ded	\$150 after ded	\$150 after ded
Mental Health Outpatient	\$60 ded waived	\$40 ded waived	\$40 ded waived
Substance Abuse Outpatient	Rehab-\$60 ded waived	Rehab-\$40 ded waived	Rehab-\$40 ded waived
<b>Emergency Care</b>			
Emergency Room	\$200 (waived if admitted) ded waived	\$400 (waived if admitted) ded waived	\$500 (waived if admitted) ded waived
Ambulance	No charge	No charge	No charge
Urgent Care	\$75 ded waived	\$65 ded waived	\$65 ded waived
<b>Recovery/Special Needs</b>			
Home Health Care	\$60 ded waived; 40 visits/contr yr	\$40 ded waived; 40 visits/contr yr	\$40 ded waived; 40 visits/contr yr
Skilled Nursing	\$500/day after ded; \$2,000 max/admit; 200 days/contr yr	20% after ded; 200 days/contr yr	20% after ded; 200 days/contr yr
Durable Medical Equipment	0% after ded	20% after ded	20% after ded

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

\*\*Gated plan which requires the selection of Primary Care Physician (PCP) and referrals to see specialists.



## January - August 2017 Summary of Benefits

	 <b>Tradition Silver</b> <b>EPO 40/60 HRx</b>	 <b>Tradition Silver</b> <b>EPO HSA 100%</b>	 <b>Value Silver</b> <b>EPO</b>
	<b>In-Network</b>	<b>In-Network</b>	<b>In-Network</b>
<b>Prescription Drugs</b>			
Drug Card	15/35/75/100 ded T2-3	0%/0%/0% IntDed	0/50/50%to\$500 IntDed T3
<b>Cost Share Information</b>			
Individual/Family Deductible	\$4,250/\$8,500	\$3,600/\$7,200	\$2,500/\$5,000
Individual/Family OOP Limit	\$7,150/\$14,300 (incl ded)	\$3,600/\$7,200 (incl ded)	\$7,100/\$14,200 (incl ded)
Co-Insurance	20%	0%	20%
<b>Office Visits</b>			
Primary Care	\$40 ded waived	0% after ded	\$35 ded waived
Specialist	\$60 ded waived	0% after ded	\$65 ded waived
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Chiropractic Care	\$60 ded waived	0% after ded	\$65 ded waived
<b>Inpatient Services</b>			
Inpatient Hospital	20% after ded	0% after ded	20% after ded
Mental Health Inpatient	20% after ded	0% after ded	20% after ded
Substance Abuse Inpatient	20% after ded	0% after ded	20% after ded
<b>Outpatient Services</b>			
Outpatient Facility	\$350 ded waived	0% after ded	20% after ded
Lab/X-Ray	\$60 ded waived	0% after ded	\$75 ded waived
Advanced Radiology	\$60 ded waived	0% after ded	\$100 ded waived
Mental Health Outpatient	\$40 ded waived	0% after ded	No charge
Substance Abuse Outpatient	\$40 ded waived	0% after ded	No charge
<b>Emergency Care</b>			
Emergency Room	\$350 (waived if admitted) ded waived	0% after ded	\$250 (waived if admitted) after ded
Ambulance	\$150 ded waived	0% after ded	\$100 ded waived
Urgent Care	\$60 ded waived	0% after ded	\$75 ded waived
<b>Recovery/Special Needs</b>			
Home Health Care	\$40 ded waived; 40 visits/yr	0% after ded; 40 visits/yr	\$35 ded waived; 40 visits/yr
Skilled Nursing	20% after ded; 200 days/yr	0% after ded; 200 days/yr	20% after ded; 200 days/yr
Durable Medical Equipment	20% after ded	0% after ded	20% after ded

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

\*\*Gated plan which requires the selection of Primary Care Physician (PCP) and referrals to see specialists.



## January - August 2017 Summary of Benefits

	 <b>Freedom Silver PPO 40/70</b>		 <b>Liberty Silver EPO 40/70</b>		 <b>Liberty Silver EPO HSA 80%</b>	
	In-Network	Out-Network	In-Network	In-Network		
<b>Prescription Drugs</b>						
Drug Card	15/45/75/100 ded T2-3		15/45/75/100 ded T2-3		15/35/75 Int ded	
<b>Cost Share Information</b>						
Individual/Family Deductible	\$2,500/\$5,000	\$4,000/\$8,000	\$2,500/\$5,000	\$2,000/\$4,000		
Individual/Family OOP Limit	\$6,850/\$13,700 (incl ded)	\$10,000/\$20,000 (incl ded)	\$6,850/\$13,700 (incl ded)	\$5,500/\$11,000 (incl ded)		
Co-Insurance	30%	50%	30%	20%		
<b>Office Visits</b>						
Primary Care	\$40 ded waived	50% after ded	\$40 ded waived	\$25 after ded		
Specialist	\$70 ded waived	50% after ded	\$70 ded waived	\$50 after ded		
Maternity Prenatal/Postnatal	No charge	50% after ded	No charge	No charge		
Chiropractic Care	\$70 ded waived; pre-auth req	50% after ded; pre-auth req	\$70 ded waived	\$50 after ded		
<b>Inpatient Services</b>						
Inpatient Hospital	30% after ded; pre-auth req	50% after ded; pre-auth req	30% after ded	20% after ded		
Mental Health Inpatient	30% after ded; pre-auth req	50% after ded; pre-auth req	30% after ded	20% after ded		
Substance Abuse Inpatient	Rehab-30% after ded; pre-auth req	Rehab-50% after ded; pre-auth req	Rehab-30% after ded	Rehab-20% after ded		
<b>Outpatient Services</b>						
Outpatient Facility	30% after ded; pre-auth req	50% after ded; pre-auth req	30% after ded	Hosp-\$250 after ded; FS- \$150 after ded		
Lab/X-Ray	Lab-No charge; X-ray-30% after ded	50% after ded	Lab-No charge; X-ray-30% after ded	Lab-20% after ded; X-ray- \$90 after ded		
Advanced Radiology	30% after ded; pre-auth req	50% after ded; pre-auth req	30% after ded	Hosp-\$100 after ded; FS-0% after ded		
Mental Health Outpatient	\$70 ded waived	50% after ded	\$70 ded waived	\$50 after ded		
Substance Abuse Outpatient	Rehab-\$70 ded waived	Rehab-50% after ded	Rehab-\$70 ded waived	Rehab-\$50 after ded		
<b>Emergency Care</b>						
Emergency Room	\$500 (waived if admitted) ded waived	Paid as in-network	\$500 (waived if admitted) ded waived	\$250 (waived if admitted) after ded		
Ambulance	30% after ded	Paid as in-network	No charge	20% after ded		
Urgent Care	\$75 ded waived	50% after ded	\$75 ded waived	\$75 after ded		
<b>Recovery/Special Needs</b>						
Home Health Care	\$70 ded waived; 40 visits/contr yr; pre-auth req	25% ded waived; 40 visits/contr yr pre-auth req visits/contr yr	\$70 ded waived; 40	\$50 after ded; 40 visits/contr yr		
Skilled Nursing	30% after ded; 200 days/contr yr; pre-auth req	50% after ded; 200 days/contr yr; re-auth req days/contr yr	30% after ded; 200	20% after ded; 200 days/contr yr		
Durable Medical Equipment	30% after ded; pre-auth	50% after ded; pre-auth	30% after ded	20% after ded		

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

\*\*Gated plan which requires the selection of Primary Care Physician (PCP) and referrals to see specialists.





## January - August 2017 Summary of Benefits

	 <b>Metro Silver EPO 30/60**</b>	 <b>Standard Bronze EPO</b>	 <b>Tradition Bronze EPO HSA 100%</b>
	<b>In-Network</b>	<b>In-Network</b>	<b>In-Network</b>
<b>Prescription Drugs</b>			
Drug Card	10/65/50%to\$800	10/35/70 Int Ded	0%/0%/0% Int Ded
<b>Cost Share Information</b>			
Individual/Family Deductible	\$2,500/\$5,000	\$4,000/\$8,000	\$6,350/\$12,700
Individual/Family OOP Limit	\$6,850/\$13,700 (incl ded)	\$7,150/\$14,300 (incl ded)	\$6,350/\$12,700 (incl ded)
Co-Insurance	30%	50%	0%
<b>Office Visits</b>			
Primary Care	\$30 ded waived	50% after ded	0% after ded
Specialist	\$60 ded waived	50% after ded	0% after ded
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Chiropractic Care	\$60 ded waived	50% after ded	0% after ded
<b>Inpatient Services</b>			
Inpatient Hospital	30% after ded	50% after ded	0% after ded
Mental Health Inpatient	30% after ded	50% after ded	0% after ded
Substance Abuse Inpatient	Rehab-30% after ded	50% after ded	0% after ded
<b>Outpatient Services</b>			
Outpatient Facility	30% after ded	50% after ded	0% after ded
Lab/X-Ray	Lab-No charge; X-ray-30% after ded	50% after ded	0% after ded
Advanced Radiology	30% after ded	50% after ded	0% after ded
Mental Health Outpatient	\$60 ded waived	50% after ded	0% after ded
Substance Abuse Outpatient	Rehab-\$60 ded waived	50% after ded	0% after ded
<b>Emergency Care</b>			
Emergency Room	30% after ded	50% after ded	0% after ded
Ambulance	No charge	50% after ded	0% after ded
Urgent Care	\$80 ded waived	50% after ded	0% after ded
<b>Recovery/Special Needs</b>			
Home Health Care	\$60 ded waived; 40 visits/contr yr	50% after ded; 40 visits/yr	0% after ded; 40 visits/yr
Skilled Nursing	30% after ded; 200 days/contr yr	50% after ded; 200 days/yr	0% after ded; 200 days/yr
Durable Medical Equipment	30% after ded	50% after ded	0% after ded

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

\*\*Gated plan which requires the selection of Primary Care Physician (PCP) and referrals to see specialists.



## January - August 2017 Summary of Benefits

	  <b>Metro Bronze</b> <b>EPO HSA 100%**</b>
	<b>In-Network</b>
<b>Prescription Drugs</b>	
Drug Card	0%/0%/0% IntDed T2-3
<b>Cost Share Information</b>	
Individual/Family Deductible	\$6,550/\$13,100
Individual/Family OOP Limit	\$6,550/\$13,100 (incl ded)
Co-Insurance	0%
<b>Office Visits</b>	
Primary Care	0% after ded
Specialist	0% after ded
Maternity Prenatal/Postnatal Care	No charge
Chiropractic Care	0% after ded
<b>Inpatient Services</b>	
Inpatient Hospital	0% after ded
Mental Health Inpatient	0% after ded
Substance Abuse Inpatient	Rehab-0% after ded
<b>Outpatient Services</b>	
Outpatient Facility	0% after ded
Lab/X-Ray	0% after ded
Advanced Radiology	0% after ded
Mental Health Outpatient	0% after ded
Substance Abuse Outpatient	Rehab-0% after ded
<b>Emergency Care</b>	
Emergency Room	0% after ded
Ambulance	0% after ded
Urgent Care	0% after ded
<b>Recovery/Special Needs</b>	
Home Health Care	0% after ded; 40 visits/contr yr
Skilled Nursing	0% after ded; 200 days/contr yr
Durable Medical Equipment	0% after ded

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

\*\*Gated plan which requires the selection of Primary Care Physician (PCP) and referrals to see specialists.