2019 HMO & POS Small Group Plans

HEALTH TRADITION

Covered Services	Platinum 1000 w/copay	Gold 1000/80 w/copay	Gold 1500/80	Gold 2000/90	Silver 1500/70 w/copay	Silver 2000/70	Silver 2600/80 w/copay
Annual Deductible Individual/Family†	$1,000/ $2,000	$1,000/ $2,000	$1,500/ $3,000	$2,000/ $4,000	$1,500/ $3,000	$2,000/ $4,000	$2,600/ $5,200
Annual Out-of-Pocket Maximum Indiv/Family†	$2,000/ $4,000	$4,000/ $8,000	$4,000/ $8,000	$4,000/ $8,000	$7,000/ $14,000	$7,500/ $15,000	$7,500/ $15,000
Preventive Care* Includes routine eye & hearing exam	100% coverage	100% coverage	100% coverage	100% coverage	100% coverage	100% coverage	100% coverage
Deductible applies unless otherwise noted (copays do not apply to deductible)							
Office Visits	$50 primary $75 specialist Deductible NA	$50 primary $75 specialist Deductible NA	20%	10%	$75 primary $150 specialist Deductible NA	30%	$75 primary $150 specialist Deductible NA
Chiropractic	$50 copay Deductible NA	$50 copay Deductible NA	20%	10%	$75 copay Deductible NA	30%	$75 copay Deductible NA
Urgent Care**	$50 copay Deductible NA	$50 copay Deductible NA	20%	10%	$75 copay Deductible NA	30%	$75 copay Deductible NA
Emergency Room Services (Deductible, copay, then coinsurance)**	Deductible, then $150 copay	Deductible applies, $150 copay and 20% coinsurance	Deductible applies, $100 copay and 20% coinsurance	Deductible applies, $100 copay and 10% coinsurance	Deductible applies, $200 copay and 30% coinsurance	Deductible applies, $200 copay and 30% coinsurance	Deductible applies, $300 copay and 20% coinsurance
Ambulance	0%	20%	20%	10%	30%	30%	20%
Hospitalization Inpatient/outpatient	0%	20%	20%	10%	30%	30%	20%
Outpatient Lab/Radiology	0%	20%	20%	10%	30%	30%	20%
Durable Medical Equipment	0%	20%	20%	10%	30%	30%	20%
Skilled Nursing Facilities With prior auth.	0%	20%	20%	10%	30%	30%	20%
Home Health Care	0%	20%	20%	10%	30%	30%	20%
Rehabilitation Services PT/OT/ST combined max of 60 visits/year	0%	20%	20%	10%	30%	30%	20%
Prenatal/Postnatal Care	0%	20%	20%	10%	30%	30%	20%
Delivery and all Inpatient Services	0%	20%	20%	10%	30%	30%	20%
Mental/Behavioral Health, Outpatient	$50 copay Deductible NA	$50 copay Deductible NA	20%	10%	$75 copay Deductible NA	30%	$75 copay Deductible NA
Mental/Behavioral Health, Inpatient	0%	20%	20%	10%	30%	30%	20%
Prescription Drugs **G=Generic B=Brand N=Non-formulary S=Specialty**	Deductible NA $15G $50 B 40% N 20% S	Deductible NA $15 G $50 B 40% N 20% S	Deductible NA $15 G $50 B 40% N 20% S	Deductible NA $25 G $60 B $80 N 20% S	Deductible NA $30 G $70 B $150 N 20% S	Deductible NA $30 G $70 B 40% N 20% S	Deductible NA $15 G $50 B 40% N 20% S

** This Benefit Plan provides 100% coverage for preventive health services as defined in Section 1001 of the Patient Protection and Affordable Care Act, with no cost sharing.*

*** Out-of-network medical emergencies, urgent care and plan prior-approved referrals are covered as in-network benefit. See Certificate of Coverage for plan detail. (In service area, out of network urgent care not covered on HMO.)*

HEALTH TRADITION

Covered Services	Bronze 6500/60	Bronze*** 7500/100	Gold HDHP 100	Silver HDHP 90	Silver HDHP 100	Bronze HDHP 50	Bronze HDHP 60	Bronze HDHP 80
Annual Deductible Individual/Family†	$6,500/ $13,000	$7,500/ $15,000	$3,000/ $6,000	$3,500/ $7,000	$5,000/ $10,000	$4,500/ $9,000	$5,000/ $10,000	$6,000/ $12,000
Annual Out-of-Pocket Maximum Individual/Family†	$7,500/ $15,000	$7,500/ $15,000	$3,000/ $6,000	$6,750/ $13,500	$5,000/ $10,000	$6,750/ $13,500	$6,750/ $13,500	$6,750/ $13,500
Preventive Care* Includes routine eye & hearing exam	100% coverage	100% coverage	100% coverage	100% coverage	100% coverage	100% coverage	100% coverage	100% coverage
In addition to meeting the deductible, member pays								
Office Visits	40%	0%	0%	10%	0%	50%	40%	20%
Chiropractic	40%	0%	0%	10%	0%	50%	40%	20%
Urgent Care**	40%	0%	0%	10%	0%	50%	40%	20%
Emergency Room Services (Deductible then coinsurance)**	40%	0%	0%	10%	0%	50%	40%	20%
Ambulance	40%	0%	0%	10%	0%	50%	40%	20%
Hospitalization Inpatient/outpatient	40%	0%	0%	10%	0%	50%	40%	20%
Outpatient Lab/Radiology	40%	0%	0%	10%	0%	50%	40%	20%
Durable Medical Equipment	40%	0%	0%	10%	0%	50%	40%	20%
Skilled Nursing Facilities With prior auth.	40%	0%	0%	10%	0%	50%	40%	20%
Home Health Care	40%	0%	0%	10%	0%	50%	40%	20%
Rehabilitation Services PT/OT/ST combined max of 60 visits/year	40%	0%	0%	10%	0%	50%	40%	20%
Prenatal/Postnatal Care	40%	0%	0%	10%	0%	50%	40%	20%
Delivery and all Inpatient Services	40%	0%	0%	10%	0%	50%	40%	20%
Mental/Behavioral Health Outpatient	40%	0%	0%	10%	0%	50%	40%	20%
Mental/Behavioral Health Inpatient	40%	0%	0%	10%	0%	50%	40%	20%
Prescription Drugs **G=Generic** **B=Brand** **N=Non-formulary** **S=Specialty**	Deductible NA $30 G $75 B $150 N 20% S	After deductible 0%	After deductible 0%	After deductible 10% G 10% B 30% N 10% S	After deductible 0%	After deductible 50%	After deductible 40% G 40% B 60% N 20% S	After deductible 20% G 20% B 40% N 20% S

† Once a member of a family plan meets the individual deductible or maximum out-of-pocket, Health Tradition begins paying for covered services for that person, regardless of whether the family deductible or out-of-pocket maximum has been met.

**** Bronze 7500 is not considered a qualified HDHP plan because it exceeds the max out of pocket set by the IRS.*