Plan Features	EPO Bronze Level 2	EPO Bronze Level 2, with H.S.A	PPO Bronze Level 1	PPO Gold	EPO 20	EPO 40	Silver Level 1 HSA	PPO Gold HSA	PPO Premium	PPO Preferred
IN NETWORK	All Plans use the Full PPO Network									
Deductibles (Indiv / Family)	$5,000 / $10,000	$5,000 / $10,000	$2,000 / $6,000	$2,000 / $6,000	None	None	$3,000 / $6,000	$1,350 / $2,700	$500 / $1,500	$1,000 / $3,000
Primary Care Visit	$60 After Deductible	$60 After Deductible	$25	$25	$20	$40	No Charge After Deductible	$25	$10	$20
Hospital Inpatient Visit	30% After Deductible	30% After Deductible	30% after deductible	$200 Copay per day, up to three days after deductible	No Charge	$500 per visit	No Charge After Deductible	$150 per day, up to three days after deductible	$100 per day, up to three days after deductible	$150 Copay per day, up to three days after deductible
Emergency Room	$300 Copay per Visit After Deductible	$300 Copay per Visit After Deductible	$500 Copay per Visit after Deductible	$200 Copay per Visit after Deductible	$100 per visit	$100 per visit	$100 After Deductible	$200 per visit after deductible	$100 Copay per Visit after Deductible	$150 Copay per Visit After Deductible
Urgent Care	$60 Copay per Visit After Deductible	$60 Copay per Visit After Deductible	$50 Copay per Visit	$35 Copay per Visit	$20 per visit	$40 per visit	No Charge After Deductible	$35 per visit	$20 per Visit	$30 per Visit
Pharmacy / RX (30 Day Supply)	$15 / $50 / $65	$15 / $50 / $65	$25 / $50 / $75	$25 / $40 / $55	$10 / $25 / $40	$15 / $35 / $50	$25 / $50 / $75 After Deductible	$25 / $40 / $55	$10 / $20 / $35	$20 / $30 / $45
Out-of-Pocket Max (Indiv / Family)	$6,250 / $12,500	$6,250 / $12,500	$6,600 / $13,200	$4,000 / $12,000	$1,500 / $3,000	$3,000 / $6,000	$3,000 / $6,000	$3,000 / $6,000	$1,000 / $3,000	$2,000 / $6,000
OUT OF NETWORK										
Deductibles (Indiv / Family)	Not Covered	Not Covered	$4,000 / $12,000	$4,000 / $12,000	Not Covered	Not Covered	$6,000 / $12,000	$5,000 /$10,000	$1,000 / $3,000	$2,000 / $6,000
Primary Care Visit	Not Covered	Not Covered	50% After Deductible	50% After Deductible	Not Covered	Not Covered	30% After Deductible	50% After Deductible	30% After Deductible	40% After Deductible
Hospital Inpatient Visit	Not Covered	Not Covered	50% After Deductible	$200 Copay per day, up to three days after deductible	Not Covered	Not Covered	30% After Deductible	$150 per day, up to three days after deductible	$100 per day, up to three days after deductible	$150 Copay per day, up to three days after deductible
Emergency Room	Not Covered	Not Covered	$500 Copay per Visit after Deductible	$200 Copay per Visit after Deductible	Not Covered	Not Covered	$100 After Deductible	$200 per visit after deductible	$100 Copay per Visit after Deductible	$150 Copay per Visit After Deductible
Urgent Care	Not Covered	Not Covered	50% After Deductible	50% After Deductible	Not Covered	Not Covered	No Charge After Deductible	50% After Deductible	30% After Deductible	40% After Deductible
Out-of-Pocket Max (Indiv / Family)	Not Covered	Not Covered	$8,000 / $24,000	$8,000 / $24,000	Not Covered	Not Covered	$12,000 / $24,000	$5,000 / $10,000	$2,000 / $6,000	$4,000 / $12,000
			Plus fees that exceed the Allowed Amounts	**Plus fees that exceed the Allowed Amounts**			**Plus fees that exceed the Allowed Amounts**	**Plus fees that exceed the Allowed Amounts**	**Plus fees that exceed the Allowed Amounts**	**Plus fees that exceed the Allowed Amounts**
MONTHLY PRICING										
Employee	$345.40	$341.00	$390.50	$420.20	$493.90	$463.10	$404.80	$447.70	$473.00	$457.60
Employee + Spouse	$690.80	$680.90	$779.90	$838.20	$986.70	$925.10	$809.60	$895.40	$944.90	$915.20
Employee + Child(ren)	$639.10	$630.30	$721.60	$776.60	$913.00	$855.80	$749.10	$828.30	$874.50	$847.00
Employee + Family	$1,036.20	$1,021.90	$1,169.30	$1,258.40	$1,480.60	$1,388.20	$1,214.40	$1,343.10	$1,417.90	$1,372.80