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Platinum Plans

These plans will cover about 90% of your service and you are responsible for the other 10%

Benefits	P1901: Platinum $0	P1902: Platinum $500	P1903: Platinum $1,000	P1904: Platinum Maintenance
Deductible (Single / Family)	$0/ $0	$500 / $1,000	$1,000 / $2,000	$0 / $0
Coinsurance	0%	20%	10%	0%
Maximum Out-of-Pocket	$4,500 / $9,000	$1,250 / $2,500	$1,500 / $3,000	$7,900 / $15,800
e-Visits	$30	$15	$10	$10
Office Visit Copay (PCP / Specialist)	$40 / $60	$25 / $50	$20 / $40	$20 / $40
Urgent Care Copay	$60	$50	$40	$40
Emergency Room Copay	$350	$100	$150	$500
Mental Health Outpatient Copay	$40	$25	$20	$20
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	$2,500 per diem IP / Ded & Coins
Pharmacy Copay	$5 / $10 / $40 / $80 / $200	$5 / $10 / $40 / $80 / $200	$5 / $10 / $40 / $80 / $200	$5 / $10 / $40 / $80 / $200
Pharmacy Maximum Out-of-Pocket (Single / Family)	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	No	No	No	No
HSA Eligible?	No	No	No	No
Embedded / Aggregate	Embedded	Embedded	Embedded	Embedded
Creditable Coverage	Creditable	Creditable	Creditable	Creditable
SBC	QU5233IPBD	Y4HWMPD	SLWFG3G	EKKFYLGMO

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Gold Plans

These plans will cover about 80% of your service and you are responsible for the other 20%

Benefits	G1901: Gold $1,500	G1902: Gold $2,000	G1903: Gold $3,500	G1904: Gold Maintenance
Deductible (Single / Family)	$1,500 / $3,000	$2,000 / $4,000	$3,500 / $7,000	$1,500 / $3,000
Coinsurance	30%	30%	0%	0%
Maximum Out-of-Pocket	$5,000 / $10,000	$5,000 / $10,000	$3,500 / $7,000	$7,900 / $15,800
e-Visits	$15	$20	Deductible then Coinsurance	$15
Office Visit Copay (PCP / Specialist)	$25 / $50	$30 / $60	Deductible then Coinsurance	$25 / $50
Urgent Care Copay	$50	$60	Deductible then Coinsurance	$50
Emergency Room Copay	$200	$250	Deductible then Coinsurance	$500
Mental Health Outpatient Copay	$25	$30	Deductible then Coinsurance	$25
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	$4,000 per diem IP / Ded & Coins
Pharmacy Copay	$5 / $10 / $40 / $80 / $200	$5 / $10 / $40 / $80 / $200	$5 / $10 / $40 / $80 / $200	$5 / $10 / $40 / $80 / $200
Pharmacy Maximum Out-of-Pocket (Single / Family)	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	No	No	No	No
HSA Eligible?	No	No	No	No
Embedded / Aggregate	Embedded	Embedded	Embedded	Embedded
Creditable Coverage	Creditable	Creditable	Creditable	Creditable
SBC	FXIAU79OT	K9S60DDWD	FXIAU79OT	KN1BZHH0

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Silver Plans

These plans will cover about 70% of your service and you are responsible for the other 30%

Benefits	S1901: Silver $2,000	S1902: Silver $4,500	S1903: Silver $5,000
Deductible (Single / Family)	$2,000 / $4,000	$4,500 / $9,000	$5,000 / $10,000
Coinsurance	40%	30%	50%
Maximum Out-of-Pocket	$7,000 / $14,000	$7,900 / $15,800	$7,900 / $15,800
e-Visits	Deductible then Coinsurance	Deductible then Coinsurance	$30
Office Visit Copay (PCP / Specialist)	Deductible then Coinsurance	Deductible then Coinsurance	$40 / $60
Urgent Care Copay	Deductible then Coinsurance	Deductible then Coinsurance	$60
Emergency Room Copay	Deductible then Coinsurance	Deductible then Coinsurance	$450
Mental Health Outpatient Copay	Deductible then Coinsurance	Deductible then Coinsurance	$40
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	$5 / $10 / $55 / $125 / $225	$5 / $10 / $55 / $125 / $225	$10 / $20 / $70 / $150 / $300
Pharmacy Maximum Out-of-Pocket (Single / Family)	Subject to Medical	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	No	No	No
HSA Eligible?	No	No	No
Embedded / Aggregate	Embedded	Embedded	Embedded
Creditable Coverage	Creditable	Creditable	Creditable
SBC	Y0G3NT8SB	EGU031M	QBTBNRK2

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Bronze Plans

These plans will cover about 60% of your service and you are responsible for the other 40%

Benefits	**B1901: Bronze $6,500**
Deductible (Single / Family)	$6,500 / $13,000
Coinsurance	50%
Maximum Out-of-Pocket	$7,900 / $15,800
e-Visits	$30
Office Visit Copay (PCP / Specialist)	$80 / $170
Urgent Care Copay	$170
Emergency Room Copay	Deductible then Coinsurance
Mental Health Outpatient Copay	$80
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance
Pharmacy Copay	$10 / $20 / $80 / $175 / $300
Pharmacy Maximum Out-of-Pocket (Single / Family)	Subject to Medical
Dental Coverage Available for an Additional Charge?	No
HSA Eligible?	No
Embedded / Aggregate	Embedded
Creditable Coverage	Creditable
SBC	UUAFS8YXI

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