

PLATINUM	2016 Individual Standard Platinum - AVC 90.05%	
Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Deductible <i>Individual</i> <i>Family</i> <i>(copayments are not applied to deductible)</i>	\$150 \$300	\$2,000 \$4,000
Out-of-Pocket Maximum <i>Individual</i> <i>Family</i>	\$2,000 \$4,000	\$4,000 \$8,000
Physician Office Visits		
Preventive Care / Screenings / Immunizations	\$0	20% coinsurance
Primary Care (injury or illness)	\$15 copay	20% coinsurance after OON deductible is met
Specialist	\$30 copay	20% coinsurance after OON deductible is met
Emergency/Urgent Care		
Urgent Care Center or Facility	\$50 copay	20% coinsurance after OON deductible is met
Emergency Room	\$100 copay	\$100 copay
Ambulance	\$0	\$0
Hospital Services		
Inpatient	\$300 copay per day after INET deductible is met to a maximum of \$600 per admission	20% coinsurance after OON deductible is met
Outpatient (performed at hospital or ambulatory facility)	\$300 copay after INET deductible is met	20% coinsurance after OON deductible is met
Skilled Nursing Facility <i>90 day calendar year maximum</i>	\$300 copay per day after INET deductible is met to a maximum of \$600 per admission	20% coinsurance after OON deductible is met
Mental Health, Substance Abuse & Behavioral Health		
Mental Health, Substance Abuse & Behavioral Health Services	Covered same as any other illness	Covered same as any other illness
Hospice Care		
Hospice Services	\$0	20% coinsurance after OON deductible is met
Outpatient Services		
Home Health Care <i>100 visit calendar year maximum</i>	\$0	20% coinsurance subject to a \$50 deductible
Advanced Radiology (CT/PET Scan, MRI)	\$75 copay per service up to a combined calendar year maximum of \$375 for MRI and CT scans; \$400 for PET scans	20% coinsurance after OON deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	\$30 copay	20% coinsurance after OON deductible is met

PLATINUM	2016 Individual Standard Platinum - AVC 90.05%	
Outpatient Services		
Laboratory Services	\$15 copay	20% coinsurance after OON deductible is met
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) <i>combined 40 visit calendar year maximum</i>	\$15 copay	20% coinsurance after OON deductible is met
Chiropractic Care <i>20 visit calendar maximum</i>	\$30 copay	20% coinsurance after OON deductible is met
Other Services		
Durable Medical Equipment	20% coinsurance	20% coinsurance after OON deductible is met
Prosthetics	20% coinsurance	20% coinsurance after OON deductible is met
Diabetic Supplies & Equipment	20% coinsurance	20% coinsurance after OON deductible is met
Prescription Drugs		
Tier 1	\$5 copay	20% coinsurance after OON deductible is met
Tier 2	\$15 copay	20% coinsurance after OON deductible is met
Tier 3	\$30 copay	20% coinsurance after OON deductible is met
Tier 4	20% coinsurance up to a maximum of \$100 per prescription	20% coinsurance after OON deductible is met
Pediatric-Only Services (for children under age 19)		
Pediatric Dental Care		
Diagnostic & Preventive (Oral Exam, Cleaning, X-ray)	\$0	50% coinsurance after OON deductible is met
Basic Restorative (Filling, Simple Extraction)	20% coinsurance	50% coinsurance after OON deductible is met
Major Restorative (Endodontic, Crown)	40% coinsurance	50% coinsurance after OON deductible is met
Orthodontia Services <i>medically necessary only</i>	50% coinsurance	50% coinsurance after OON deductible is met
Pediatric Vision Care		
Routine Eye Exam	\$10 copay	20% coinsurance
Prescription Eye Glasses <i>one pair of frames & lenses per calendar year</i>	lenses: \$0 collection frames: \$0 non-collection frames: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit equal to the cost of the collection frame and will be entitled to a negotiated discount	100% coinsurance

GOLD

2016 Standard Gold - **AVC 81.04%**

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Medical Deductible <i>Individual</i> <i>Family</i> <i>(copayments are not applied to deductible)</i>	\$1,000 \$2,000	\$3,000 \$6,000
Prescription Drug Deductible <i>Individual</i> <i>Family</i> <i>(copayments are not applied to deductible)</i>	\$25 \$50	\$350 \$700
Out-of-Pocket Maximum <i>Individual</i> <i>Family</i>	\$3,000 \$6,000	\$6,000 \$12,000
Physician Office Visits		
Preventive Care / Screenings / Immunizations	\$0	30% coinsurance
Primary Care (injury or illness)	\$20 copayment	30% coinsurance after OON medical deductible is met
Specialist	\$40 copayment	30% coinsurance after OON medical deductible is met
Emergency/Urgent Care		
Urgent Care Center or Facility	\$50 copayment	30% coinsurance after OON medical deductible is met
Emergency Room	\$100 copayment	\$100 copayment
Ambulance	\$0	\$0
Hospital Services		
Inpatient	\$500 copayment per day to a maximum of \$1,000 per admission after INET medical deductible is met	30% coinsurance after OON medical deductible is met
Outpatient (performed at hospital or ambulatory facility)	\$500 copayment after INET medical deductible is met	30% coinsurance after OON medical deductible is met
Skilled Nursing Facility <i>90 day calendar year maximum</i>	\$500 copayment per day to a maximum of \$1,000 per admission after INET medical deductible is met	30% coinsurance after OON medical deductible is met
Mental Health, Substance Abuse & Behavioral	Covered same as any other illness	Covered same as any other illness
Hospice Care		
Hospice Services	\$0	30% coinsurance after OON medical deductible is met

Outpatient Services		
Home Health Care <i>100 visit calendar year maximum</i>	\$0	25% coinsurance subject to a \$50 deductible
Advanced Radiology (CT/PET Scan, MRI)	\$65 copay per service up to a combined calendar year maximum of \$375 for MRI and CT scans; \$400 for PET scans	30% coinsurance after OON medical deductible is met
Outpatient Services		
Non-Advanced Radiology (X-ray, Diagnostic)	\$40 copayment	30% coinsurance after OON medical deductible is met
Laboratory Services	\$25 copayment	30% coinsurance after OON medical deductible is met
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) <i>combined 40 visit calendar year maximum</i>	\$20 copayment	30% coinsurance after OON medical deductible is met
Chiropractic Care <i>20 visit calendar maximum</i>	\$40 copayment	30% coinsurance after OON medical deductible is met
Other Services		
Durable Medical Equipment	30% coinsurance	30% coinsurance after OON medical deductible is met
Prosthetics	30% coinsurance	30% coinsurance after OON medical deductible is met
Diabetic Supplies & Equipment	30% coinsurance	30% coinsurance after OON medical deductible is met
Prescription Drugs		
Tier 1	\$5 copayment	30% coinsurance after OON prescription drug deductible is met
Tier 2	\$25 copayment	30% coinsurance after OON prescription drug deductible is met
Tier 3	\$50 copayment	30% coinsurance after OON prescription drug deductible is met
Tier 4	20% coinsurance after INET prescription drug deductible is met up to a maximum of \$100 per prescription	30% coinsurance after OON prescription drug deductible is met

Pediatric-Only Services (for children under age 19)

Pediatric Dental Care		
Diagnostic & Preventive (Oral Exam, Cleaning, X-ray)	\$0	50% coinsurance after OON medical deductible is met
Basic Restorative (Filling, Simple Extraction)	20% coinsurance	50% coinsurance after OON medical deductible is met
Major Restorative (Endodontic, Crown)	40% coinsurance	50% coinsurance after OON medical deductible is met
Orthodontia Services <i>medically necessary only</i>	50% coinsurance	50% coinsurance after OON medical deductible is met
Pediatric Vision Care		
Routine Eye Exam by Specialist	\$45 copayment	30% coinsurance
Prescription Eye Glasses <i>one pair of frames & lenses per calendar year</i>	lenses: \$0; collection frames: \$0 non-collection frames: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit equal to the cost of the collection frame and will be entitled to a negotiated discount	100% coinsurance

SILVER STANDARD Plan - 70%

Plan Overview
Medical Deductible <i>Individual</i> <i>Family</i> <i>(copayments are not applied to deductible)</i>
Prescription Drug Deductible <i>Individual</i> <i>Family</i> <i>(copayments are not applied to deductible)</i>
Out-of-Pocket Maximum <i>Individual</i> <i>Family</i>
Physician Office Visits
Preventive Care / Screenings / Immunizations
Primary Care (injury or illness)
Specialist
Emergency/Urgent Care
Urgent Care Center or Facility
Emergency Room
Ambulance
Hospital Services
Inpatient
Outpatient (performed at hospital or ambulatory facility)
Skilled Nursing Facility <i>90 day calendar year maximum</i>
Mental Health, Substance Abuse & Behavioral Health Care
Mental Health, Substance Abuse & Behavioral Health Services
Hospice Care
Hospice Services

2016 Standard Silver 70% - AVC 71.10%

In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
\$2,900 \$5,800	\$6,000 \$12,000
\$150 \$300	\$350 \$700
\$6,850 \$13,700	\$12,500 \$25,000
\$0	40% coinsurance
\$30 copayment	40% coinsurance after OON medical deductible is met
\$50 copayment	40% coinsurance after OON medical deductible is met
\$75 copayment	40% coinsurance after OON medical deductible is met
\$150 copayment	\$150 copayment
\$0	\$0
\$500 copayment per day to a maximum of \$2,000 per admission after INET medical deductible is met	40% coinsurance after OON medical deductible is met
\$500 copayment after INET medical deductible is met	40% coinsurance after OON medical deductible is met
\$500 copayment per day to a maximum of \$2,000 per admission after INET medical deductible is met	40% coinsurance after OON medical deductible is met
Covered same as any other illness	Covered same as any other illness
\$0	40% coinsurance after OON medical deductible is met

SILVER STANDARD Plan - 70%

Plan Overview
Outpatient Services
Home Health Care <i>100 visit calendar year maximum</i>
Advanced Radiology (CT/PET Scan, MRI)
Non-Advanced Radiology (X-ray, Diagnostic)
Laboratory Services
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) <i>combined 40 visit calendar year maximum</i>
Chiropractic Care <i>20 visit calendar maximum</i>
Other Services
Durable Medical Equipment
Prosthetics
Diabetic Supplies & Equipment
Prescription Drugs
Tier 1
Tier 2
Tier 3
Tier 4

2016 Standard Silver 70% - AVC 71.10%

In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
\$0	25% coinsurance subject to a \$50 deductible
\$75 copayment per service up to a combined calendar year maximum of \$375 for MRI and CT scans; \$400 for PET scans	40% coinsurance after OON medical deductible is met
\$50 copayment	40% coinsurance after OON medical deductible is met
\$40 copayment	40% coinsurance after OON medical deductible is met
\$30 copayment	40% coinsurance after OON medical deductible is met
\$50 copayment	40% coinsurance after OON medical deductible is met
40% coinsurance	40% coinsurance after OON medical deductible is met
40% coinsurance	40% coinsurance after OON medical deductible is met
40% coinsurance	40% coinsurance after OON medical deductible is met
\$5 copayment	40% coinsurance after OON prescription drug deductible is met
\$35 copayment	40% coinsurance after OON prescription drug deductible is met
\$55 copayment	40% coinsurance after OON prescription drug deductible is met
20% coinsurance up to a maximum of \$150 per prescription after INET prescription drug deductible is met	40% coinsurance after OON prescription drug deductible is met

SILVER STANDARD Plan - 70%

Plan Overview

Pediatric-Only Services (for children under age 19)

Pediatric Dental Care

Diagnostic & Preventive

(Oral Exam, Cleaning, X-ray)

Basic Restorative

(Filling, Simple Extraction)

Major Restorative

(Endodontic, Crown)

Orthodontia Services

medically necessary only

Pediatric Vision Care

Routine Eye Exam by Specialist

Prescription Eye Glasses

one pair of frames & lenses per calendar year

2016 Standard Silver 70% - AVC 71.10%

In-Network (INET) Member Pays

Out-of-Network (OON) Member Pays

In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
\$0	50% coinsurance after OON medical deductible is met
40% coinsurance	50% coinsurance after OON medical deductible is met
50% coinsurance	50% coinsurance after OON medical deductible is met
50% coinsurance	50% coinsurance after OON medical deductible is met
\$50 copayment	40% coinsurance
lenses: \$0; collection frames: \$0 non-collection frames: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit equal to the cost of the collection frame and will be entitled to a negotiated discount	100% coinsurance

SILVER CSR PLAN 73%

Plan Overview
Medical Deductible <i>Individual</i> <i>Family</i> <i>(copayments are not applied to deductible)</i>
Prescription Drug Deductible <i>Individual</i> <i>Family</i> <i>(copayments are not applied to deductible)</i>
Out-of-Pocket Maximum <i>Individual</i> <i>Family</i>
Physician Office Visits
Preventive Care / Screenings / Immunizations
Primary Care (injury or illness)
Specialist
Emergency/Urgent Care
Urgent Care Center or Facility
Emergency Room
Ambulance
Hospital Services
Inpatient
Outpatient (performed at hospital or ambulatory facility)
Skilled Nursing Facility <i>90 day calendar year maximum</i>
Mental Health, Substance Abuse & Behavioral Health Care
Mental Health, Substance Abuse & Behavioral Health Services
Hospice Care
Hospice Services

2016 Individual Standard Silver 73% CSR - AVC 73.83%

In-Network Member Pays	Out-of-Network Member Pays
\$2,200	\$6,000
\$4,400	\$12,000
\$100	\$350
\$200	\$700
\$5,200	\$12,500
\$10,400	\$25,000
\$0	40% coinsurance
\$30 copayment	40% coinsurance after OON medical deductible is met
\$50 copayment	40% coinsurance after OON medical deductible is met
\$75 copayment	40% coinsurance after OON medical deductible is met
\$150 copayment	\$150 copayment
\$0	\$0
\$500 copayment per day to a maximum of \$2,000 per admission after INET medical deductible is met	40% coinsurance after OON medical deductible is met
\$500 copayment after INET medical deductible is met	40% coinsurance after OON medical deductible is met
\$500 copayment per day to a maximum of \$2,000 per admission after INET medical deductible is met	40% coinsurance after OON medical deductible is met
Covered same as any other illness	Covered same as any other illness
\$0	40% coinsurance after OON medical deductible is met

SILVER CSR PLAN 73%

Plan Overview
Outpatient Services
Home Health Care <i>100 visit calendar year maximum</i>
Advanced Radiology (CT/PET Scan, MRI)
Non-Advanced Radiology (X-ray, Diagnostic)
Laboratory Services
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) <i>combined 40 visit calendar year maximum</i>
Chiropractic Care <i>20 visit calendar maximum</i>
Other Services
Durable Medical Equipment
Prosthetics
Diabetic Supplies & Equipment
Prescription Drugs
Tier 1
Tier 2
Tier 3
Tier 4

2016 Individual Standard Silver 73% CSR - AVC 73.83%

In-Network Member Pays	Out-of-Network Member Pays
\$0	25% coinsurance subject to a \$50 deductible
\$75 copayment per service up to a combined calendar year maximum of \$375 for MRI and CT scans; \$400 for PET scans	40% coinsurance after OON medical deductible is met
\$45 copayment	40% coinsurance after OON medical deductible is met
\$35 copayment	40% coinsurance after OON medical deductible is met
\$30 copayment	40% coinsurance after OON medical deductible is met
\$30 copayment	40% coinsurance after OON medical deductible is met
40% coinsurance	40% coinsurance after OON medical deductible is met
40% coinsurance	40% coinsurance after OON medical deductible is met
40% coinsurance	40% coinsurance after OON medical deductible is met
\$5 copayment	40% coinsurance after OON prescription drug deductible is met
\$35 copayment	40% coinsurance after OON prescription drug deductible is met
\$55 copayment	40% coinsurance after OON prescription drug deductible is met
20% coinsurance up to a maximum of \$100 per prescription after INET prescription drug deductible is met	40% coinsurance after OON prescription drug deductible is met

SILVER CSR PLAN 73%

Plan Overview

Pediatric-Only Services (for children under age 19)

Pediatric Dental Care

Diagnostic & Preventive

(Oral Exam, Cleaning, X-ray)

Basic Restorative

(Filling, Simple Extraction)

Major Restorative

(Endodontic, Crown)

Orthodontia Services

medically necessary only

Pediatric Vision Care

Routine Eye Exam by Specialist

Prescription Eye Glasses

one pair of frames & lenses per calendar year

2016 Individual Standard Silver 73% CSR - AVC 73.83%

In-Network Member Pays

Out-of-Network Member Pays

\$0	50% coinsurance after OON medical deductible is met
40% coinsurance	50% coinsurance after OON medical deductible is met
50% coinsurance	50% coinsurance after OON medical deductible is met
50% coinsurance	50% coinsurance after OON medical deductible is met
\$50 copayment	40% coinsurance 100% coinsurance
lenses: \$0; collection frames: \$0 non-collection frames: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit equal to the cost of the collection frame and will be entitled to a negotiated discount	

SILVER CSR PLAN 87%
Plan Overview
Medical Deductible <i>Individual</i> <i>Family</i> <i>(copayments are not applied to deductible)</i>
Prescription Drug Deductible <i>Individual</i> <i>Family</i> <i>(copayments are not applied to deductible)</i>
Out-of-Pocket Maximum <i>Individual</i> <i>Family</i>
Physician Office Visits
Preventive Care / Screenings / Immunizations
Primary Care (injury or illness)
Specialist
Emergency/Urgent Care Urgent Care Center or Facility
Emergency Room
Ambulance
Hospital Services
Inpatient
Outpatient (performed at hospital or ambulatory facility)
Skilled Nursing Facility <i>90 day calendar year maximum</i>
Mental Health, Substance Abuse & Behavioral Health Care
Mental Health, Substance Abuse & Behavioral Health Services
Hospice Care
Hospice Services

2016 Individual Standard Silver 87% CSR - AVC 87.15%	
In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
\$500 \$1000	\$6,000 \$12,000
\$50 \$100	\$350 \$700
\$1,800 \$3,600	\$12,500 \$25,000
\$0	40% coinsurance
\$20 copayment	40% coinsurance after OON medical deductible is met
\$35 copayment	40% coinsurance after OON medical deductible is met
\$35 copayment	40% coinsurance after OON medical deductible is met
\$75 copayment	\$75 copayment
\$0	\$0
\$100 copayment per day to a maximum of \$400 per admission after INET medical deductible is met	40% coinsurance after OON medical deductible is met
\$100 copayment after INET medical deductible is met	40% coinsurance after OON medical deductible is met
\$100 copayment per day to a maximum of \$400 per admission after INET medical deductible is met	40% coinsurance after OON medical deductible is met
Covered same as any other illness	Covered same as any other illness
\$0	40% coinsurance after OON medical deductible is met

SILVER CSR PLAN 87%
Plan Overview
Outpatient Services
Home Health Care <i>100 visit calendar year maximum</i>
Advanced Radiology (CT/PET Scan, MRI)
Non-Advanced Radiology (X-ray, Diagnostic)
Laboratory Services
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) <i>combined 40 visit calendar year maximum</i>
Chiropractic Care <i>20 visit calendar maximum</i>
Other Services
Durable Medical Equipment
Prosthetics
Diabetic Supplies & Equipment
Prescription Drugs
Tier 1
Tier 2
Tier 3
Tier 4

2016 Individual Standard Silver 87% CSR - AVC 87.15%	
In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
\$0	25% coinsurance subject to a \$50 deductible
\$60 copayment per service up to a combined calendar year maximum of \$360 for MRI and CT scans; \$400 for PET scans	40% coinsurance after OON medical deductible is met
\$30 copayment	40% coinsurance after OON medical deductible is met
\$25 copayment	40% coinsurance after OON medical deductible is met
\$20 copayment	40% coinsurance after OON medical deductible is met
\$30 copayment	40% coinsurance after OON medical deductible is met
40% coinsurance	40% coinsurance after OON medical deductible is met
40% coinsurance	40% coinsurance after OON medical deductible is met
40% coinsurance	40% coinsurance after OON medical deductible is met
\$5 copayment	40% coinsurance after OON prescription drug deductible is met
\$20 copayment	40% coinsurance after OON prescription drug deductible is met
\$35 copayment	40% coinsurance after OON prescription drug deductible is met
20% coinsurance up to a maximum of \$60 per prescription after INET prescription drug deductible is met	40% coinsurance after OON prescription drug deductible is met

SILVER CSR PLAN 87%
Plan Overview
Pediatric-Only Services (for children under age 19)
Pediatric Dental Care
Diagnostic & Preventive (Oral Exam, Cleaning, X-ray)
Basic Restorative (Filling, Simple Extraction)
Major Restorative (Endodontic, Crown)
Orthodontia Services <i>medically necessary only</i>
Pediatric Vision Care
Routine Eye Exam by Specialist
Prescription Eye Glasses <i>one pair of frames & lenses per calendar year</i>

2016 Individual Standard Silver 87% CSR - AVC 87.15%	
In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
\$0	50% coinsurance after OON medical deductible is met
40% coinsurance	50% coinsurance after OON medical deductible is met
50% coinsurance	50% coinsurance after OON medical deductible is met
50% coinsurance	50% coinsurance after OON medical deductible is met
\$35 copayment	40% coinsurance
lenses: \$0; collection frames: \$0 non-collection frames: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit equal to the cost of the collection frame and will be entitled to a negotiated discount	100% coinsurance

SILVER CSR PLAN 94%
Plan Overview
Medical Deductible <i>Individual</i> <i>Family</i> <i>(copayments are not applied to deductible)</i>
Prescription Drug Deductible <i>Individual</i> <i>Family</i> <i>(copayments are not applied to deductible)</i>
Out-of-Pocket Maximum <i>Individual</i> <i>Family</i>
Physician Office Visits
Preventive Care / Screenings / Immunizations
Primary Care (injury or illness)
Specialist
Emergency/Urgent Care
Urgent Care Center or Facility
Emergency Room
Ambulance
Hospital Services
Inpatient
Outpatient (performed at hospital or ambulatory facility)
Skilled Nursing Facility <i>90 day calendar year maximum</i>
Mental Health, Substance Abuse & Behavioral Health Care
Mental Health, Substance Abuse & Behavioral Health Services
Hospice Care
Hospice Services

2016 Individual Standard Silver 94% CSR - AVC 94.62%	
In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
\$0	\$6,000
\$0	\$12,000
\$0	\$350
\$0	\$700
\$800	\$12,500
\$1,600	\$25,000
\$0	40% coinsurance
\$10 copayment	40% coinsurance after OON medical deductible is met
\$30 copayment	40% coinsurance after OON medical deductible is met
\$25 copayment	40% coinsurance after OON medical deductible is met
\$50 copayment	\$50 copayment
\$0	\$0
\$75 copayment per day to a maximum of \$300 per admission	40% coinsurance after OON medical deductible is met
\$75 copayment	40% coinsurance after OON medical deductible is met
\$75 copayment per day to a maximum of \$300 per admission	40% coinsurance after OON medical deductible is met
Covered same as any other illness	Covered same as any other illness
\$0	40% coinsurance after OON medical deductible is met

SILVER CSR PLAN 94%
Plan Overview
Outpatient Services
Home Health Care <i>100 visit calendar year maximum</i>
Advanced Radiology (CT/PET Scan, MRI)
Non-Advanced Radiology (X-ray, Diagnostic)
Laboratory Services
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) <i>combined 40 visit calendar year maximum</i>
Chiropractic Care <i>20 visit calendar maximum</i>
Other Services
Durable Medical Equipment
Prosthetics
Diabetic Supplies & Equipment
Prescription Drugs
Tier 1
Tier 2
Tier 3
Tier 4

2016 Individual Standard Silver 94% CSR - AVC 94.62%	
In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
\$0	25% coinsurance subject to a \$50 deductible
\$50 copayment per service up to a combined calendar year maximum of \$350 for MRI and CT scans; \$400 for PET scans	40% coinsurance after OON medical deductible is met
\$25 copayment	40% coinsurance after OON medical deductible is met
\$15 copayment	40% coinsurance after OON medical deductible is met
\$20 copayment	40% coinsurance after OON medical deductible is met
\$30 copayment	40% coinsurance after OON medical deductible is met
40% coinsurance	40% coinsurance after OON medical deductible is met
40% coinsurance	40% coinsurance after OON medical deductible is met
40% coinsurance	40% coinsurance after OON medical deductible is met
\$5 copayment	40% coinsurance after OON prescription drug deductible is met
\$10 copayment	40% coinsurance after OON prescription drug deductible is met
\$30 copayment	40% coinsurance after OON prescription drug deductible is met
20% coinsurance up to a maximum of \$60 per prescription	40% coinsurance after OON prescription drug deductible is met

SILVER CSR PLAN 94%
Plan Overview
Pediatric-Only Services (for children under age 19)
Pediatric Dental Care
Diagnostic & Preventive (Oral Exam, Cleaning, X-ray)
Basic Restorative (Filling, Simple Extraction)
Major Restorative (Endodontic, Crown)
Orthodontia Services <i>medically necessary only</i>
Pediatric Vision Care
Routine Eye Exam by Specialist
Prescription Eye Glasses <i>one pair of frames & lenses per calendar year</i>

2016 Individual Standard Silver 94% CSR - AVC 94.62%	
In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
\$0	50% coinsurance after OON medical deductible is met
40% coinsurance	50% coinsurance after OON medical deductible is met
50% coinsurance	50% coinsurance after OON medical deductible is met
50% coinsurance	50% coinsurance after OON medical deductible is met
\$35 copayment	40% coinsurance
lenses: \$0; collection frames: \$0 non-collection frames: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit equal to the cost of the collection frame and will be entitled to a negotiated discount	100% coinsurance

BRONZE	2016 Standard Bronze - AVC 61.05%	
Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Deductible <i>Individual</i> <i>Family</i> <i>(copayments are not applied to deductible)</i>	\$5,500 \$11,000	\$10,000 \$20,000
Out-of-Pocket Maximum <i>Individual</i> <i>Family</i>	\$6,850 \$13,700	\$13,200 \$26,400
Physician Office Visits		
Preventive Care / Screenings / Immunizations	\$0	50% coinsurance
Primary Care (injury or illness)	\$40 copayment	50% coinsurance after OON deductible is met
Specialist	\$50 copayment after INET deductible is met	50% coinsurance after OON deductible is met
Emergency/Urgent Care		
Urgent Care Center or Facility	\$75 copayment	50% coinsurance after OON deductible is met
Emergency Room	\$200 copayment after INET deductible is met	\$200 copayment after INET deductible is met
Ambulance	\$0 after INET deductible is met	\$0 after INET deductible is met
Hospital Services		
Inpatient	\$500 copayment per day to a maximum of \$1,000 per admission after INET medical deductible is met	50% coinsurance after OON deductible is met
Outpatient (performed at hospital or ambulatory facility)	\$500 copayment after INET medical deductible is met	50% coinsurance after OON deductible is met
Skilled Nursing Facility <i>90 day calendar year maximum</i>	\$500 copayment per day to a maximum of \$1,000 per admission after INET medical deductible is met	50% coinsurance after OON deductible is met

BRONZE	2016 Standard Bronze - AVC 61.05%	
Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Mental Health, Substance Abuse & Behavioral Health		
Mental Health, Substance Abuse & Behavioral Health Services	Covered same as any other illness	Covered same as any other illness
Hospice Care		
Hospice Services	\$0 after INET deductible is met	50% coinsurance after OON deductible is met
Outpatient Services		
Home Health Care <i>100 visit calendar year maximum</i>	25% coinsurance subject to a \$50 deductible	25% coinsurance subject to a \$50 deductible
Advanced Radiology (CT/PET Scan, MRI)	\$75 copay per service after INET deductible is met up to a combined calendar year maximum of \$375 for MRI and CT scans; \$400 for PET scans	50% coinsurance after OON deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	\$45 copay after INET deductible is met	50% coinsurance after OON deductible is met
Laboratory Services	\$35 copay after INET deductible is met	50% coinsurance after OON deductible is met
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) <i>combined 40 visit calendar year maximum</i>	\$30 copay after INET deductible is met	50% coinsurance after OON deductible is met
Chiropractic Care <i>20 visit calendar maximum</i>	\$50 copayment after INET deductible is met	50% coinsurance after OON deductible is met
Other Services		
Durable Medical Equipment	40% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Prosthetics	40% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Diabetic Supplies & Equipment	40% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Prescription Drugs		
Tier 1	\$5 copayment after INET deductible is met	50% coinsurance after OON deductible is met
Tier 2	50% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Tier 3	50% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Tier 4	50% coinsurance up to a maximum of \$500 per prescription after INET deductible is met	50% coinsurance after OON deductible is met

BRONZE	2016 Standard Bronze - AVC 61.05%	
Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Pediatric-Only Services (for children under age 19)		
Pediatric Dental Care		
Diagnostic & Preventive (Oral Exam, Cleaning, X-ray)	\$0	50% coinsurance after OON deductible is met
Basic Restorative (Filling, Simple Extraction)	45% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Major Restorative (Endodontic, Crown)	50% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Orthodontia Services <i>medically necessary only</i>	50% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Pediatric Vision Care		
Routine Eye Exam by Specialist	\$50 copayment	50% coinsurance after OON deductible is met
Prescription Eye Glasses <i>one pair of frames & lenses per calendar year</i>	lenses: \$0; collection frames: \$0 non-collection frames: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit equal to the cost of the collection frame and will be entitled to a negotiated discount	100% coinsurance

BRONZE HSA	2016 Standard Bronze HSA- AVC 61.52%	
Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Deductible <i>Individual Family</i> <i>(copayments are not applied to deductible)</i>	5,300 \$10,600	\$9,200 \$18,400
Out-of-Pocket Maximum <i>Individual Family</i>	\$6,500 \$13,000	\$12,900 \$25,800
Physician Office Visits		
Preventive Care / Screenings / Immunizations	\$0	50% coinsurance
Primary Care (injury or illness)	10% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Specialist	10% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Emergency/Urgent Care		
Urgent Care Center or Facility	10% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Emergency Room	10% coinsurance after INET deductible is met	10% coinsurance after INET deductible is met
Ambulance	10% coinsurance after INET deductible is met	10% coinsurance after INET deductible is met
Hospital Services		
Inpatient	10% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Outpatient (performed at hospital or ambulatory facility)	10% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Skilled Nursing Facility <i>90 day calendar year maximum</i>	10% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Mental Health, Substance Abuse & Behavioral Health		
Mental Health, Substance Abuse & Behavioral Health Services	Covered same as any other illness	Covered same as any other illness
Hospice Care		
Hospice Services	10% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met

BRONZE HSA	2016 Standard Bronze HSA- AVC 61.52%	
Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Outpatient Services		
Home Health Care <i>100 visit calendar year maximum</i>	10% coinsurance after INET deductible is met	25% coinsurance after INET deductible is met
Advanced Radiology (CT/PET Scan, MRI)	10% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	10% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Laboratory Services	10% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) <i>combined 40 visit calendar year maximum</i>	10% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Chiropractic Care <i>20 visit calendar maximum</i>	10% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Other Services		
Durable Medical Equipment	10% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Prosthetics	10% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Diabetic Supplies & Equipment	10% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Prescription Drugs		
Tier 1	10% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Tier 2	15% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Tier 3	25% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Tier 4	30% coinsurance up to a maximum of \$500 per prescription after INET deductible is met	50% coinsurance after OON deductible is met

BRONZE HSA	2016 Standard Bronze HSA- AVC 61.52%	
Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Pediatric-Only Services (for children under age 19)		
Pediatric Dental Care		
Diagnostic & Preventive (Oral Exam, Cleaning, X-ray)	\$0	50% coinsurance after OON deductible is met
Basic Restorative (Filling, Simple Extraction)	40% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Major Restorative (Endodontic, Crown)	50% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Orthodontia Services <i>medically necessary only</i>	50% coinsurance after INET deductible is met	50% coinsurance after OON deductible is met
Pediatric Vision Care		
Routine Eye Exam by Specialist	\$0	50% coinsurance after OON deductible is met
Prescription Eye Glasses <i>one pair of frames & lenses per calendar year</i>	lenses: \$0 after INET deductible is met; collection frames: \$0 after INET deductible is met; non-collection frames: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit equal to the cost of the collection frame and will be entitled to a negotiated discount	100% coinsurance