






## 2019 Summary of Benefits

|                                   | <br><b>Platinum Pro EPO</b> | <br><b>Circle Platinum</b> | <br><b>Circle Plus Platinum</b> |
|-----------------------------------|--|---|--|
|                                   | In-Network   | In-Network  | In-Network   |
| <b>Prescription Drugs</b>         |  |   |  |
| Drug Card                         | 10/30/60   | 10/30/75  | 10/30/75   |
| <b>Cost Share Information</b>     |  |   |  |
| Individual/Family Deductible      | N/A  | N/A   | N/A  |
| Individual/Family OOP Limit       | \$2,000/\$4,000  | \$2,000/\$4,000   | \$2,000/\$4,000  |
| Co-Insurance                      | 0%   | 0%  | 0%   |
| Lifetime Max                      | None   | None  | None   |
| <b>Office Visits</b>              |  |   |  |
| Primary Care                      | \$20   | \$10  | \$10   |
| Specialist                        | \$35   | \$25  | \$25   |
| Adult Preventive Care             | No charge  | No charge   | No charge  |
| Child Preventive Care             | No charge  | No charge   | No charge  |
| Maternity Prenatal/Postnatal Care | No charge  | No charge   | No charge  |
| Rehabilitation Services           | \$35; 60 visits/cond/plan yr comb PT/OT/ST   | \$25; 60 visits/cond/plan yr comb PT/OT/ST  | \$25; 60 visits/cond/plan yr comb PT/OT/ST   |
| Chiropractic Care                 | \$35   | \$25  | \$25   |
| <b>Inpatient Services</b>         |  |   |  |
| Inpatient Hospital                | \$500/admit  | \$500/admit   | \$500/admit  |
| Inpatient Surgery                 | \$100  | \$50  | \$50   |
| Maternity Delivery/Inpatient      | Delivery-\$100; IP-\$500/admit   | \$500/admit   | \$500/admit  |
| Mental Health Inpatient           | \$500/admit  | \$500/admit   | \$500/admit  |
| Substance Abuse Inpatient         | \$500/admit  | \$500/admit   | \$500/admit  |
| <b>Outpatient Services</b>        |  |   |  |
| Outpatient Facility               | \$200  | \$100   | \$100  |
| Outpatient Surgery                | \$100  | \$50  | \$50   |
| Lab/X-Ray                         | PCP-\$20; SP-\$35  | Lab-\$15; X-ray-\$50  | Lab-\$15; X-ray-\$50   |
| Advanced Radiology                | \$35   | \$100   | \$100  |
| Mental Health Outpatient          | \$20   | \$25  | \$25   |
| Substance Abuse Outpatient        | \$20   | \$25  | \$25   |
| <b>Emergency Care</b>             |  |   |  |
| Emergency Room                    | \$250 (waived if admitted)   | \$500   | \$500  |
| Ambulance                         | \$150  | \$500   | \$500  |
| Urgent Care                       | \$50   | \$75  | \$75   |
| <b>Recovery/Special Needs</b>     |  |   |  |
| Home Health Care                  | \$20; 40 visits/plan yr  | \$25; 40 visits/plan yr   | \$25; 40 visits/plan yr  |
| Habilitation services             | \$35; 60 visits/cond/plan yr comb PT/OT/ST   | \$25; 60 visits/cond/plan yr comb PT/OT/ST  | \$25; 60 visits/cond/plan yr comb PT/OT/ST   |
| Skilled Nursing                   | \$500/admit; 200 days/plan yr  | \$500/admit; 200 days/plan yr   | \$500/admit; 200 days/plan yr  |
| Durable Medical Equipment         | 10%  | 20%   | 20%  |
| Hospice Services                  | \$500/admit IP; \$20 OP; 210 days/plan yr  | 20%; 210 days/plan yr   | 20%; 210 days/plan yr  |

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



## 2019 Summary of Benefits

|                                   | <br><b>Liberty Advantage Platinum<br/>EPO 15/35 G</b> | <br><b>Gold Pro EPO</b>                    | <br><b>Gold 25/50/0 Pro EPO</b>            |
|-----------------------------------|---|--|--|
|                                   | In-Network  | In-Network                                 | In-Network                                 |
| <b>Prescription Drugs</b>         |   |  |  |
| Drug Card                         | 5/30/60/150 ded T2-3                                  | 10/50/85                                   | 10/50/85                                   |
| <b>Cost Share Information</b>     |   |  |  |
| Individual/Family Deductible      | \$250/\$500   | N/A  | N/A  |
| Individual/Family OOP Limit       | \$3,000/\$6,000 (incl ded)                            | \$5,000/\$10,000 (incl ded)                | \$7,000/\$14,000 (incl ded)                |
| Co-Insurance                      | 10%   | 0%   | 0%   |
| Lifetime Max                      | None  | None                                       | None                                       |
| <b>Office Visits</b>              |   |  |  |
| Primary Care                      | \$15 ded waived                                       | \$25                                       | 25   |
| Specialist                        | \$35 ded waived                                       | \$40                                       | 50   |
| Adult Preventive Care             | No charge   | No charge                                  | No charge                                  |
| Child Preventive Care             | No charge   | No charge                                  | No charge                                  |
| Maternity Prenatal/Postnatal Care | No charge   | No charge                                  | No charge                                  |
| Rehabilitation Services           | \$35 ded waived; 60 visits/cal yr combPT/OT/ST        | \$40; 60 visits/cond/plan yr comb PT/OT/ST | \$50; 60 visits/cond/plan yr comb PT/OT/ST |
| Chiropractic Care                 | \$35 ded waived                                       | \$40                                       | 50   |
| <b>Inpatient Services</b>         |   |  |  |
| Inpatient Hospital                | 10% after ded   | \$500/admit                                | \$500/admit                                |
| Inpatient Surgery                 | 10% after ded   | \$100                                      | 100  |
| Maternity Delivery/Inpatient      | 10% after ded   | Delivery-\$100; IP-\$500/admit             | Delivery-\$100; IP-\$500/admit             |
| Mental Health Inpatient           | 10% after ded   | \$500/admit                                | \$500/admit                                |
| Substance Abuse Inpatient         | Rehab-10% after ded                                   | \$500/admit                                | \$500/admit                                |
| <b>Outpatient Services</b>        |   |  |  |
| Outpatient Facility               | 10% after ded   | \$300                                      | 300  |
| Outpatient Surgery                | 10% after ded   | \$100                                      | 100  |
| Lab/X-Ray                         | 10% after ded   | PCP-\$25; SP-\$40                          | PCP-\$25; SP-\$50                          |
| Advanced Radiology                | 10% after ded   | \$40                                       | 50   |
| Mental Health Outpatient          | \$35 ded waived                                       | \$25                                       | 25   |
| Substance Abuse Outpatient        | Rehab-\$35 ded waived                                 | \$25                                       | 25   |
| <b>Emergency Care</b>             |   |  |  |
| Emergency Room                    | 10% after ded   | \$350 (waived if admitted)                 | \$350 (waived if admitted)                 |
| Ambulance                         | No charge   | 150  | 150  |
| Urgent Care                       | \$35 ded waived                                       | 60   | 60   |
| <b>Recovery/Special Needs</b>     |   |  |  |
| Home Health Care                  | \$35 ded waived; 40 visits/cal yr                     | \$25; 40 visits/plan yr                    | \$25; 40 visits/plan yr                    |
| Habilitation services             | \$35 ded waived; 60 visits/cal yr combPT/OT/ST        | \$40; 60 visits/cond/plan yr comb PT/OT/ST | \$50; 60 visits/cond/plan yr comb PT/OT/ST |
| Skilled Nursing                   | 10% after ded; 200 days/cal yr                        | \$500/admit; 200 days/plan yr              | \$500/admit; 200 days/plan yr              |
| Durable Medical Equipment         | 10% after ded   | 15%  | 15%  |
| Hospice Services                  | 10% after ded   | \$500/admit IP; \$25 OP; 210 days/plan yr  | \$500/admit IP; \$25 OP; 210 days/plan yr  |

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## 2019 Summary of Benefits

|                                   | <b>OSCAR</b><br>Circle Gold                | <b>OSCAR</b><br>Circle Plus Gold           | <b>OSCAR</b><br>Circle Gold 750                       |
|-----------------------------------|--|--|---|
|                                   | In-Network                                 | In-Network                                 | In-Network  |
| <b>Prescription Drugs</b>         |  |  |   |
| Drug Card                         | 10/25/100                                  | 10/25/100                                  | 15/50/100/100 ded T2-3                                |
| <b>Cost Share Information</b>     |  |  |   |
| Individual/Family Deductible      | N/A  | N/A  | \$750/\$1,500   |
| Individual/Family OOP Limit       | \$5,000/\$10,000                           | \$5,000/\$10,000                           | \$7,500/\$15,000 (incl ded)                           |
| Co-Insurance                      | 0%   | 0%   | 20%   |
| Lifetime Max                      | None                                       | None                                       | None  |
| <b>Office Visits</b>              |  |  |   |
| Primary Care                      | 25   | 25   | \$25 ded waived                                       |
| Specialist                        | 50   | 50   | \$50 ded waived                                       |
| Adult Preventive Care             | No charge                                  | No charge                                  | No charge   |
| Child Preventive Care             | No charge                                  | No charge                                  | No charge   |
| Maternity Prenatal/Postnatal Care | No charge                                  | No charge                                  | No charge   |
| Rehabilitation Services           | \$25; 60 visits/cond/plan yr comb PT/OT/ST | \$25; 60 visits/cond/plan yr comb PT/OT/ST | \$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST |
| Chiropractic Care                 | 25   | 25   | \$25 ded waived                                       |
| <b>Inpatient Services</b>         |  |  |   |
| Inpatient Hospital                | \$500/day; 5 days/admit                    | \$500/day; 5 days/admit                    | 20% after ded   |
| Inpatient Surgery                 | 150  | 150  | 20% after ded   |
| Maternity Delivery/Inpatient      | \$500/day; 5 days/admit                    | \$500/day; 5 days/admit                    | 20% after ded   |
| Mental Health Inpatient           | \$500/day; 5 days/admit                    | \$500/day; 5 days/admit                    | 20% after ded   |
| Substance Abuse Inpatient         | \$500/day; 5 days/admit                    | \$500/day; 5 days/admit                    | 20% after ded   |
| <b>Outpatient Services</b>        |  |  |   |
| Outpatient Facility               | 150  | 150  | 20% after ded   |
| Outpatient Surgery                | 150  | 150  | 20% after ded   |
| Lab/X-Ray                         | 50   | 50   | 20%   |
| Advanced Radiology                | 125  | 125  | 20% after ded   |
| Mental Health Outpatient          | 25   | 25   | \$25 ded waived                                       |
| Substance Abuse Outpatient        | 25   | 25   | \$25 ded waived                                       |
| <b>Emergency Care</b>             |  |  |   |
| Emergency Room                    | 750  | 750  | 20% after ded   |
| Ambulance                         | 750  | 750  | 20% after ded   |
| Urgent Care                       | 75   | 75   | \$75 ded waived                                       |
| <b>Recovery/Special Needs</b>     |  |  |   |
| Home Health Care                  | \$50; 40 visits/plan yr                    | \$50; 40 visits/plan yr                    | \$50 ded waived; 40 visits/plan yr                    |
| Habilitation services             | \$25; 60 visits/cond/plan yr comb PT/OT/ST | \$25; 60 visits/cond/plan yr comb PT/OT/ST | \$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST |
| Skilled Nursing                   | \$500/day; 5 days/admit; 200 days/plan yr  | \$500/day; 5 days/admit; 200 days/plan yr  | 20% after ded; 200 days/plan yr                       |
| Durable Medical Equipment         | 20%  | 20%  | 20% after ded   |
| Hospice Services                  | 20%; 210 days/plan yr                      | 20%; 210 days/plan yr                      | 20% after ded; 210 days/plan yr                       |

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## 2019 Summary of Benefits

|                                   | <b>OSCAR</b><br>Circle Plus Gold 750                  | <b>OSCAR</b><br>Circle Gold 2000                      | <b>OSCAR</b><br>Circle Plus Gold 2000                 |
|-----------------------------------|---|---|---|
|                                   | In-Network  | In-Network  | In-Network  |
| <b>Prescription Drugs</b>         |   |   |   |
| Drug Card                         | 15/50/100/100 ded T2-3                                | 10/50/100/150 ded T2-3                                | 10/50/100/150 ded T2-3                                |
| <b>Cost Share Information</b>     |   |   |   |
| Individual/Family Deductible      | \$750/\$1,500   | \$2,000/\$4,000                                       | \$2,000/\$4,000                                       |
| Individual/Family OOP Limit       | \$7,500/\$15,000 (incl ded)                           | \$7,000/\$14,000 (incl ded)                           | \$7,000/\$14,000 (incl ded)                           |
| Co-Insurance                      | 20%   | 20%   | 20%   |
| Lifetime Max                      | None  | None  | None  |
| <b>Office Visits</b>              |   |   |   |
| Primary Care                      | \$25 ded waived                                       | \$25 ded waived                                       | \$25 ded waived                                       |
| Specialist                        | \$50 ded waived                                       | \$50 ded waived                                       | \$50 ded waived                                       |
| Adult Preventive Care             | No charge   | No charge   | No charge   |
| Child Preventive Care             | No charge   | No charge   | No charge   |
| Maternity Prenatal/Postnatal Care | No charge   | No charge   | No charge   |
| Rehabilitation Services           | \$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST | \$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST | \$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST |
| Chiropractic Care                 | \$25 ded waived                                       | \$25 ded waived                                       | \$25 ded waived                                       |
| <b>Inpatient Services</b>         |   |   |   |
| Inpatient Hospital                | 20% after ded   | 20% after ded   | 20% after ded   |
| Inpatient Surgery                 | 20% after ded   | 20% after ded   | 20% after ded   |
| Maternity Delivery/Inpatient      | 20% after ded   | 20% after ded   | 20% after ded   |
| Mental Health Inpatient           | 20% after ded   | 20% after ded   | 20% after ded   |
| Substance Abuse Inpatient         | 20% after ded   | 20% after ded   | 20% after ded   |
| <b>Outpatient Services</b>        |   |   |   |
| Outpatient Facility               | 20% after ded   | 20% after ded   | 20% after ded   |
| Outpatient Surgery                | 20% after ded   | 20% after ded   | 20% after ded   |
| Lab/X-Ray                         | 20%   | 20%   | 20%   |
| Advanced Radiology                | 20% after ded   | 20% after ded   | 20% after ded   |
| Mental Health Outpatient          | \$25 ded waived                                       | \$25 ded waived                                       | \$25 ded waived                                       |
| Substance Abuse Outpatient        | \$25 ded waived                                       | \$25 ded waived                                       | \$25 ded waived                                       |
| <b>Emergency Care</b>             |   |   |   |
| Emergency Room                    | 20% after ded   | \$250 ded waived                                      | \$250 ded waived                                      |
| Ambulance                         | 20% after ded   | \$250 ded waived                                      | \$250 ded waived                                      |
| Urgent Care                       | \$75 ded waived                                       | \$75 ded waived                                       | \$75 ded waived                                       |
| <b>Recovery/Special Needs</b>     |   |   |   |
| Home Health Care                  | \$50 ded waived; 40 visits/plan yr                    | \$50 ded waived; 40 visits/plan yr                    | \$50 ded waived; 40 visits/plan yr                    |
| Habilitation services             | \$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST | \$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST | \$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST |
| Skilled Nursing                   | 20% after ded; 200 days/plan yr                       | 20% after ded; 200 days/plan yr                       | 20% after ded; 200 days/plan yr                       |
| Durable Medical Equipment         | 20% after ded   | 20% after ded   | 20% after ded   |
| Hospice Services                  | 20% after ded; 210 days/plan yr                       | 20% after ded; 210 days/plan yr                       | 20% after ded; 210 days/plan yr                       |

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## 2019 Summary of Benefits

|                                   | <br><b>Liberty Gold EPO 30/60 NG</b> | <br><b>Liberty Gold EPO 30/60 G</b> | <br><b>Metro Gold EPO 25/40 NG</b> |
|-----------------------------------|---|--|---|
|                                   | In-Network  | In-Network   | In-Network  |
| <b>Prescription Drugs</b>         |   |  |   |
| Drug Card                         | 15/45/75/100 ded T2-3   | 15/35/75/100 ded T2-3  | 10/65/90/100 ded T2-3   |
| <b>Cost Share Information</b>     |   |  |   |
| Individual/Family Deductible      | \$2,000/\$4,000   | \$1,000/\$2,000  | \$1,250/\$2,500   |
| Individual/Family OOP Limit       | \$7,900/\$15,800 (incl ded)   | \$4,500/\$9,000 (incl ded)   | \$5,000/\$10,000 (incl ded)   |
| Co-Insurance                      | 30%   | 0%   | 20%   |
| Lifetime Max                      | None  | None   | None  |
| <b>Office Visits</b>              |   |  |   |
| Primary Care                      | \$30 ded waived   | \$30 ded waived  | \$25 ded waived   |
| Specialist                        | \$60 ded waived   | \$60 ded waived  | \$40 ded waived   |
| Adult Preventive Care             | No charge   | No charge  | No charge   |
| Child Preventive Care             | No charge   | No charge  | No charge   |
| Maternity Prenatal/Postnatal Care | No charge   | No charge  | No charge   |
| Rehabilitation Services           | \$60 ded waived; 60 visits/cal yr comb PT/OT/ST   | \$60 ded waived; 60 visits/cal yr comb PT/OT/ST  | \$40 ded waived; 60 visits/cal yr comb PT/OT/ST   |
| Chiropractic Care                 | \$60 ded waived   | \$60 ded waived  | \$40 ded waived   |
| <b>Inpatient Services</b>         |   |  |   |
| Inpatient Hospital                | 30% after ded   | \$500/day after ded; \$2,000 max/admit   | 20% after ded   |
| Inpatient Surgery                 | 30% after ded   | 0% after ded   | 20% after ded   |
| Maternity Delivery/Inpatient      | 30% after ded   | \$500/day after ded; \$2,000 max/admit   | 20% after ded   |
| Mental Health Inpatient           | 30% after ded   | \$500/day after ded; \$2,000 max/admit   | 20% after ded   |
| Substance Abuse Inpatient         | Rehab-30% after ded   | Rehab-\$500/day after ded; \$2,000 max/admit   | Rehab-20% after ded   |
| <b>Outpatient Services</b>        |   |  |   |
| Outpatient Facility               | 30% after ded   | Hosp-\$250 after ded; FS-\$150 after ded   | Hosp-\$500 after ded; FS-\$200 after ded  |
| Outpatient Surgery                | 30% after ded   | Included in Outpatient Facility  | 20% after ded   |
| Lab/X-Ray                         | Lab-No charge; X-ray-30% after ded  | Lab-No charge; X-ray-\$35 after ded  | Lab-\$15 ded waived; X-ray-\$50 after ded   |
| Advanced Radiology                | 30% after ded   | \$100 after ded  | \$150 after ded   |
| Mental Health Outpatient          | \$60 ded waived   | \$60 ded waived  | \$40 ded waived   |
| Substance Abuse Outpatient        | Rehab-\$60 ded waived   | Rehab-\$60 ded waived  | Rehab-\$40 ded waived   |
| <b>Emergency Care</b>             |   |  |   |
| Emergency Room                    | \$500 (waived if admitted) ded waived   | \$500 (waived if admitted) ded waived  | \$400 (waived if admitted) ded waived   |
| Ambulance                         | No charge   | No charge  | No charge   |
| Urgent Care                       | \$75 ded waived   | \$75 ded waived  | \$65 ded waived   |
| <b>Recovery/Special Needs</b>     |   |  |   |
| Home Health Care                  | \$60 ded waived; 40 visits/cal yr   | \$60 ded waived; 40 visits/cal yr  | \$40 ded waived; 40 visits/cal yr   |
| Habilitation services             | \$60 ded waived; 60 visits/cal yr comb PT/OT/ST   | \$60 ded waived; 60 visits/cal yr comb PT/OT/ST  | \$40 ded waived; 60 visits/cal yr comb PT/OT/ST   |
| Skilled Nursing                   | 30% after ded; 200 days/cal yr  | \$500/day after ded; \$2,000 max/admit; 200 days/cal yr  | 20% after ded; 200 days/cal yr  |
| Durable Medical Equipment         | 30% after ded   | 0% after ded   | 20% after ded   |
| Hospice Services                  | 30% after ded   | \$500/day after ded; \$2,000 max/admit   | 20% after ded   |

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## 2019 Summary of Benefits

|                                   | <br><b>Metro Gold EPO 25/40 G</b>               | <br><b>Silver Pro EPO</b>                              | <br><b>Silver 40/75/4700 Pro EPO</b>                   |
|-----------------------------------|---|--|--|
|                                   | In-Network                                      | In-Network   | In-Network   |
| <b>Prescription Drugs</b>         |   |  |  |
| Drug Card                         | 10/65/90/100 ded T2-3                           | 20/60/110  | 20/60/110  |
| <b>Cost Share Information</b>     |   |  |  |
| Individual/Family Deductible      | \$1,250/\$2,500                                 | \$2,950/\$5,900  | \$4,700/\$9,400  |
| Individual/Family OOP Limit       | \$5,500/\$11,000 (incl ded)                     | \$7,900/\$15,800 (incl ded)                            | \$7,900/\$15,800 (incl ded)                            |
| Co-Insurance                      | 20%   | 40%  | 45%  |
| Lifetime Max                      | None  | None   | None   |
| <b>Office Visits</b>              |   |  |  |
| Primary Care                      | \$25 ded waived                                 | \$35 ded waived  | \$40 ded waived  |
| Specialist                        | \$40 ded waived                                 | \$70 ded waived  | \$75 ded waived  |
| Adult Preventive Care             | No charge                                       | No charge  | No charge  |
| Child Preventive Care             | No charge                                       | No charge  | No charge  |
| Maternity Prenatal/Postnatal Care | No charge                                       | No charge  | No charge  |
| Rehabilitation Services           | \$40 ded waived; 60 visits/cal yr comb PT/OT/ST | \$70 ded waived; 60 visits/cond/plan yr comb PT/OT/ST  | \$75 ded waived; 60 visits/cond/plan yr comb PT/OT/ST  |
| Chiropractic Care                 | \$40 ded waived                                 | \$70 ded waived  | \$75 ded waived  |
| <b>Inpatient Services</b>         |   |  |  |
| Inpatient Hospital                | 20% after ded                                   | 40% after ded  | 45% after ded  |
| Inpatient Surgery                 | 20% after ded                                   | 200  | \$200 after ded  |
| Maternity Delivery/Inpatient      | 20% after ded                                   | Delivery-\$200 after ded; IP-40% after ded             | Delivery-\$200 after ded; IP-45% after ded             |
| Mental Health Inpatient           | 20% after ded                                   | 40% after ded  | 45% after ded  |
| Substance Abuse Inpatient         | Rehab-20% after ded                             | 40% after ded  | 45% after ded  |
| <b>Outpatient Services</b>        |   |  |  |
| Outpatient Facility               | Hosp-\$500 after ded; FS-\$200 after ded        | 40% after ded  | 45% after ded  |
| Outpatient Surgery                | 20% after ded                                   | \$200 after ded  | \$200 after ded  |
| Lab/X-Ray                         | Lab-\$15 ded waived; X-ray-\$50 after ded       | PCP-\$35 ded waived; SP-\$70 ded waived                | PCP-\$40 ded waived; SP-\$75 ded waived                |
| Advanced Radiology                | \$150 after ded                                 | \$70 after ded   | \$75 after ded   |
| Mental Health Outpatient          | \$40 ded waived                                 | \$35 ded waived  | \$40 ded waived  |
| Substance Abuse Outpatient        | Rehab-\$40 ded waived                           | \$35 ded waived  | \$40 ded waived  |
| <b>Emergency Care</b>             |   |  |  |
| Emergency Room                    | \$500 (waived if admitted) ded waived           | \$600 (waived if admitted) after ded                   | \$600 (waived if admitted) after ded                   |
| Ambulance                         | No charge                                       | \$300 after ded  | \$300 after ded  |
| Urgent Care                       | \$65 ded waived                                 | \$70 ded waived  | \$75 ded waived  |
| <b>Recovery/Special Needs</b>     |   |  |  |
| Home Health Care                  | \$40 ded waived; 40 visits/cal yr               | \$35 after ded; 40 visits/plan yr                      | \$40 after ded; 40 visits/plan yr                      |
| Habilitation services             | \$40 ded waived; 60 visits/cal yr comb PT/OT/ST | \$70 ded waived; 60 visits/cond/plan yr comb PT/OT/ST  | \$75 ded waived; 60 visits/cond/plan yr comb PT/OT/ST  |
| Skilled Nursing                   | 20% after ded; 200 days/cal yr                  | 40% after ded; 200 days/plan yr                        | 45% after ded; 200 days/plan yr                        |
| Durable Medical Equipment         | 20% after ded                                   | 40% after ded  | 45% after ded  |
| Hospice Services                  | 20% after ded                                   | 40% after ded IP; \$35 ded waived OP; 210 days/plan yr | 45% after ded IP; \$40 ded waived OP; 210 days/plan yr |

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## 2019 Summary of Benefits

|                                   | <b>OSCAR</b><br>Circle Silver              | <b>OSCAR</b><br>Circle Plus Silver         | <b>OSCAR</b><br>Circle Silver 2700                    |
|-----------------------------------|--|--|---|
|                                   | In-Network                                 | In-Network                                 | In-Network  |
| <b>Prescription Drugs</b>         |  |  |   |
| Drug Card                         | 20/50/50%/100 ded T3                       | 20/50/50%/100 ded T3                       | 20/50/100   |
| <b>Cost Share Information</b>     |  |  |   |
| Individual/Family Deductible      | N/A  | N/A  | \$2,700/\$5,400                                       |
| Individual/Family OOP Limit       | \$7,900/\$15,800                           | \$7,900/\$15,800                           | \$7,900/\$15,800 (incl ded)                           |
| Co-Insurance                      | 0%   | 0%   | 30%   |
| Lifetime Max                      | None                                       | None                                       | None  |
| <b>Office Visits</b>              |  |  |   |
| Primary Care                      | \$50                                       | \$50                                       | \$40 ded waived                                       |
| Specialist                        | \$75                                       | \$75                                       | \$70 ded waived                                       |
| Adult Preventive Care             | No charge                                  | No charge                                  | No charge   |
| Child Preventive Care             | No charge                                  | No charge                                  | No charge   |
| Maternity Prenatal/Postnatal Care | No charge                                  | No charge                                  | No charge   |
| Rehabilitation Services           | \$50; 60 visits/cond/plan yr comb PT/OT/ST | \$50; 60 visits/cond/plan yr comb PT/OT/ST | \$40 ded waived; 60 visits/cond/plan yr comb PT/OT/ST |
| Chiropractic Care                 | \$50                                       | \$50                                       | \$40 ded waived                                       |
| <b>Inpatient Services</b>         |  |  |   |
| Inpatient Hospital                | \$1,000/admit                              | \$1,000/admit                              | 30% after ded   |
| Inpatient Surgery                 | 250  | 250  | 30% after ded   |
| Maternity Delivery/Inpatient      | \$1,000/admit                              | \$1,000/admit                              | 30% after ded   |
| Mental Health Inpatient           | \$1,000/admit                              | \$1,000/admit                              | 30% after ded   |
| Substance Abuse Inpatient         | \$1,000/admit                              | \$1,000/admit                              | 30% after ded   |
| <b>Outpatient Services</b>        |  |  |   |
| Outpatient Facility               | \$500                                      | \$500                                      | 30% after ded   |
| Outpatient Surgery                | \$250                                      | \$250                                      | 30% after ded   |
| Lab/X-Ray                         | \$75                                       | \$75                                       | 30%   |
| Advanced Radiology                | \$150                                      | \$150                                      | 30% after ded   |
| Mental Health Outpatient          | \$50                                       | \$50                                       | \$40 ded waived                                       |
| Substance Abuse Outpatient        | \$50                                       | \$50                                       | \$40 ded waived                                       |
| <b>Emergency Care</b>             |  |  |   |
| Emergency Room                    | \$650                                      | \$650                                      | 30% after ded   |
| Ambulance                         | \$650                                      | \$650                                      | 30% after ded   |
| Urgent Care                       | \$75                                       | \$75                                       | \$75 ded waived                                       |
| <b>Recovery/Special Needs</b>     |  |  |   |
| Home Health Care                  | \$75; 40 visits/plan yr                    | \$75; 40 visits/plan yr                    | \$70 ded waived; 40 visits/plan yr                    |
| Habilitation services             | \$50; 60 visits/cond/plan yr comb PT/OT/ST | \$50; 60 visits/cond/plan yr comb PT/OT/ST | \$40 ded waived; 60 visits/cond/plan yr comb PT/OT/ST |
| Skilled Nursing                   | \$1,000/admit; 200 days/plan yr            | \$1,000/admit; 200 days/plan yr            | 30% after ded; 200 days/plan yr                       |
| Durable Medical Equipment         | 20%  | 20%  | 30% after ded   |
| Hospice Services                  | 20%; 210 days/plan yr                      | 20%; 210 days/plan yr                      | 30% after ded; 210 days/plan yr                       |

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



## 2019 Summary of Benefits

|                                   | <b>OSCAR</b><br>Circle Plus Silver 2700               | <b>OSCAR</b><br>Circle Silver 4500                    | <b>OSCAR</b><br>Circle Plus Silver 4500               |
|-----------------------------------|---|---|---|
|                                   | In-Network  | In-Network  | In-Network  |
| <b>Prescription Drugs</b>         |   |   |   |
| Drug Card                         | 20/50/100   | 10/50%/50% IntDed T2-3                                | 10/50%/50% IntDed T2-3                                |
| <b>Cost Share Information</b>     |   |   |   |
| Individual/Family Deductible      | \$2,700/\$5,400                                       | \$4,500/\$9,000                                       | \$4,500/\$9,000                                       |
| Individual/Family OOP Limit       | \$7,900/\$15,800 (incl ded)                           | \$7,000/\$14,000 (incl ded)                           | \$7,000/\$14,000 (incl ded)                           |
| Co-Insurance                      | 30%   | 50%   | 50%   |
| Lifetime Max                      | None  | None  | None  |
| <b>Office Visits</b>              |   |   |   |
| Primary Care                      | \$40 ded waived                                       | \$25 ded waived                                       | \$25 ded waived                                       |
| Specialist                        | \$70 ded waived                                       | \$75 ded waived                                       | \$75 ded waived                                       |
| Adult Preventive Care             | No charge   | No charge   | No charge   |
| Child Preventive Care             | No charge   | No charge   | No charge   |
| Maternity Prenatal/Postnatal Care | No charge   | No charge   | No charge   |
| Rehabilitation Services           | \$40 ded waived; 60 visits/cond/plan yr comb PT/OT/ST | \$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST | \$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST |
| Chiropractic Care                 | \$40 ded waived                                       | \$25 ded waived                                       | \$25 ded waived                                       |
| <b>Inpatient Services</b>         |   |   |   |
| Inpatient Hospital                | 30% after ded   | 50% after ded   | 50% after ded   |
| Inpatient Surgery                 | 30% after ded   | 50% after ded   | 50% after ded   |
| Maternity Delivery/Inpatient      | 30% after ded   | 50% after ded   | 50% after ded   |
| Mental Health Inpatient           | 30% after ded   | 50% after ded   | 50% after ded   |
| Substance Abuse Inpatient         | 30% after ded   | 50% after ded   | 50% after ded   |
| <b>Outpatient Services</b>        |   |   |   |
| Outpatient Facility               | 30% after ded   | 50% after ded   | 50% after ded   |
| Outpatient Surgery                | 30% after ded   | 50% after ded   | 50% after ded   |
| Lab/X-Ray                         | 30%   | 50%   | 50%   |
| Advanced Radiology                | 30% after ded   | 50% after ded   | 50% after ded   |
| Mental Health Outpatient          | \$40 ded waived                                       | \$25 ded waived                                       | \$25 ded waived                                       |
| Substance Abuse Outpatient        | \$40 ded waived                                       | \$25 ded waived                                       | \$25 ded waived                                       |
| <b>Emergency Care</b>             |   |   |   |
| Emergency Room                    | 30% after ded   | 50% after ded   | 50% after ded   |
| Ambulance                         | 30% after ded   | 50% after ded   | 50% after ded   |
| Urgent Care                       | \$75 ded waived                                       | \$75 ded waived                                       | \$75 ded waived                                       |
| <b>Recovery/Special Needs</b>     |   |   |   |
| Home Health Care                  | \$70 ded waived; 40 visits/plan yr                    | \$75 ded waived; 40 visits/plan yr                    | \$75 ded waived; 40 visits/plan yr                    |
| Habilitation services             | \$40 ded waived; 60 visits/cond/plan yr comb PT/OT/ST | \$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST | \$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST |
| Skilled Nursing                   | 30% after ded; 200 days/plan yr                       | 50% after ded; 200 days/plan yr                       | 50% after ded; 200 days/plan yr                       |
| Durable Medical Equipment         | 30% after ded   | 50% after ded   | 50% after ded   |
| Hospice Services                  | 30% after ded; 210 days/plan yr                       | 50% after ded; 210 days/plan yr                       | 50% after ded; 210 days/plan yr                       |

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





## 2019 Summary of Benefits

|                                   | <br><b>Circle Silver HSA 3000</b>                   | <br><b>Circle Plus Silver HSA 3000</b>              | <br><b>Liberty Silver 40/70 NG</b>              |
|-----------------------------------|---|---|---|
|                                   | In-Network  | In-Network  | In-Network                                      |
| <b>Prescription Drugs</b>         |   |   |   |
| Drug Card                         | 20%/20%/20% IntDed                                  | 20%/20%/20% IntDed                                  | 15/45/75/200 ded T2-3                           |
| <b>Cost Share Information</b>     |   |   |   |
| Individual/Family Deductible      | \$3,000/\$6,000                                     | \$3,000/\$6,000                                     | \$2,500/\$5,000                                 |
| Individual/Family OOP Limit       | \$5,000/\$10,000 (incl ded)                         | \$5,000/\$10,000 (incl ded)                         | \$7,900/\$15,800 (incl ded)                     |
| Co-Insurance                      | 20%   | 20%   | 30%   |
| Lifetime Max                      | None  | None  | None  |
| <b>Office Visits</b>              |   |   |   |
| Primary Care                      | 20% after ded                                       | 20% after ded                                       | \$40 ded waived                                 |
| Specialist                        | 20% after ded                                       | 20% after ded                                       | \$70 ded waived                                 |
| Adult Preventive Care             | No charge   | No charge   | No charge                                       |
| Child Preventive Care             | No charge   | No charge   | No charge                                       |
| Maternity Prenatal/Postnatal Care | No charge   | No charge   | No charge                                       |
| Rehabilitation Services           | 20% after ded; 60 visits/cond/plan yr comb PT/OT/ST | 20% after ded; 60 visits/cond/plan yr comb PT/OT/ST | \$70 ded waived; 60 visits/cal yr comb PT/OT/ST |
| Chiropractic Care                 | 20% after ded                                       | 20% after ded                                       | \$70 ded waived                                 |
| <b>Inpatient Services</b>         |   |   |   |
| Inpatient Hospital                | 20% after ded                                       | 20% after ded                                       | 30% after ded                                   |
| Inpatient Surgery                 | 20% after ded                                       | 20% after ded                                       | 30% after ded                                   |
| Maternity Delivery/Inpatient      | 20% after ded                                       | 20% after ded                                       | 30% after ded                                   |
| Mental Health Inpatient           | 20% after ded                                       | 20% after ded                                       | 30% after ded                                   |
| Substance Abuse Inpatient         | 20% after ded                                       | 20% after ded                                       | Rehab-30% after ded                             |
| <b>Outpatient Services</b>        |   |   |   |
| Outpatient Facility               | 20% after ded                                       | 20% after ded                                       | 30% after ded                                   |
| Outpatient Surgery                | 20% after ded                                       | 20% after ded                                       | 30% after ded                                   |
| Lab/X-Ray                         | 20% after ded                                       | 20% after ded                                       | Lab-\$20 ded waived; X-ray-30% after ded        |
| Advanced Radiology                | 20% after ded                                       | 20% after ded                                       | 30% after ded                                   |
| Mental Health Outpatient          | 20% after ded                                       | 20% after ded                                       | \$70 ded waived                                 |
| Substance Abuse Outpatient        | 20% after ded                                       | 20% after ded                                       | Rehab-\$70 ded waived                           |
| <b>Emergency Care</b>             |   |   |   |
| Emergency Room                    | 20% after ded                                       | 20% after ded                                       | 30% after ded                                   |
| Ambulance                         | 20% after ded                                       | 20% after ded                                       | No charge                                       |
| Urgent Care                       | 20% after ded                                       | 20% after ded                                       | \$75 ded waived                                 |
| <b>Recovery/Special Needs</b>     |   |   |   |
| Home Health Care                  | 20% after ded; 40 visits/plan yr                    | 20% after ded; 40 visits/plan yr                    | \$70 ded waived; 40 visits/cal yr               |
| Habilitation services             | 20% after ded; 60 visits/cond/plan yr comb PT/OT/ST | 20% after ded; 60 visits/cond/plan yr comb PT/OT/ST | \$70 ded waived; 60 visits/cal yr comb PT/OT/ST |
| Skilled Nursing                   | 20% after ded; 200 days/plan yr                     | 20% after ded; 200 days/plan yr                     | 30% after ded; 200 days/cal yr                  |
| Durable Medical Equipment         | 20% after ded                                       | 20% after ded                                       | 30% after ded                                   |
| Hospice Services                  | 20% after ded; 210 days/plan yr                     | 20% after ded; 210 days/plan yr                     | 30% after ded                                   |

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






## 2019 Summary of Benefits

|                                   | <br><b>Liberty Advantage<br/>Silver EPO 30/70 G</b> | <br><b>Metro Silver EPO 30/80 NG</b>            | <br><b>Metro Silver EPO 30/80 G</b>             |
|-----------------------------------|---|---|---|
|                                   | In-Network  | In-Network                                      | In-Network                                      |
| <b>Prescription Drugs</b>         |   |   |   |
| Drug Card                         | 15/50/90/150 ded T2-3                               | 10/65/90/100 ded T2-3                           | 10/65/90/100 ded T2-3                           |
| <b>Cost Share Information</b>     |   |   |   |
| Individual/Family Deductible      | \$4,000/\$8,000                                     | \$3,000/\$6,000                                 | \$3,000/\$6,000                                 |
| Individual/Family OOP Limit       | \$7,350/\$14,700 (incl ded)                         | \$7,900/\$15,800 (incl ded)                     | \$7,900/\$15,800 (incl ded)                     |
| Co-Insurance                      | 40%   | 30%   | 30%   |
| Lifetime Max                      | None  | None  | None  |
| <b>Office Visits</b>              |   |   |   |
| Primary Care                      | \$30 ded waived                                     | \$30 ded waived                                 | \$30 ded waived                                 |
| Specialist                        | \$70 ded waived                                     | \$80 ded waived                                 | \$80 ded waived                                 |
| Adult Preventive Care             | No charge   | No charge                                       | No charge                                       |
| Child Preventive Care             | No charge   | No charge                                       | No charge                                       |
| Maternity Prenatal/Postnatal Care | No charge   | No charge                                       | No charge                                       |
| Rehabilitation Services           | \$70 ded waived; 60 visits/cal yr comb PT/OT/ST     | \$80 ded waived; 60 visits/cal yr comb PT/OT/ST | \$80 ded waived; 60 visits/cal yr comb PT/OT/ST |
| Chiropractic Care                 | \$70 ded waived                                     | \$80 ded waived                                 | \$80 ded waived                                 |
| <b>Inpatient Services</b>         |   |   |   |
| Inpatient Hospital                | 40% after ded                                       | 30% after ded                                   | 30% after ded                                   |
| Inpatient Surgery                 | 40% after ded                                       | 30% after ded                                   | 30% after ded                                   |
| Maternity Delivery/Inpatient      | 40% after ded                                       | 30% after ded                                   | 30% after ded                                   |
| Mental Health Inpatient           | 40% after ded                                       | 30% after ded                                   | 30% after ded                                   |
| Substance Abuse Inpatient         | Rehab-40% after ded                                 | Rehab-30% after ded                             | Rehab-30% after ded                             |
| <b>Outpatient Services</b>        |   |   |   |
| Outpatient Facility               | 40% after ded                                       | 30% after ded                                   | 30% after ded                                   |
| Outpatient Surgery                | 40% after ded                                       | 30% after ded                                   | 30% after ded                                   |
| Lab/X-Ray                         | 40% after ded                                       | Lab-\$15 ded waived; X-ray-30% after ded        | Lab-\$15 ded waived; X-ray-30% after ded        |
| Advanced Radiology                | 40% after ded                                       | 30% after ded                                   | 30% after ded                                   |
| Mental Health Outpatient          | \$70 ded waived                                     | \$80 ded waived                                 | \$80 ded waived                                 |
| Substance Abuse Outpatient        | Rehab-\$70 ded waived                               | Rehab-\$80 ded waived                           | Rehab-\$80 ded waived                           |
| <b>Emergency Care</b>             |   |   |   |
| Emergency Room                    | 40% after ded                                       | 30% after ded                                   | 30% after ded                                   |
| Ambulance                         | No charge   | No charge                                       | No charge                                       |
| Urgent Care                       | \$70 ded waived                                     | \$80 ded waived                                 | \$80 ded waived                                 |
| <b>Recovery/Special Needs</b>     |   |   |   |
| Home Health Care                  | \$70 ded waived; 40 visits/cal yr                   | \$80 ded waived; 40 visits/cal yr               | \$80 ded waived; 40 visits/cal yr               |
| Habilitation services             | \$70 ded waived; 60 visits/cal yr comb PT/OT/ST     | \$80 ded waived; 60 visits/cal yr comb PT/OT/ST | \$80 ded waived; 60 visits/cal yr comb PT/OT/ST |
| Skilled Nursing                   | 40% after ded; 200 days/cal yr                      | 30% after ded; 200 days/cal yr                  | 30% after ded; 200 days/cal yr                  |
| Durable Medical Equipment         | 40% after ded                                       | 30% after ded                                   | 30% after ded                                   |
| Hospice Services                  | 40% after ded                                       | 30% after ded                                   | 30% after ded                                   |

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



## 2019 Summary of Benefits

|                                   | <br><b>Bronze Pro EPO HSA</b> | <br><b>Bronze 6650 Pro EPO HSA</b> | <br><b>Circle Bronze 4000</b> |
|-----------------------------------|--|---|--|
|                                   | In-Network   | In-Network  | In-Network   |
| <b>Prescription Drugs</b>         |  |   |  |
| Drug Card                         | 20%/20%/20% IntDed   | 0%/0%/0% IntDed   | 20/50/100 IntDed   |
| <b>Cost Share Information</b>     |  |   |  |
| Individual/Family Deductible      | \$4,000/\$8,000  | \$6,650/\$13,300  | \$4,000/\$8,000  |
| Individual/Family OOP Limit       | \$6,650/\$13,300 (incl ded)  | \$6,650/\$13,300 (incl ded)   | \$7,900/\$15,800 (incl ded)  |
| Co-Insurance                      | 20%  | 0%  | 50%  |
| Lifetime Max                      | None   | None  | None   |
| <b>Office Visits</b>              |  |   |  |
| Primary Care                      | 20% after ded  | 0% after ded  | 50% after ded  |
| Specialist                        | 20% after ded  | 0% after ded  | 50% after ded  |
| Adult Preventive Care             | No charge  | No charge   | No charge  |
| Child Preventive Care             | No charge  | No charge   | No charge  |
| Maternity Prenatal/Postnatal Care | No charge  | No charge   | No charge  |
| Rehabilitation Services           | 20% after ded; 60 visits/cond/plan yr comb PT/OT/ST  | 0% after ded; 60 visits/cond/plan yr comb PT/OT/ST  | 50% after ded; 60 visits/cond/plan yr comb PT/OT/ST  |
| Chiropractic Care                 | 20% after ded  | 0% after ded  | 50% after ded  |
| <b>Inpatient Services</b>         |  |   |  |
| Inpatient Hospital                | 20% after ded  | 0% after ded  | 50% after ded  |
| Inpatient Surgery                 | 20% after ded  | 0% after ded  | 50% after ded  |
| Maternity Delivery/Inpatient      | 20% after ded  | 0% after ded  | 50% after ded  |
| Mental Health Inpatient           | 20% after ded  | 0% after ded  | 50% after ded  |
| Substance Abuse Inpatient         | 20% after ded  | 0% after ded  | 50% after ded  |
| <b>Outpatient Services</b>        |  |   |  |
| Outpatient Facility               | 20% after ded  | 0% after ded  | 50% after ded  |
| Outpatient Surgery                | 20% after ded  | 0% after ded  | 50% after ded  |
| Lab/X-Ray                         | 20% after ded  | 0% after ded  | 50% after ded  |
| Advanced Radiology                | 20% after ded  | 0% after ded  | 50% after ded  |
| Mental Health Outpatient          | 20% after ded  | 0% after ded  | 50% after ded  |
| Substance Abuse Outpatient        | 20% after ded  | 0% after ded  | 50% after ded  |
| <b>Emergency Care</b>             |  |   |  |
| Emergency Room                    | 20% after ded  | 0% after ded  | 50% after ded  |
| Ambulance                         | 20% after ded  | 0% after ded  | 50% after ded  |
| Urgent Care                       | 20% after ded  | 0% after ded  | \$75 ded waived  |
| <b>Recovery/Special Needs</b>     |  |   |  |
| Home Health Care                  | 20% after ded; 40 visits/plan yr   | 0% after ded; 40 visits/plan yr   | 50% after ded; 40 visits/plan yr   |
| Habilitation services             | 20% after ded; 60 visits/cond/plan yr comb PT/OT/ST  | 0% after ded; 60 visits/cond/plan yr comb PT/OT/ST  | 50% after ded; 60 visits/cond/plan yr comb PT/OT/ST  |
| Skilled Nursing                   | 20% after ded; 200 days/plan yr  | 0% after ded; 200 days/plan yr  | 50% after ded; 200 days/plan yr  |
| Durable Medical Equipment         | 20% after ded  | 0% after ded  | 50% after ded  |
| Hospice Services                  | 20% after ded; 210 days/plan yr  | 0% after ded; 210 days/plan yr  | 50% after ded; 210 days/plan yr  |

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





## 2019 Summary of Benefits

|                                   | <b>oscar</b><br>Circle Plus Bronze 4000             | <b>oscar</b><br>Circle Bronze 7900                 | <b>oscar</b><br>Circle Plus Bronze 7900            |
|-----------------------------------|---|--|--|
|                                   | In-Network  | In-Network   | In-Network   |
| <b>Prescription Drugs</b>         |   |  |  |
| Drug Card                         | 20/50/100 IntDed                                    | 0%/0%/0% IntDed                                    | 0%/0%/0% IntDed                                    |
| <b>Cost Share Information</b>     |   |  |  |
| Individual/Family Deductible      | \$4,000/\$8,000                                     | \$7,900/\$15,800                                   | \$7,900/\$15,800                                   |
| Individual/Family OOP Limit       | \$7,900/\$15,800 (incl ded)                         | \$7,900/\$15,800 (incl ded)                        | \$7,900/\$15,800 (incl ded)                        |
| Co-Insurance                      | 50%   | 0%   | 0%   |
| Lifetime Max                      | None  | None   | None   |
| <b>Office Visits</b>              |   |  |  |
| Primary Care                      | 50% after ded                                       | 0% after ded                                       | 0% after ded                                       |
| Specialist                        | 50% after ded                                       | 0% after ded                                       | 0% after ded                                       |
| Adult Preventive Care             | No charge   | No charge  | No charge  |
| Child Preventive Care             | No charge   | No charge  | No charge  |
| Maternity Prenatal/Postnatal Care | No charge   | No charge  | No charge  |
| Rehabilitation Services           | 50% after ded; 60 visits/cond/plan yr comb PT/OT/ST | 0% after ded; 60 visits/cond/plan yr comb PT/OT/ST | 0% after ded; 60 visits/cond/plan yr comb PT/OT/ST |
| Chiropractic Care                 | 50% after ded                                       | 0% after ded                                       | 0% after ded                                       |
| <b>Inpatient Services</b>         |   |  |  |
| Inpatient Hospital                | 50% after ded                                       | 0% after ded                                       | 0% after ded                                       |
| Inpatient Surgery                 | 50% after ded                                       | 0% after ded                                       | 0% after ded                                       |
| Maternity Delivery/Inpatient      | 50% after ded                                       | 0% after ded                                       | 0% after ded                                       |
| Mental Health Inpatient           | 50% after ded                                       | 0% after ded                                       | 0% after ded                                       |
| Substance Abuse Inpatient         | 50% after ded                                       | 0% after ded                                       | 0% after ded                                       |
| <b>Outpatient Services</b>        |   |  |  |
| Outpatient Facility               | 50% after ded                                       | 0% after ded                                       | 0% after ded                                       |
| Outpatient Surgery                | 50% after ded                                       | 0% after ded                                       | 0% after ded                                       |
| Lab/X-Ray                         | 50% after ded                                       | 0% after ded                                       | 0% after ded                                       |
| Advanced Radiology                | 50% after ded                                       | 0% after ded                                       | 0% after ded                                       |
| Mental Health Outpatient          | 50% after ded                                       | 0% after ded                                       | 0% after ded                                       |
| Substance Abuse Outpatient        | 50% after ded                                       | 0% after ded                                       | 0% after ded                                       |
| <b>Emergency Care</b>             |   |  |  |
| Emergency Room                    | 50% after ded                                       | 0% after ded                                       | 0% after ded                                       |
| Ambulance                         | 50% after ded                                       | 0% after ded                                       | 0% after ded                                       |
| Urgent Care                       | \$75 ded waived                                     | \$75 ded waived                                    | \$75 ded waived                                    |
| <b>Recovery/Special Needs</b>     |   |  |  |
| Home Health Care                  | 50% after ded; 40 visits/plan yr                    | 0% after ded; 40 visits/plan yr                    | 0% after ded; 40 visits/plan yr                    |
| Habilitation services             | 50% after ded; 60 visits/cond/plan yr comb PT/OT/ST | 0% after ded; 60 visits/cond/plan yr comb PT/OT/ST | 0% after ded; 60 visits/cond/plan yr comb PT/OT/ST |
| Skilled Nursing                   | 50% after ded; 200 days/plan yr                     | 0% after ded; 200 days/plan yr                     | 0% after ded; 200 days/plan yr                     |
| Durable Medical Equipment         | 50% after ded                                       | 0% after ded                                       | 0% after ded                                       |
| Hospice Services                  | 50% after ded; 210 days/plan yr                     | 0% after ded; 210 days/plan yr                     | 0% after ded; 210 days/plan yr                     |

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



## 2019 Summary of Benefits

|                                   | <br><b>Circle Bronze HSA 6650</b>                  | <br><b>Circle Plus Bronze HSA 6650</b>             | <br><b>Liberty Bronze EPO HSA 3300 NG</b>      | <br><b>Metro Bronze EPO HSA 6550 G</b>       |
|-----------------------------------|--|--|--|--|
|                                   | In-Network   | In-Network   | In-Network                                     | In-Network                                   |
| <b>Prescription Drugs</b>         |  |  |  |  |
| Drug Card                         | 0%/0%/0% IntDed                                    | 0%/0%/0% IntDed                                    | 30%/30%/30% IntDed                             | 0%/0%/0% IntDed                              |
| <b>Cost Share Information</b>     |  |  |  |  |
| Individual/Family Deductible      | \$6,650/\$13,300                                   | \$6,650/\$13,300                                   | \$3,300/\$6,600                                | \$6,550/\$13,100                             |
| Individual/Family OOP Limit       | \$6,650/\$13,300 (incl ded)                        | \$6,650/\$13,300 (incl ded)                        | \$6,700/\$13,400 (incl ded)                    | \$6,700/\$13,400 (incl ded)                  |
| Co-Insurance                      | 0%   | 0%   | 30%  | 0%   |
| Lifetime Max                      | None   | None   | None   | None   |
| <b>Office Visits</b>              |  |  |  |  |
| Primary Care                      | 0% after ded                                       | 0% after ded                                       | \$25 after ded                                 | 0% after ded                                 |
| Specialist                        | 0% after ded                                       | 0% after ded                                       | \$75 after ded                                 | 0% after ded                                 |
| Adult Preventive Care             | No charge  | No charge  | No charge                                      | No charge                                    |
| Child Preventive Care             | No charge  | No charge  | No charge                                      | No charge                                    |
| Maternity Prenatal/Postnatal Care | No charge  | No charge  | No charge                                      | No charge                                    |
| Rehabilitation Services           | 0% after ded; 60 visits/cond/plan yr comb PT/OT/ST | 0% after ded; 60 visits/cond/plan yr comb PT/OT/ST | \$75 after ded; 60 visits/cal yr comb PT/OT/ST | 0% after ded; 60 visits/cal yr comb PT/OT/ST |
| Chiropractic Care                 | 0% after ded                                       | 0% after ded                                       | \$75 after ded                                 | 0% after ded                                 |
| <b>Inpatient Services</b>         |  |  |  |  |
| Inpatient Hospital                | 0% after ded                                       | 0% after ded                                       | 30% after ded                                  | 0% after ded                                 |
| Inpatient Surgery                 | 0% after ded                                       | 0% after ded                                       | 30% after ded                                  | 0% after ded                                 |
| Maternity Delivery/Inpatient      | 0% after ded                                       | 0% after ded                                       | 30% after ded                                  | 0% after ded                                 |
| Mental Health Inpatient           | 0% after ded                                       | 0% after ded                                       | 30% after ded                                  | 0% after ded                                 |
| Substance Abuse Inpatient         | 0% after ded                                       | 0% after ded                                       | Rehab-30% after ded                            | Rehab-0% after ded                           |
| <b>Outpatient Services</b>        |  |  |  |  |
| Outpatient Facility               | 0% after ded                                       | 0% after ded                                       | 30% after ded                                  | 0% after ded                                 |
| Outpatient Surgery                | 0% after ded                                       | 0% after ded                                       | 30% after ded                                  | 0% after ded                                 |
| Lab/X-Ray                         | 0% after ded                                       | 0% after ded                                       | 30% after ded                                  | 0% after ded                                 |
| Advanced Radiology                | 0% after ded                                       | 0% after ded                                       | 30% after ded                                  | 0% after ded                                 |
| Mental Health Outpatient          | 0% after ded                                       | 0% after ded                                       | \$75 after ded                                 | 0% after ded                                 |
| Substance Abuse Outpatient        | 0% after ded                                       | 0% after ded                                       | Rehab-\$75 after ded                           | Rehab-0% after ded                           |
| <b>Emergency Care</b>             |  |  |  |  |
| Emergency Room                    | 0% after ded                                       | 0% after ded                                       | 30% after ded                                  | 0% after ded                                 |
| Ambulance                         | 0% after ded                                       | 0% after ded                                       | 30% after ded                                  | 0% after ded                                 |
| Urgent Care                       | 0% after ded                                       | 0% after ded                                       | 30% after ded                                  | 0% after ded                                 |
| <b>Recovery/Special Needs</b>     |  |  |  |  |
| Home Health Care                  | 0% after ded; 40 visits/plan yr                    | 0% after ded; 40 visits/plan yr                    | \$75 after ded; 40 visits/cal yr               | 0% after ded; 40 visits/cal yr               |
| Habilitation services             | 0% after ded; 60 visits/cond/plan yr comb PT/OT/ST | 0% after ded; 60 visits/cond/plan yr comb PT/OT/ST | \$75 after ded; 60 visits/cal yr comb PT/OT/ST | 0% after ded; 60 visits/cal yr comb PT/OT/ST |
| Skilled Nursing                   | 0% after ded; 200 days/plan yr                     | 0% after ded; 200 days/plan yr                     | 30% after ded; 200 days/cal yr                 | 0% after ded; 200 days/cal yr                |
| Durable Medical Equipment         | 0% after ded                                       | 0% after ded                                       | 30% after ded                                  | 0% after ded                                 |
| Hospice Services                  | 0% after ded; 210 days/plan yr                     | 0% after ded; 210 days/plan yr                     | 30% after ded                                  | 0% after ded                                 |

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