

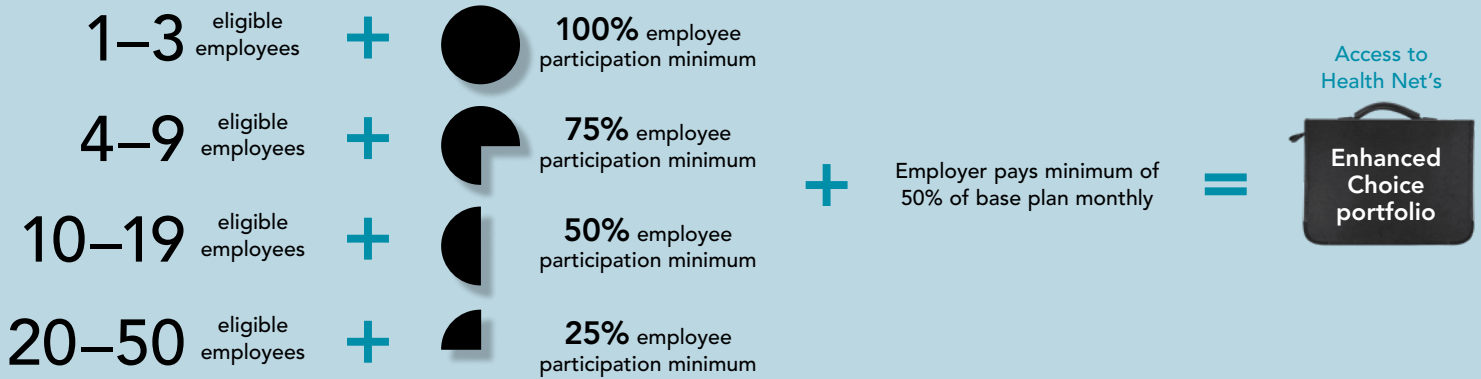
Plan name	Member(s) responsibility											
	Metal level	Deductible <sup>2</sup> (single / family)	Out-of-pocket maximum <sup>2</sup> (single / family)	Office visit (PCP / Spec.)	Coinsurance <sup>3</sup> (In-network / Out-of-network)	Deductible waived		Inpatient hospital	Outpatient surgery (ASC / Hospital)	Emergency room (copay waived if admitted)	Urgent care	Pharmacy <sup>4</sup>
						Lab and X-ray	CT/MRI/PET/SPEC					
<b>PPO</b>												
W25-750-2-2500LX	Platinum	\$750 / \$1,500	\$2,500 / \$5,000	\$25	20% / 50%	20% / Yes	20% / Yes	20%	15% / 20%	\$250 + 20% ded. waived	\$50	\$10 / \$30 / \$90 / 50%
W25-1000-2-3000LX	Platinum	\$1,000 / \$2,000	\$3,000 / \$6,000	\$25	20% / 50%	20% / Yes	20% / Yes	20%	15% / 20%	\$350 + 20% ded. waived	\$50	\$10 / \$30 / \$90 / 50%
W40-1500-2-6000DX	Gold	\$1,500 / \$3,000	\$6,000 / \$12,000	\$40	20% / 50%	20% / Yes	20% / No	20%	15% / 20%	\$500 + 20% ded. waived	\$50	\$15 / \$45 / \$100 / 50%
W40-2500-2-6000DX	Gold	\$2,500 / \$5,000	\$6,000 / \$12,000	\$40	20% / 50%	20% / Yes	20% / No	20%	15% / 20%	\$500 + 20% ded. waived	\$50	\$15 / \$45 / \$100 / 50%
W40-3500-2-7000DX	Gold	\$3,500 / \$7,000	\$7,000 / \$14,000	\$40	20% / 50%	20% / Yes	20% / No	20%	15% / 20%	\$500 + 20% ded. waived	\$50	\$15 / \$45 / \$100 / 50%
W45-4500-3-7350ES	Silver	\$4,500 / \$9,000	\$7,350 / \$14,700	\$45	30% / 50%	30% / No	30% / No	30%	25% / 30%	30%	\$50	\$15 / \$40 / 50% / 50%
W55-5500-3-7350ES	Silver	\$5,500 / \$11,000	\$7,350 / \$14,700	\$55	30% / 50%	30% / No	30% / No	30%	25% / 30%	30%	\$50	\$15 / \$40 / 50% / 50%
W6000-3-7000ES	Silver	\$6,000 / \$12,000	\$7,000 / \$14,000	30%	30% / 50%	30% / No	30% / No	30%	25% / 30%	\$500 + 30% ded. waived	\$50	\$10 / \$20 / \$50 / 50%
W75-5000-5-7900ES	Bronze	\$5,000 / \$10,000	\$7,900 / \$15,800	\$75, after ded.	50% / 50%	50% / No	50% / No	50%	45% / 50%	50%	50%	\$15 / 30%, after ded. / 50%, after ded. / 50%, after ded.
W7350-0-7350ES	Bronze	\$7,350 / \$14,700	\$7,350 / \$14,700	0%	0% / 50%	0% / No	0% / No	0%	0% / 0%	0%	0%	0%, after ded.
HD2700-2-6550ES	Silver	\$2,700 / \$5,400	\$6,550 / \$13,100	20%	20% / 50%	20% / No	20% / No	20%	15% / 20%	20%	20%	20%, after ded. / 20%, after ded. / 50%, after ded.
HD6550-0-6550ES	Bronze	\$6,550 / \$13,100	\$6,550 / \$13,100	0%	0% / 50%	0% / No	0% / No	0%	0% / 0%	0%	0%	0%, after ded.

Plan name	Member(s) responsibility			
	Alternative Care Core			
	Office visit (15 visits maximum each; naturopaths unlimited)			
PPO	Chiropractic care (In-network / Out-of-network)	Acupuncture care (In-network / Out-of-network)	Naturopathic care (In-network / Out-of-network)	Massage therapy (In-network / Out-of-network)
W25-750-2-2500LX	\$25 / 50%	\$25 / 50%	\$25 / 50%	\$25 / 50%
W25-1000-2-3000LX	\$25 / 50%	\$25 / 50%	\$25 / 50%	\$25 / 50%
W40-1500-2-6000DX	\$40 / 50%	\$40 / 50%	\$40 / 50%	\$40 / 50%
W40-2500-2-6000DX	\$40 / 50%	\$40 / 50%	\$40 / 50%	\$40 / 50%
W40-3500-2-7000DX	\$40 / 50%	\$40 / 50%	\$40 / 50%	\$40 / 50%
W45-4500-3-7350ES	\$45 / 50%	\$45 / 50%	\$45 / 50%	\$45 / 50%
W55-5500-3-7350ES	\$55 / 50%	\$55 / 50%	\$55 / 50%	\$55 / 50%
W6000-3-7000ES	30% / 50%	30% / 50%	30% / 50%	30% / 50%
W75-5000-5-7350ES	\$75, after ded. / 50%	\$75, after ded. / 50%	\$75, after ded. / 50%	\$75, after ded. / 50%

(continued)

Plan name	Member(s) responsibility					
	Alternative Care Core					
PPO	Office visit (15 visits maximum each; naturopaths unlimited)					
	Chiropractic care (In-network / Out-of-network)	Acupuncture care (In-network / Out-of-network)	Naturopathic care (In-network / Out-of-network)	Massage therapy (In-network / Out-of-network)		
W7350-0-7350ES	0%, after ded. / 50%	0%, after ded. / 50%	0%, after ded. / 50%	0%, after ded. / 50%		
HD2700-2-6550ES	20% / 50%	20% / 50%	20% / 50%	20% / 50%		
HD6550-0-6550ES	0%, after ded. / 50%	0%, after ded. / 50%	0%, after ded. / 50%	0%, after ded. / 50%		
Adult dental	Deductible (single / family)	Maximum calendar year	Coinsurance (Preventive/basic/major/ortho)	Cleanings	Exams	X-rays
Plus WD50-185-1500	\$50 / \$150	\$1,500	0% / 20% / 50% / Not covered	0%	0%	0%

## Participation guidelines



<sup>1</sup>All medical plans include pediatric vision and pediatric dental coverage.

<sup>2</sup>The annual out-of-pocket maximum includes the annual deductible, copayments and coinsurance. After the out-of-pocket maximum is reached in a calendar year, we will pay the covered services during the rest of that calendar year at 100% of our contract rates for participating provider services and at 100% of the maximum allowable amount (MAA) for out-of-network (OON) services. Members are still responsible for OON-billed charges that exceed MAA.

<sup>3</sup>Coinsurance is subject to the annual deductible.

<sup>4</sup>Prescription drug tiers are Tier 1: Generic; Tier 2: Brand Preferred; Tier 3: Non-Preferred; SP: Specialty. Deductible waived unless otherwise noted.

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