

Health Insurance Comparison		
	Current-WEA Trust	New rates - Lifestyle Health Plan
Deductible	\$2,000/\$4,000	\$2,500/\$5,000
Out of Network Deductible	\$4,000/\$8,000	\$5,000/\$10,000
Max out of pocket - In Network	\$4,000/\$8,000	\$2,500/\$5,000
Max out of pocket - Out Network	\$8,000/\$16,000	\$7,500/\$15,000
Primary Care visit-injury or illness	\$25 copay/visit. Ded does not apply	\$30 copay, then 100% to \$250 per visit, then ded.
Specialist Visit	\$50 copay/visit. Ded does not apply.	\$50 copay, then 100% to \$250 per visit, then ded.
Preventive care/screening/immunization	no charge	no charge
Diagnostic tests (x-ray, blood work)	0% coinsurance. Ded & coins. Do not apply to lab & x-ray service performed within 7 calendar days before or after a Network office Visit	X-ray: Ded/0% coins. Blood work: 100% coverage if preferred vendor, otherwise ded./0% coins.
Imaging (CT/PET scans, MRI's)	\$100 copay/test; ded., co-ins. & copay do not apply to lab & x-ray services performed within 7 days	Ded. Then 0 coins. ; if through hospital outpatient, \$500 copay, then ded/coins.
Drug coverage		
Value Drugs	no charge	
Generic/tier 1	\$10; ded. does not apply	tier 1, \$1 & tier 2 \$15
Preferred/tier 2	\$30; ded. Does not apply	\$50 copay retail
Non-preferred/tier 3	\$60; ded. Does not apply	\$80 copay retail
Specialty/tier 4	10% coins. Up to \$150 per fill	50% copay retail
diabetic supplies	na	100% through preferred vendor OR 50% copay
allergy injections	na	\$25 copay; max paid per injection is \$100
Outpatient Surgery		
Facility fee (e.g., ambulatory surgery center)	0% coins	Ded/0% coins.
Physician/surgeon fees	0% coins	Ded/0% coins.
Immediate medical attention		
ER care (facility charge only)	\$200 copay	\$250 copay
Emergency medical transportation	0% coins	Ded/0% coins.
Urgent Care	\$75 copay/visit	\$50 copay, then 100% to \$500 per visit; then ded/coins
Hospital Stay		
Facility Fee (hospital room)	0% coins	\$500 copay per confinement, then ded/0% coins
Physician/surgeon fees	0% coins	Ded/coins.
Mental Health		
Outpatient services	\$25 copay/visit; ded does not apply to office visit.	0% coins after ded.
Inpatient services	0% coins	ded/0% coins
Pregnancy		
Prenatal Care & Postnatal Care	0% co ins	0% coins after ded is met
Childbirth/delivery professional services	0% co ins	0% coins after ded is met
Childbirth/delivery facility fee (room)	0% co ins	0% coins after ded is met

Recovering or other special health		
Home health care	0% co ins	0% coins after ded is met
Rehabilitation	\$25 copay/visit for physical occupational and speech therapy. Ded. Does not apply to office visit. 0% coinsurance for cardiac & pulmonary rehab & skilled rehab facility charge.	0% coins after ded is met
Habilitation	\$25 copay/visit. Ded does not apply to office visit.	0% coins after ded is met
skilled nursing care	0% co ins	0% coins after ded is met
durable medical equip	0% co ins	0% coins after ded is met
hospice services	0% co ins	0% coins after ded is met
Child care needs		
Children eye exam	not covered	no charge
Children glasses	not covered	not covered
Children dental check-up	not covered	no charge

Health Insurance Premium Comparison

Premiums	Monthly			Annual		
	Monthly Premium	Employer Share - 90%	Employees Share -10%	Annual Premium	Employer Share- 90%	Employees Share-10%
WEA - 2018 premiums	8,886.82	7,998.14	888.68	106,641.84	95,977.66	10,664.18
WEA - Nov 2018 premiums	11,797.40	10,617.66	1,179.74	141,568.80	127,411.92	14,156.88
WEA Trust -2019	12,257.40	11,031.66	1,225.74	147,088.80	132,379.92	14,708.88
Lifestyle Health Plan-2019	9,759.29	8,783.36	975.93	117,111.48	105,400.33	11,711.15

2019 Options

WEA Trust -2019	12,257.40	9,805.92	2,451.48	147,088.80	117,671.04	29,417.76
Lifestyle Health Plan-2019	9,759.29	7,807.43	1,951.86	117,111.48	93,689.18	23,422.30

	Single	EM + Spouse	EM +child	Family	Total	Village share
WEA Trust annual	9,368.64	18,269.04	17,800.80	22,953.36	147,088.80	
WEA Trust monthly	780.72	1,522.42	1,483.40	1,912.78	12,257.40	
Employee share 10%	936.86	1,826.90	1,780.08	2,295.34	14,708.88	132,379.92
Employee share 12%	1,124.24	2,192.28	2,136.10	2,754.40	17,650.66	129,438.14
Employee share 15%	1,405.30	2,740.36	2,670.12	3,443.00	22,063.32	125,025.48
	Single	EM + Spouse	EM +child	Family	Total	Village share
Lifestyle Health Plan-annual	6,889.56	14,611.20	11,962.20	18,521.52	117,087.60	
Lifestyle Health Plan-monthly	574.13	1,217.60	996.85	1,543.46	9,757.30	
Employee share 10%	688.96	1,461.12	1,196.22	1,852.15	11,708.76	105,378.84
Employee share 12%	826.75	1,753.34	1,435.46	2,222.58	14,050.51	103,037.09
Employee share 15%	1,033.43	2,191.68	1,794.33	2,778.23	17,563.14	99,524.46

Employee share per payroll

	Single	EM + Spouse	EM +child	Family
WEA Trust annual	9,368.64	18,269.04	17,800.80	22,953.36
WEA Trust monthly	780.72	1,522.42	1,483.40	1,912.78
Employee share 10% per payroll	36.03	70.27	68.46	88.28
Employee share 12% per payroll	43.24	84.32	82.16	105.94
Employee share 15% per payroll	54.05	105.40	102.70	132.42
	Single	EM + Spouse	EM +child	Family
Lifestyle Health Plan-annual	6,889.56	14,611.20	11,962.20	18,521.52
Lifestyle Health Plan-monthly	574.13	1,217.60	996.85	1,543.46
Employee share 10% per payroll	26.50	56.20	46.01	71.24
Employee share 12% per payroll	31.80	67.44	55.21	85.48
Employee share 15% per payroll	39.75	84.30	69.01	106.85

Current

Summary of Small Group Benefit Plans

Village of Colfax
Colfax, WI

Agent: Jerry Den Boer

Effective Date: January 01, 2019

Benefit	Expiring Plan with the Western WI Municipal Consortium WEA Trust		Renewing 2019 Plan with the Western WI Municipal Consortium WEA Trust		Alternative 2019 Renewal Options with the Western Wisconsin Municipal Consortium WEA Trust		Option 2		Option 4 Embedded-HSA	
	In Network	Out Network	In Network	Out Network	In Network	Out Network	In Network	Out Network	In Network	Out Network
Deductible - Individual	\$2,000	\$4,000	\$2,000	\$4,000	\$1,000	\$2,000	\$1,000	\$2,000	\$3,000	\$6,000
Deductible - Family	\$4,000	\$8,000	\$4,000	\$8,000	\$2,000	\$4,000	\$2,000	\$4,000	\$6,000	\$12,000
Coinsurance	100%	80%	100%	80%	100%	80%	100%	80%	100%	80%
Out-of-Pocket Max	\$4,000	\$8,000	\$4,000	\$8,000	\$2,500	\$5,000	\$3,000	\$6,000	\$3,000	\$8,000
Office Visit Co-Pay	\$25/\$50 copay	\$50/\$100 copay	\$25/\$50 copay	\$50/\$100 copay	\$25/\$50 copay	\$50/\$100 copay	\$25/\$50 copay	\$50/\$100 copay	Deductible	ded/coins
Emergency Room Co-Pay	\$200 copay	\$200 copay	\$200 copay	\$200 copay	\$200 copay	\$200 copay	\$200 copay	\$200 copay	Deductible	ded/coins
Drugs	\$0/\$10/\$30/\$60/10%	\$0/\$10/\$30/\$60/10%	\$0/\$10/\$30/\$60/10%	\$0/\$10/\$30/\$60/10%	\$0/\$10/\$30/\$60/10%	\$0/\$10/\$30/\$60/10%	\$0/\$10/\$30/\$60/10%	\$0/\$10/\$30/\$60/10%	Deductible	ded/coins
Single (2)	\$751.42	\$780.72	\$858.94	\$884.02	\$858.94	\$884.02	\$858.94	\$884.02	\$666.96	\$1,300.66
Employee + Spouse (2)	\$1,465.28	\$1,522.42	\$1,674.96	\$1,726.34	\$1,674.96	\$1,726.34	\$1,674.96	\$1,726.34	\$1,300.66	\$2,601.32
Employee + Child(ren)	\$1,427.72	\$1,483.40	\$1,631.70	\$1,687.24	\$1,631.70	\$1,687.24	\$1,631.70	\$1,687.24	\$1,300.66	\$2,601.32
Family (4)	\$1,841.00	\$1,912.78	\$2,104.36	\$2,176.14	\$2,104.36	\$2,176.14	\$2,104.36	\$2,176.14	\$1,634.08	\$3,268.16
Total Monthly Premium	\$11,797.40	\$12,257.40	\$13,485.24	\$13,945.24	\$13,485.24	\$13,945.24	\$13,485.24	\$13,945.24	\$10,471.56	\$20,943.12
Total Annual Premium	\$141,568.80	\$147,088.80	\$161,822.88	\$167,342.88	\$161,822.88	\$167,342.88	\$161,822.88	\$167,342.88	\$125,658.72	\$251,307.36
Renewal Increase		3.9%		14.3%		11.0%		11.0%		-11.2%

Presented By:

Benefit Advisors
1825 Sunset Lane
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Renewal

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit our website at www.weatrust.com or call us at 1-800-279-4000. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-800-279-4000 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>\$2,000/individual or \$4,000 /family for Network providers. \$4,000/person or \$8,000 family for non-network providers.</p>	<p>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. The following services are covered before you meet your deductible: prescription drugs; e-visits and convenience care clinic services, primary and specialty care office visits, chiropractic treatment, outpatient mental health and substance abuse services, and outpatient therapy services when performed by a Network provider; all laboratory, ultrasound and X ray services performed within 7 calendar days before or after a Network office visit; and preventive care.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For Network providers \$4,000 individual / \$8,000 family; for non-network providers \$8,000 individual / \$16,000 family.</p>	<p>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance-billing charges, non-network copays, penalties for failure to satisfy preauthorization or hospital admission notification requirements, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.weatrust.com or call 1-800-279-4000 for a list of network providers.</p>	<p>This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network</p>

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	<p><u>provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (a <u>balance bill</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit. <u>Deductible</u> does not apply.	\$50 <u>copay</u> /visit then 20% <u>coinsurance</u>	_____ none _____
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit. <u>Deductible</u> does not apply.	\$100 <u>copay</u> /visit then 20% <u>coinsurance</u>	_____ none _____
	<u>Preventive care</u> / <u>screening</u> /immunization	No Charge	\$50 <u>copay</u> /visit then 20% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u> . <u>Deductible</u> and <u>coinsurance</u> do not apply to laboratory and X ray services performed within 7 calendar days before or after a <u>Network</u> office visit.	20% <u>coinsurance</u>	<u>Preauthorization</u> required for genetic testing. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.
	Imaging (CT/PET scans, MRIs)	\$100 <u>copay</u> /test <u>Deductible</u> , <u>coinsurance</u> , and <u>copayments</u> do not apply to laboratory and X ray services performed within 7 calendar days	\$200 <u>copay</u> /test then 20% <u>coinsurance</u>	<u>Preauthorization</u> required. Non-compliance may result in <u>claim</u> denial or penalty of 50% up to \$500.

* For more information about limitations and exceptions, see the plan or policy document at www.weaktrust.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.wwww.wwatrust.com	Value Drugs (subset of Tier 1)	before or after a <u>Network</u> office visit.		Covers 30-day supply for retail purchase. 90-day Home Delivery may only be subject to two <u>copayments</u> instead of three. See www.wwatrust.com for list of drugs that are excluded or require <u>preauthorization</u> . Failure to <u>preauthorize</u> may result in <u>claim denial</u> or penalty of 50% up to \$500.
	Tier 1 (Most generic, some brand and some over-the-counter drugs)	No Charge		
	Tier 2 (Preferred brand and some generic drugs)	\$10 <u>copay</u> . <u>Deductible</u> does not apply.		
	Tier 3 (Non-preferred brand and some generic drugs)	\$30 <u>copay</u> . <u>Deductible</u> does not apply.		
	Tier 4 (Specialty Drugs)	\$60 <u>copay</u> . <u>Deductible</u> does not apply.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> up to \$150 per fill. <u>Deductible</u> does not apply.		See www.wwatrust.com for list of drugs that are excluded or require <u>preauthorization</u> . Failure to <u>preauthorize</u> may result in <u>claim denial</u> or penalty of 50% up to \$500.
	Physician/surgeon fees	0% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Emergency room care	0% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you need immediate medical attention	Emergency medical transportation	\$200 <u>copay/visit</u>		<u>Preauthorization</u> required for certain outpatient surgeries. See our website www.wwatrust.com for a list of services that require <u>preauthorization</u> . Non-compliance may result in <u>claim denial</u> or penalty of 50% up to \$500. *See Sections 5 & 6.
	Urgent care	0% <u>coinsurance</u>		
	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>		
If you have a hospital stay	Physician/surgeon fees	\$75 <u>copay/visit</u>		<u>Copay</u> waived if admitted as inpatient for at least 24 hours. _____none _____none
		0% <u>coinsurance</u>	20% <u>coinsurance</u>	

* For more information about limitations and exceptions, see the plan or policy document at www.wwatrust.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay/visit. Deductible does not apply to the office visit.	\$50 copay/visit then 20% coinsurance	Preauthorization required for ECT, all partial hospitalization and intensive outpatient services, and all elective or planned inpatient admissions to a hospital or residential treatment facility. See our website www.weatrust.com for a list of other services that require preauthorization. Non-compliance may result in claim denial or penalty of 50% up to \$500. Notification required for emergency admissions. Non-compliance penalty of up to \$250/service may apply. *See Sections 5 & 6.
	Inpatient services	0% coinsurance	20% coinsurance	
If you are pregnant	Office visits	0% coinsurance	20% coinsurance	Cost-sharing does not apply for Network preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	Notification required. Non-compliance penalty of up to \$250/service may apply.
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	Notification required. Non-compliance penalty of up to \$250/service may apply.
	Home health care	0% coinsurance	20% coinsurance	Limited to 60 visits/Benefit Period. Preauthorization required. Non-compliance may result in claim denial or penalty of 50% up to \$500.
If you need help recovering or have other special health needs	Rehabilitation services	\$25 copay/visit for physical, occupational, and speech therapy. Deductible does not apply to the office visit. 0% coinsurance for cardiac and pulmonary rehab, and skilled rehab facility services.	\$50 copay/visit then 20% coinsurance for physical, occupational, and speech therapy. 20% coinsurance for cardiac and pulmonary rehab, and skilled rehab facility services.	Physical, occupational, speech therapy - Limited to 20 visits/Benefit Period for each. Preauthorization required for all services except evaluations. Non-compliance may result in claim denial or penalty of 50% up to \$500. Cardiac Rehab – 36 visits/Benefit Period. Pulmonary Rehab – 20 visits/Benefit Period. Skilled Rehab Facility – 60 visits/Benefit Period.

* For more information about limitations and exceptions, see the plan or policy document at www.weatrust.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<u>Habilitation services</u>	\$25 copay/visit. <u>Deductible</u> does not apply to the office visit.	\$50 copay/visit then 20% coinsurance	Physical, occupational, speech therapy - Limited to 20 visits/Benefit Period for each. <u>Preauthorization</u> required for all services except evaluations. Non-compliance may result in <u>claim denial</u> or penalty of 50% up to \$500.
	<u>Skilled nursing care</u>	0% coinsurance	20% coinsurance	Limited to 30 days per confinement. <u>Preauthorization</u> required. Non-compliance may result in <u>claim denial</u> or penalty of 50% up to \$500.
	<u>Durable medical equipment</u>	0% coinsurance	20% coinsurance	<u>Preauthorization</u> required for certain <u>DME</u> services. See our website www.weaktrust.com for a list of services that require <u>preauthorization</u> . Non-compliance may result in <u>claim denial</u> or penalty of 50% up to \$500. *See Sections 5 and 6.
If your child needs dental or eye care	<u>Hospice services</u>	0% coinsurance	20% coinsurance	_____none_____
	Children's eye exam	Not Covered	Not Covered	<u>Excluded service</u>
	Children's glasses	Not Covered	Not Covered	<u>Excluded service</u>
	Children's dental check-up	Not Covered	Not Covered	<u>Excluded service</u>

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)	
<ul style="list-style-type: none"> • Acupuncture • Bariatric Surgery • Children's Eye Exam • Children's glasses • Children's Dental Check-up 	<ul style="list-style-type: none"> • Cosmetic Surgery • Dental Care (Adult) • Infertility Treatment • Long-Term Care • Non-emergency care when traveling outside the U.S. • Private Duty Nursing • Routine Eye Care (Adult) • Routine Foot Care • Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
<ul style="list-style-type: none"> • Chiropractic Care 	<ul style="list-style-type: none"> • Hearing Aids

* For more information about limitations and exceptions, see the plan or policy document at www.weaktrust.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517 or oci.wi.gov; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the WEA Insurance Corporation at 1-800-279-4000 or www.weatrust.com; the Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517 or oci.wi.gov; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of Network pre-natal care and a hospital delivery)

- The plan's overall deductible **\$2,000**
- Specialist copay **\$50**
- Hospital (facility) coinsurance **0%**
- Other coinsurance **0%**

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost **\$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2000
Copayments	\$
Coinsurance	\$
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2060

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible **\$2,000**
- Specialist copay **\$50**
- Hospital (facility) coinsurance **0%**
- Other coinsurance **0%**

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost **\$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$661
Copayments	\$225
Coinsurance	\$
<i>What isn't covered</i>	
Limits or exclusions	\$221
The total Joe would pay is	\$1108

Mia's Simple Fracture

(Network emergency room visit and follow up care)

- The plan's overall deductible **\$2,000**
- Specialist copay **\$50**
- Hospital (facility) coinsurance **0%**
- Other coinsurance **0%**

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost **\$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1495
Copayments	\$400
Coinsurance	\$
<i>What isn't covered</i>	
Limits or exclusions	\$
The total Mia would pay is	\$1895

The plan would be responsible for the other costs of these EXAMPLE covered services.

WGA

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact Medova Healthcare Financial Group. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.lifestylehealthbenefits.com or call 1-800-827-6607 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>\$2,500* person / \$5,000* family for participating providers. \$5,000* person / \$10,000* family for non-participating providers.</p>	<p>You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. *Up to a \$500 deductible credit is made available to plan members for the voluntary participation in the Lifestyle Health Wellness Program.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes.</p>	<p>Services listed as "Copayments" are not part of your overall plan deductible. Preventive Services are also covered at 100% with in-network providers.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For participating providers \$2,500 person / \$5,000 family. For non-participating providers \$7,500 person / \$15,000 family.</p>	<p>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for healthcare expenses. Once this limit is achieved, copayments and Rx copayments may continue to accrue until the ACA out-of-pocket maximum limit, which for participating providers is \$7,350 person / \$14,700 family and for non-participating providers is unlimited.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, copayments and Rx copayments, balance-billed charges, and health care this plan excludes.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.PHCS.com or call 1-800-922-4362 for a list of participating providers.</p>	<p>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</p>

Do you need a <u>referral</u> to see a <u>specialist</u> ?	No. You don't need a referral to use a specialist.	You can see the specialist you choose without permission from the plan.
--	--	---

A All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 Copay, then 100% to \$250 per visit, then Deductible / 0% Co-insurance	50% Coinsurance	\$30 Copay, then 100% to \$250 max per visit for all services provided during visit except lab services, then Deductible / Co-insurance
	Specialist visit	\$50 Copay, then 100% to \$250 per visit, then Deductible / 0% Co-insurance	50% Coinsurance	\$50 Copay, then 100% to \$250 max per visit for all services provided during visit except lab services, then Deductible / Co-insurance
	Chiropractor	0% Coinsurance	50% Coinsurance	After deductible is met
	Preventive care/screening/immunization	No Charge	No Charge	None
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: Deductible / 0% Coinsurance Blood work: 100% Coverage if preferred vendor, otherwise Deductible / 0% Coinsurance	50% Coinsurance	X-ray: Deductible / Coinsurance. Bloodwork: 100% Coverage for laboratory services through DirectHealth program, otherwise Deductible / Coinsurance.
	Imaging (CT/PET scans, MRIs)	Pre-certification required prior to scheduling, then Deductible / 0% Coinsurance	50% Coinsurance	Requires pre-certification. If through physician office / freestanding imaging center, then Deductible / Coinsurance. If through hospital outpatient, \$500 Copay, then Deductible / Coinsurance.

* For more information about limitations and exceptions, see the plan or policy document at www.lifestylehealthbenefits.com.

<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.prescriptionnetwork.info</p>	Generic drugs	Tier 1: \$1 Copay Tier 2: \$15 Copay	Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	\$50 Copay Retail	Not Covered	\$50 Copay through standard Rx benefit. Refer to Preferred Formulary & SPD for more details. \$0 Copay option available for certain brand drugs through International Mail Order preferred Vendor (participation voluntary)
	Non-preferred brand drugs	\$80 Copay Retail	Not Covered	None
	<u>Specialty drugs</u>	50% Copay Retail	Not Covered	None
	Diabetic Supplies	100% if preferred Vendor is utilized. Otherwise, 50% Copay Retail	50% Coinsurance	100% if preferred Vendor is utilized. Otherwise, 50% Copay Retail through pharmacy benefit or benefits applicable to Deductible / Coinsurance if through In-network DME supplier.
	Allergy Injections	\$25 Copay	50% Coinsurance	\$100 per injection maximum
	Facility fee (e.g., ambulatory surgery center)	Pre-certification required prior to scheduling, then Deductible / 0% Coinsurance	50% Coinsurance	Requires pre-certification. If through physician office / freestanding imaging center, then Deductible / Coinsurance. If through hospital outpatient, \$1,000 Copay per visit, then Deductible / Coinsurance.
	Physician/surgeon fees	Pre-certification required prior to scheduling, then Deductible / 0% Coinsurance	50% Coinsurance	Requires pre-certification. After Deductible is met.
	<u>Emergency room care</u> (facility charge only)	\$250 Copay, then Deductible / 0% Coinsurance	\$250 Copay, then Deductible / 50% Coinsurance	Copay waived if admitted. Out of Network Providers used during an emergency are paid preferred benefit levels based on negotiated preferred allowances.
	<p>If you need immediate medical attention</p>	<u>Emergency medical transportation</u>	Deductible / 0% Coinsurance	50% Coinsurance
<u>Urgent care</u>		\$50 Copay, then 100% to \$500 per visit	50% Coinsurance	Then Deductible / Coinsurance for in-network providers.

* For more information about limitations and exceptions, see the plan or policy document at www.lifestylehealthbenefits.com.

If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 Copay per confinement, then Deductible / 0% Coinsurance	50% Coinsurance	\$500 Copay per confinement, then Deductible Co-insurance. All non-emergency confinements must be pre-certified and emergency confinements must be reported within 48 hours of when confinement begins.
	Physician/surgeon fees	Deductible / 0% Coinsurance	50% Coinsurance	After Deductible is met
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% Coinsurance	50% Coinsurance	After Deductible is met
	Inpatient services	0% Coinsurance	50% Coinsurance	After Deductible is met
If you are pregnant	Prenatal Care and Postnatal Care	0% Coinsurance	50% Coinsurance	After Deductible is met
	Childbirth/delivery professional services	0% Coinsurance	50% Coinsurance	After Deductible is met
	Childbirth/delivery facility fee (e.g., hospital room)	0% Coinsurance	50% Coinsurance	After Deductible is met
	Home health care	0% Coinsurance	50% Coinsurance	After Deductible is met
	Rehabilitation services	0% Coinsurance	50% Coinsurance	After Deductible is met
	Habilitation services	0% Coinsurance	50% Coinsurance	After Deductible is met
If you need help recovering or have other special health needs	Skilled nursing care	0% Coinsurance	50% Coinsurance	After Deductible is met
	Durable medical equipment	0% Coinsurance	50% Coinsurance	After Deductible is met
	Hospice services	0% Coinsurance	50% Coinsurance	After Deductible is met
	Children's eye exam	No Charge	No Charge	None
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	No Charge	No Charge	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care

* For more information about limitations and exceptions, see the plan or policy document at www.lifestylehealthbenefits.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Medova Healthcare Financial Group at 345 N. Riverview, Suite 600, Wichita, KS 67203 or The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes, this plan or policy does provide minimum essential coverage.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

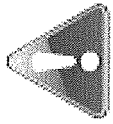
Does this plan meet the Minimum Value Standards? Yes, this health coverage does meet the minimum value standard for the benefits it provides.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-827-6607.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible **\$2500**
- Specialist [cost sharing] **\$ 50**
- Hospital (facility) [cost sharing] **0%**
- Other [cost sharing] **0%**

This EXAMPLE event includes services like:
 Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost **\$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,698
Copayments	\$515
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$573
The total Peg would pay is	\$3,786

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible **\$2500**
- Specialist [cost sharing] **\$ 50**
- Hospital (facility) [cost sharing] **0%**
- Other [cost sharing] **0%**

This EXAMPLE event includes services like:
 Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost **\$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$360
Copayments	\$1,721
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$2,136

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible **\$2500**
- Specialist [cost sharing] **\$ 50**
- Hospital (facility) [cost sharing] **0%**
- Other [cost sharing] **0%**

This EXAMPLE event includes services like:
 Emergency room care (*including medical supplies*)
 Diagnostic test (*X-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost **\$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,441
Copayments	\$150
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,591

The plan would be responsible for the other costs of these EXAMPLE covered services.



GROUP BENEFIT PROGRAM PROPOSAL

PROPOSAL DESIGNED FOR: Village of Colfax

EFFECTIVE DATE: Jan 01, 2019

Prepared By: National Insurance Partners Corporation *Proposal Date: Nov 19, 2018*

OUR MAJOR MEDICAL PROGRAM INCLUDES:

- ◆ **HealthyChoice** ◆ **HealthyValue**
- ◆ **Healthy100** ◆ **HealthyConsumer**

WITH AVAILABLE ANCILLARY BENEFITS:

- ◆ **Lifestyle DentalCare**
- ◆ **Lifestyle VisionCare**


GET TO KNOW LIFESTYLE HEALTH PLANS


Improve Health, Lower Costs


Lifestyle Health Plans is an innovative and strategic group health benefit solution designed for employers with 4 to 500 employees. Healthcare costs are consistently listed as one of the greatest concerns facing business owners and employees today. Lifestyle Health Plans believes that the only way to truly manage healthcare costs is to improve the health and wellness of our members.


Our Level-funded benefit program provides turnkey major medical health benefits with an integrated wellness and lifestyle improvement program designed to address the root cause of the escalating cost of healthcare - employee health behaviors. By design, our approach seeks to truly stabilize premium costs for employers from year to year to create a strategic and sustainable benefits program. Let our innovative and flexible plan designs, consumer-driven features, deductible credits, and cash reward incentives form the basis of a long-term benefits solution for your group.


What Makes Us Different?

- 

Level-funded group health plan designs available through our "A" Rated reinsurance carrier partnerships
- 

Premium savings in most cases of 5-15% versus traditional insurance products
- 

Consumer-driven program features designed to save both employer and employee alike
- 

Integrated wellness program with deductible credit and cash reward incentives for program participation
- 

Provides sustainable health benefit program that addresses underlying causes of healthcare costs without reliance on being tied to a single carrier

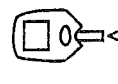
Integrated Benefit Features:



OnCall MED - On-demand access to telemedicine consultations anywhere, anytime at \$0 Copay for Lifestyle Health Plans members



DirectHealth - 100% outpatient lab benefit program through preferred lab vendor designed to save employer and employee alike



Just Diabetic Supplies - Auto-ship program offers 100% benefit for diabetic testing supplies for enrolled participants to encourage regular testing and provide out-of-pocket savings



Patient Care Coordination - Program offers assistance in scheduling all outpatient diagnostic and surgery services



OUR INSURANCE PLATFORM

What is a Level-funded Plan?

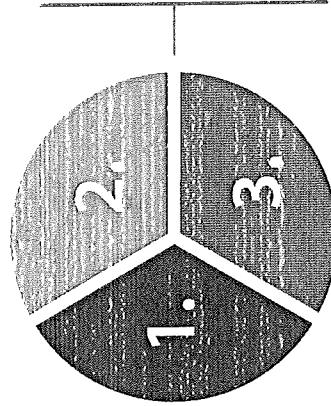
Lifestyle Health Plans is a unique group health benefits solution that is built on an innovative Level-funded platform and designed from an insurance perspective that differs from traditional self-funded plans. The plan is 'level funded' meaning that by design, any risk to the sponsoring employer has been removed beyond the 12 months of premiums paid. By

blending a specific and aggregate insurance coverage for each specific group, participating employers are able to gain the flexibility they desire without taking on the risk associated with traditional self-funding. Our Level-funded plans are governed primarily by the Federal Employee Retirement Income and Security Act (ERISA), which can result in lower

costs and expenses for sponsoring employers. Based on employer size, we can offer a unique, self-funded health benefits program that maximizes the benefits to employees, while implementing cost-saving opportunities for employers to stabilize benefit costs without reducing benefits.

How it Works

The monthly group health premium paid to Lifestyle Health Plans for your group is comprised of three separate components:



1. Custom Stop Loss (CSL)

Insurance Coverage

2. Administration & Excess

Loss Coverage

3. Claims Fund

Your maximum annual claims, including claims run-off liability, are predetermined and you pay 1/12 of this cost each month for the 12 months of your plan year. After you have paid this amount, there are no other charges for the claims fund. Once all claims have been paid for the plan year, any unused dollars in the claims fund will be used to reduce future premium rate increases. In the event of plan termination, each employer is eligible to receive back any unused dollars in the claims fund.



Truly Level-funded

Our Level-funded program is designed to truly 'levelize the funding' for your group health benefits from year to year. We recognize that the best way to stabilize employer health benefit costs is through a combined effort of accurately underwritten rates, proactive cost-containment measures, integrated wellness, patient care coordination and the ability to reinvest claim fund dollars to offset future rate increases over multi-year periods.

Rather than rate up your group to ensure a claims fund refund at the end of the plan year, our approach is designed to stabilize costs between plan years. This way, your group will have the best outcomes from an overall cost containment and population health management perspective!

COST CONTAINMENT STRATEGIES

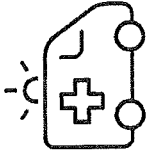
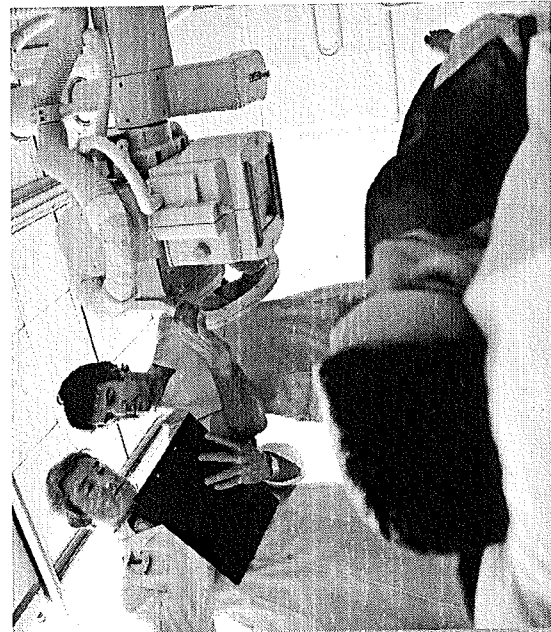


Strategies for Containing Costs

A key focus for Lifestyle Health Plans is finding innovative ways to manage healthcare costs. Traditional benefit designs and cost management techniques have been relatively unsuccessful in assisting employers and their members with cost containment. Lifestyle Health has integrated a number of cost management programs and benefit coverage solutions into our plan designs.

Unfortunately, most members today are totally uneducated regarding the cost of healthcare services. Consumer awareness and education regarding the cost of services is a key element that makes Lifestyle Health unique. Once informed of their options, most members are open to doing their part in managing costs.

We partner with our members to provide multiple cost-effective healthcare delivery options, education with regards to the cost differentials, and then freedom for the member to decide where they would like their care provided. In the end, empowering change through consumer awareness is a unique difference offered through Lifestyle Health.



ER Utilization

Emergency Room utilization has been deemed in a retrospective review to be an inappropriate place of service for up to half of all ER visits. Lifestyle Health, through our OnCall MED concierge telemedicine service, provides instant telephonic access to board-certified primary care physicians to assist in the triage of emergent situations to help our members determine the most appropriate place of service for their emergency.

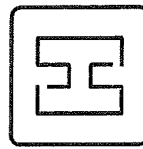
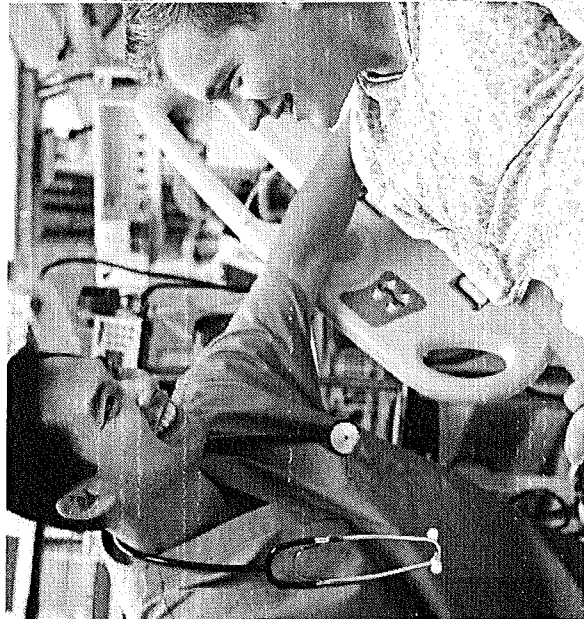


Outpatient Imaging and Surgical Services

Utilizing a freestanding imaging center for outpatient radiology, imaging, and surgical services needs can provide significant savings to our members. Claims data indicate that services provided through a freestanding imaging or surgical center average \$1,600 less per procedure for imaging services and \$6,700 per procedure less for outpatient surgical

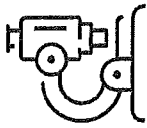
services when compared to the same services provided through a hospital outpatient setting. Our care coordinators will assist all members in need of outpatient imaging and surgical services in finding the right care setting suitable for you and your physician.

COST CONTAINMENT STRATEGIES



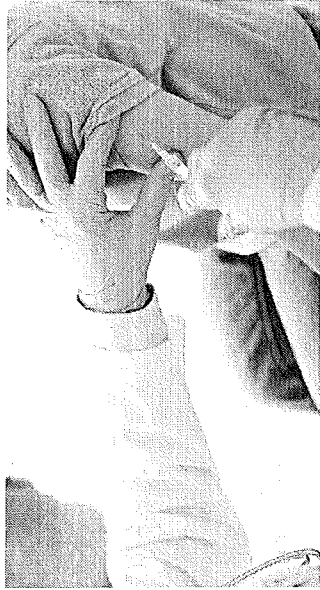
Implant Cost Containment

Some of the highest hidden costs to healthcare consumers come in the manner in which hospitals charge for certain supplies, implants, and other misc. charges associated with a hospital admission. We approach these costs in a manner that provides the hospital with a reasonable markup of their services but reduces the 300 - 500% markup that is often associated with these charges. Our prevailing fee and Medicare reimbursement based resources and methodologies assist our groups in managing these costs.



Specialty Medications and Injectibles

Specialty medications are the fastest rising cost item in healthcare today. By analyzing the current utilization needs within each group, Lifestyle Health can lower your premium costs dramatically by excluding certain medications that can be covered through other advocacy programs. Through this approach, members can still access these specialty medications at affordable prices, while reducing the exposure for our groups. The end result is lower claims costs for participating groups, better benefit renewals, and leveling of healthcare costs and premiums over a multi-year period.



As part of our group underwriting process, we work to identify such medications and begin the dialogue regarding options for each employer. To learn more about specific medications that are typically not covered under our standard medical plan designs, consult with your Lifestyle Health Plans sales representative.



Alternative Generic Drug Utilization

The majority of brand-name medications on the market today have an alternative generic drug replacement that provides the same care management results, but at a fraction of the cost of brand name prescriptions. Our team of care coordination specialists works with our members and their physicians to evaluate the efficacy of converting to a generic prescription



when appropriate. Further, through our step-therapy methodology, we ensure that there is a financial incentive for members to select a generic form of a brand drug, providing significant savings for employer and employee alike!

MEDICAL PLAN PROPOSAL

Presentation - Firm Rates

Presented To: Village of Colfax

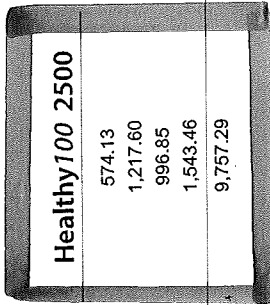
Presented By: National Insurance Partners Corporation

Date Of Quote: Nov 19, 2018

Proposed Effective Date: Jan 01, 2019

Please Circle Selected Plan(s) Below and Sign Here for Acceptance

HealthyChoice	PARTICIPANTS	HealthyChoice 1000	HealthyChoice 1500	HealthyChoice 2000	HealthyChoice 2500
Employee	2	621.35	591.53	569.16	546.79
Employee / Spouse	2	1,317.75	1,254.50	1,207.06	1,159.62
Employee / Child(ren)	0	1,078.84	1,027.06	988.22	949.38
Family	4	1,670.41	1,590.23	1,530.10	1,469.96
Total	8	10,559.84	10,052.97	9,672.81	9,292.66



Healthy100	PARTICIPANTS	Healthy100 2500	Healthy100 3000	Healthy100 3500	Healthy100 5000
Employee	2	574.13	554.24	534.98	500.81
Employee / Spouse	2	1,217.60	1,175.43	1,134.58	1,062.11
Employee / Child(ren)	0	996.85	962.33	928.88	869.55
Family	4	1,543.46	1,490.01	1,438.22	1,346.35
Total	8	9,757.29	9,419.38	9,092.02	8,511.23

HealthyValue	PARTICIPANTS	HealthyValue 2500	HealthyValue 3500	HealthyValue 6850	HealthyValue 10,000
Employee	2	515.10	493.97	466.01	427.49
Employee / Spouse	2	1,092.41	1,047.61	988.31	906.61
Employee / Child(ren)	0	894.36	857.68	809.13	742.24
Family	4	1,384.77	1,327.98	1,252.81	1,149.24
Total	8	8,754.11	8,395.07	7,919.88	7,265.17

HealthyConsumer	PARTICIPANTS	HealthyConsumer 3000	HealthyConsumer 3500	HealthyConsumer 5000	HealthyConsumer 6500
Employee	2	503.29	487.14	449.24	428.11
Employee / Spouse	2	1,067.38	1,033.12	952.73	907.93
Employee / Child(ren)	0	873.86	845.81	780.00	743.32
Family	4	1,353.03	1,309.60	1,207.71	1,150.91
Total	8	8,553.47	8,278.91	7,634.76	7,275.73

NOTE:

- Final rates will be based on the review and receipt of individual health applications, employer disclosure statement, final census data, large claim data, employer applications, copy of current and renewal rates with current carrier, and executed benefit services agreement.
- Minimum participation may be required for eligible full time employees.
- Additional requirements and benefit details are available through plan administrator.
- Plans are offered through current broker and selected insurance carrier.
- An administrative fee of \$25.00 will be added to the monthly invoice.
- Insurance Carrier Selection: ANICO
- Network Selection: Triogy Health Network / F



MEDICAL PLAN PROPOSAL

Presentation - Firm Rates Detailed Rate Matrix

Presented To: Village of Colfax
Presented By: National Insurance Partners Corporation
Date Of Quote: Nov 19, 2018
Proposed Effective Date: Jan 01, 2019

ENROLLMENT	EE	ES	EC	FAMILY	TOTAL
HealthyChoice PLANS	2	2	0	4	8
HealthyChoice 1000					
Specific Stop Loss Premium	36.00	292.50	210.00	226.25	1,562.00
Administration & Excess Loss Coverage	353.82	584.97	502.20	805.20	5098.40
Claims Fund	231.53	440.28	366.64	638.96	3899.44
Total	621.35	1,317.75	1,078.84	1,670.41	10,559.84
Healthy100 PLANS	2	2	0	4	8
Healthy100 2500					
Specific Stop Loss Premium	36.00	292.50	210.00	226.25	1,562.00
Administration & Excess Loss Coverage	329.27	532.89	459.56	739.19	4681.07
Claims Fund	208.86	392.21	327.29	578.02	3514.22
Total	574.13	1,217.60	996.85	1,543.46	9,757.29

ENROLLMENT	EE	ES	EC	FAMILY	TOTAL
Healthy100 3000					
Specific Stop Loss Premium	36.00	292.50	210.00	226.25	1,562.00
Administration & Excess Loss Coverage	318.93	510.97	441.61	711.39	4505.36
Claims Fund	199.32	371.97	310.72	552.36	3352.02
Total	554.24	1,175.43	962.33	1,490.01	9,419.38

ENROLLMENT	EE	ES	EC	FAMILY	TOTAL
Healthy100 3500					
Specific Stop Loss Premium	36.00	292.50	210.00	226.25	1,562.00
Administration & Excess Loss Coverage	308.91	489.72	424.22	684.47	4335.13
Claims Fund	190.07	352.36	294.66	527.51	3194.89
Total	534.98	1,134.58	928.88	1,438.22	9,092.02

ENROLLMENT	EE	ES	EC	FAMILY	TOTAL
Healthy100 5000					
Specific Stop Loss Premium	36.00	292.50	210.00	226.25	1,562.00
Administration & Excess Loss Coverage	291.14	452.04	393.36	636.69	4033.12
Claims Fund	173.67	317.57	266.18	483.41	2916.11
Total	500.81	1,062.11	869.55	1,346.35	8,511.23

NOTE:
 1) Final rates will be based on the review and receipt of individual health applications, employer disclosure statement, final census data, large claim data, employer applications, copy of current and renewal rates with current carrier, and executed benefit services agreement.
 2) Minimum participation may be required for eligible full time employees.
 3) Additional requirements and benefit details are available through plan administrator.
 4) Plans are offered through current broker and selected insurance carrier.
 5) An administrative fee of \$25.00 will be added to the monthly invoice.
 6) Insurance Carrier Selection: ANICO
 7) Network Selection: Triology Health Networks / F

ACCEPTED BY: _____ SIGNATURE _____ TITLE _____ DATE _____



MEDICAL PLAN PROPOSAL

Presentation - Firm Rates Detailed Rate Matrix

Presented To: Village of Colfax
Presented By: National Insurance Partners Corporation
Date Of Quote: Nov 19, 2018
Proposed Effective Date: Jan 01, 2019

ENROLLMENT	EE	ES	EC	FAMILY	TOTAL	ENROLLMENT	EE	ES	EC	FAMILY	TOTAL
HealthyValue 2500											
Specific Stop Loss Premium	36.00	292.50	210.00	226.25	1,562.00	Specific Stop Loss Premium	36.00	292.50	210.00	226.25	1,562.00
Administration & Excess Loss Coverage	298.57	467.80	406.27	656.67	4159.42	Administration & Excess Loss Coverage	292.43	454.78	395.61	640.17	4055.08
Claims Fund	180.53	332.12	278.09	501.85	3032.69	Claims Fund	174.86	320.10	268.25	486.62	2936.39
Total	515.10	1,092.41	894.36	1,384.77	8,754.11	Total	503.29	1,067.38	873.86	1,353.03	8,563.47
HealthyValue 3500											
Specific Stop Loss Premium	36.00	292.50	210.00	226.25	1,562.00	Specific Stop Loss Premium	36.00	292.50	210.00	226.25	1,562.00
Administration & Excess Loss Coverage	287.59	444.50	387.19	627.14	3972.72	Administration & Excess Loss Coverage	284.03	436.96	381.02	617.58	3912.32
Claims Fund	170.39	310.61	260.49	474.59	2860.35	Claims Fund	167.11	303.66	254.79	465.77	2804.60
Total	493.97	1,047.61	857.68	1,327.98	8,395.07	Total	487.14	1,033.12	845.81	1,309.60	8,278.91
HealthyValue 6850											
Specific Stop Loss Premium	36.00	292.50	210.00	226.25	1,562.00	Specific Stop Loss Premium	36.00	292.50	210.00	226.25	1,562.00
Administration & Excess Loss Coverage	273.05	413.66	361.95	588.05	3725.62	Administration & Excess Loss Coverage	264.32	395.16	346.80	564.60	3577.36
Claims Fund	156.97	282.15	237.18	438.51	2632.26	Claims Fund	148.91	265.07	223.20	416.86	2495.41
Total	466.01	988.31	809.13	1,252.81	7,919.88	Total	449.24	952.73	780.00	1,207.71	7,634.76
HealthyValue 10,000											
Specific Stop Loss Premium	36.00	292.50	210.00	226.25	1,562.00	Specific Stop Loss Premium	36.00	292.50	210.00	226.25	1,562.00
Administration & Excess Loss Coverage	253.01	371.18	327.17	534.20	3385.17	Administration & Excess Loss Coverage	253.34	371.86	327.73	535.06	3390.66
Claims Fund	138.47	242.93	205.08	388.80	2318.00	Claims Fund	138.77	243.57	205.59	389.60	2323.07
Total	427.49	906.61	742.24	1,149.24	7,265.17	Total	428.11	907.93	743.32	1,150.91	7,275.73

- NOTE:
- Final rates will be based on the review and receipt of individual health applications, employer disclosure statement, final census data, large claim data, employer applications, copy of current and renewal rates with current carrier, and executed benefit services agreement.
 - Minimum participation may be required for eligible full time employees.
 - Additional requirements and benefit details are available through plan administrator.
 - Plans are offered through current broker and selected insurance carrier.
 - An administrative fee of \$25.00 will be added to the monthly invoice.
 - Insurance Carrier Selection: ANICO
 - Network Selection: Trilogy Health Networks / FI

ACCEPTED BY: _____ TITLE _____
SIGNATURE _____ DATE _____

MEDICAL PLAN COMPARISON

Lifestyle Health Plans offers 16 standard medical plan designs grouped into four different product families. Designed with maximum flexibility in plan selection in mind, you can mix and match plans for the benefit program that is right for your group.

HealthyChoice

- 80/20 Co-insurance Plans
- Lower Deductible Levels - \$1,000 / \$1,500 / \$2,000 / \$2,500
- Copays for Office Visit, Urgent Care, Hospital/ER and Rx
- 100% Coverage for Preventive Services, Outpatient Lab and Diabetic Testing Supplies
- Integrated Wellness Program, Reward Incentives and Patient Care Coordination at no additional cost

Healthy100

- 100% Co-insurance Plans
- Deductible Levels - \$2,500 / \$3,000 / \$3,500 / \$5,000
- Copays for Office Visit, Urgent Care, Hospital/ER and Rx
- 100% Coverage for Preventive Services, Outpatient Lab and Diabetic Testing Supplies
- Integrated Wellness Program, Reward Incentives and Patient Care Coordination at no additional cost

HealthyValue

- Cost-saving Plan Designs
- Higher Deductible Levels / Variations of Co-insurance
- Deductible Levels of \$2,500 / \$3,500 / \$6,850 / \$10,000
- Copays for Office Visit, Urgent Care, Hospital/ER and Rx
- 100% Coverage for Preventive Services, Outpatient Lab and Diabetic Testing Supplies
- Integrated Wellness Program, Reward Incentives and Patient Care Coordination at no additional cost

HealthyConsumer

- Qualified HDHP Plan Designs for HRA / HSA integration
- Higher Deductibles (Embedded) - \$3,000 / \$3,500 / \$5,000 / \$6,500
- 100% Co-insurance after Deductible is met
- Preventive Services are covered at 100%
- Office Visit and Rx Copays apply once Deductible is met
- Integrated Wellness Program, Reward Incentives and Patient Care Coordination at no additional cost

HealthyEssentials

Our HealthyEssentials plans are designed to supplement our major medical plans as a "wellness and preventive services" plan design. Some plan designs also include limited medical benefits in addition to wellness and preventive service coverage. Consult your Lifestyle Health sales representative to learn more about these products.

HealthyChoice

HealthyChoice 1000

HealthyChoice 1500

HealthyChoice 2000

HealthyChoice 2500

DEDUCTIBLE \$1,000 Single / \$2,000 Family \$1,500 Single / \$3,000 Family \$2,000 Single / \$4,000 Family \$2,500 Single / \$5,000 Family

LIFESTYLE DEDUCTIBLE (Reduced Deductible based on wellness points earned) \$500 Single / \$1,000 Family \$500 Single / \$1,000 Family \$500 Single / \$1,000 Family \$500 Single / \$1,000 Family

CO-INSURANCE 80/20 80/20 80/20 80/20

CO-INSURANCE MAXIMUM \$2,500 Single / \$5,000 Family \$2,500 Single / \$5,000 Family \$2,500 Single / \$5,000 Family \$2,500 Single / \$5,000 Family

OUT-OF-POCKET LIMIT (Deductible + Co-insurance Max) (OOP Limit does not include copays and Rx copays) \$3,500 Single / \$7,000 Family \$4,000 Single / \$8,000 Family \$4,500 Single / \$9,000 Family \$5,000 Single / \$10,000 Family

ACA MAXIMUM OUT-OF-POCKET \$7,900 Single / \$15,800 Family \$7,900 Single / \$15,800 Family \$7,900 Single / \$15,800 Family \$7,900 Single / \$15,800 Family

PREVENTIVE SERVICES 100% Coverage

PHYSICIAN SERVICES Office visit benefit includes all services provided during visit except lab services

- Primary Care Office Visit \$30 Copay, then 100% to \$250 per visit, then Deductible / Co-insurance
- Specialist Office Visit \$50 Copay, then 100% to \$250 per visit, then Deductible / Co-insurance

- Physician & Surgeon Professional Services Deductible / Co-insurance

- Anesthesia Services (Physician / CRNA) Deductible / Co-insurance

TELEPHONIC PHYSICIAN CONSULTATIONS \$0 Copay

OUTPATIENT LAB 100% Coverage if preferred vendor, otherwise Deductible / Co-insurance

OUTPATIENT RADIOLOGY AND IMAGING Pre-certification required prior to scheduling for MRI, CT, PET and Nuclear Imaging

- Physician Office / Freestanding Imaging Ctr. Deductible / Co-insurance

- Hospital Outpatient \$500 Copay, then Deductible / Co-insurance

DIABETIC SUPPLIES 100% Coverage if preferred vendor, otherwise 50% cost to member through Rx Benefit

ALLERGY TREATMENT \$25 Copay, then 100% to \$100 per visit

OUTPATIENT REHAB & THERAPY Deductible / Co-insurance

CHIROPRACTIC SERVICES Deductible / Co-insurance

EMERGENCY SERVICES

- Hospital ER (Facility Charge Only) \$250 Copay, then Deductible / Co-insurance (Copay waived if admitted)

- Urgent Care / ER Professional Services \$50 Copay, then 100% to \$500 per visit, then Deductible / Co-insurance

- Ambulance Deductible / Co-insurance

- Air Ambulance \$2,500 Copay, then Deductible / Co-insurance

OUTPATIENT SURGICAL PROCEDURES Pre-certification required prior to scheduling

- Physician Office / Freestanding Surgery Ctr. Deductible / Co-insurance

- Hospital Outpatient \$1,000 Copay per visit, then Deductible / Co-insurance

- Implant Device Deductible / Co-insurance (Benefit Max of 200% of manufacturer invoice. See Summary Plan Document for additional details.)

INPATIENT HOSPITALIZATION All non-emergency confinements must be pre-certified and emergency confinements must be reported within 48 hours of when confinement begins

- Medical Facility Services \$500 Copay per confinement, then Deductible / Co-insurance

- Anesthesiologist & Surgeon Fees Deductible / Co-insurance

INPATIENT SURGICAL PROCEDURES Deductible / Co-insurance

- Implant Device Deductible / Co-insurance (Benefit Max of 200% of manufacturer invoice. See Summary Plan Document for additional details.)

HOME HEALTH, SKILLED NURSING & HOSPICE CARE Deductible / Co-insurance

MENTAL HEALTH & SUBSTANCE ABUSE Deductible / Co-insurance

DURABLE MEDICAL EQUIPMENT Deductible / Co-insurance

PRESCRIPTION DRUG BENEFITS Refer to Preferred Formulary and Summary Plan Document (SPD) for additional details

- Generic \$1 Copay / \$15 Copay

- Brand / Non-Preferred Brand / Specialty \$50 Copay / \$80 Copay / 50%

- International Mail Order - Brand \$0 Copay if preferred vendor (voluntary participation)

NOTE: This outline is intended as a brief overview of the actual plan and represents in-network benefit levels. The In-network, Out-of-Pocket Maximum (including deductible, co-insurance, copays and Rx copays) for each plan is \$7,900 Single / \$15,800 Family. Out-of-network deductibles are 2x in-network Deductible. Out-of-network Co-insurance percentage and out-of-pocket amounts vary by plan selection. Please refer to your Summary Plan Document (SPD) for the actual benefits, limitations, and exclusions. If there is any inconsistency between this outline and the SPD, the SPD shall govern. You may request a SPD from Lifestyle Health Plans or your sales representative. Certain procedures require pre-certification prior to scheduling in order to qualify for benefits. Failure to do so will result in penalties and/or non coverage of services.



Healthy100 2500

Healthy100 3000

Healthy100 3500

Healthy100 5000

DEDUCTIBLE \$2,500 Single / \$5,000 Family \$3,000 Single / \$6,000 Family \$3,500 Single / \$7,000 Family \$5,000 Single / \$10,000 Family

LIFESTYLE DEDUCTIBLE
(Reduced Deductible based on wellness points earned)

\$500 Single / \$1,000 Family

\$500 Single / \$1,000 Family

\$500 Single / \$1,000 Family

\$500 Single / \$1,000 Family

CO-INSURANCE None

None

None

None

CO-INSURANCE MAXIMUM No Co-insurance Responsibility

No Co-insurance Responsibility

No Co-insurance Responsibility

No Co-insurance Responsibility

OUT-OF-POCKET LIMIT (Deductible + Co-insurance Max)
(COOP Limit does not include copays and Rx copays)

\$2,500 Single / \$5,000 Family

\$3,000 Single / \$6,000 Family

\$3,500 Single / \$7,000 Family

\$5,000 Single / \$10,000 Family

ACA MAXIMUM OUT-OF-POCKET \$7,900 Single / \$15,800 Family

\$7,900 Single / \$15,800 Family

\$7,900 Single / \$15,800 Family

\$7,900 Single / \$15,800 Family

PREVENTIVE SERVICES

100% Coverage

PHYSICIAN SERVICES Office visit benefit includes all services provided during visit except lab services

- Primary Care Office Visit: \$30 Copay, then 100% to \$250 per visit; then Deductible / Co-insurance

- Specialist Office Visit: \$50 Copay, then 100% to \$250 per visit; then Deductible / Co-insurance

- Physician & Surgeon Professional Services: Deductible / Co-insurance

- Anesthesia Services (Physician / CRNA): Deductible / Co-insurance

TELEPHONIC PHYSICIAN CONSULTATIONS

\$0 Copay

OUTPATIENT LAB 100% Coverage if preferred vendor; otherwise Deductible / Co-insurance

OUTPATIENT RADIOLOGY AND IMAGING Pre-certification required prior to scheduling for MRI, CT, PET and Nuclear Imaging

- Physician Office / Freestanding Imaging Ctr: Deductible / Co-insurance

- Hospital Outpatient: \$500 Copay, then Deductible / Co-insurance

DIABETIC SUPPLIES 100% Coverage if preferred vendor; otherwise 50% cost to member through Rx Benefit

ALLERGY TREATMENT \$25 Copay, then 100% to \$100 per visit

OUTPATIENT REHAB & THERAPY Deductible / Co-insurance

CHIROPRACTIC SERVICES Deductible / Co-insurance

EMERGENCY SERVICES

- Hospital ER (Facility Charge Only) \$250 Copay, then Deductible / Co-insurance (Copay waived if admitted)

- Urgent Care / ER Professional Services: \$50 Copay, then 100% to \$500 per visit; then Deductible / Co-insurance

- Ambulance: Deductible / Co-insurance

- Air Ambulance: \$2,500 Copay, then Deductible / Co-insurance

OUTPATIENT SURGICAL PROCEDURES

- Physician Office / Freestanding Surgery Ctr: Pre-certification required prior to scheduling

- Hospital Outpatient: \$1,000 Copay per visit, then Deductible / Co-insurance

- Implant Device: Deductible / Co-insurance (Benefit Max of 200% of manufacturer invoice. See Summary Plan Document for additional details.)

INPATIENT HOSPITALIZATION All non-emergency confinements must be pre-certified and emergency confinements must be reported within 48 hours of when confinement begins

- Medical Facility Services: \$500 Copay per confinement, then Deductible / Co-insurance

- Anesthesiologist & Surgeon Fees: Deductible / Co-insurance

INPATIENT SURGICAL PROCEDURES

- Implant Device: Deductible / Co-insurance

(Benefit Max of 200% of manufacturer invoice. See Summary Plan Document for additional details.)

HOME HEALTH, SKILLED NURSING & HOSPICE CARE Deductible / Co-insurance

MENTAL HEALTH & SUBSTANCE ABUSE Deductible / Co-insurance

DURABLE MEDICAL EQUIPMENT Deductible / Co-insurance

PRESCRIPTION DRUG BENEFITS Refer to Preferred Formulary and Summary Plan Document (SPD) for additional details

- Generic: \$1 Copay / \$15 Copay

- Brand / Non-Preferred Brand / Specialty: \$50 Copay / \$80 Copay / 50%

- International Mail Order - Brand: \$0 Copay if preferred vendor (voluntary participation)

NOTE: This outline is intended as a brief overview of the actual plan and represents in-network benefit levels. The In-network Out-of-Pocket Maximum (including deductible, co-insurance, copays and Rx copays) for each plan is \$7,900 Single / \$15,800 Family. Out-of-network deductibles are 2x In-network Deductible. Out-of-network Co-insurance percentage and out-of-pocket amounts vary by plan selection. Please refer to your Summary Plan Document (SPD) for the actual benefits, limitations, and exclusions. If there is any inconsistency between this outline and the SPD, the SPD shall govern. You may request a SPD from Lifestyle Health Plans or your sales representative. Certain procedures require pre-certification prior to scheduling in order to qualify for benefits. Failure to do so will result in penalties and/or non coverage of services.

HealthyValue

HealthyValue 2500

HealthyValue 3500

HealthyValue 6850

HealthyValue 10,000

DEDUCTIBLE	\$2,500 Single / \$5,000 Family	\$3,500 Single / \$7,000 Family	\$6,850 Single / \$13,700 Family	\$10,000 Single / \$20,000 Family
LIFESTYLE DEDUCTIBLE <small>(Reduced Deductible based on wellness points earned)</small>	\$500 Single / \$1,000 Family	\$500 Single / \$1,000 Family	\$500 Single / \$1,000 Family	\$500 Single / \$1,000 Family
CO-INSURANCE	50/50	50/50	None	None
CO-INSURANCE MAXIMUM	\$3,000 Single / \$6,000 Family	\$2,500 Single / \$5,000 Family	No Co-insurance Responsibility	No Co-insurance Responsibility
OUT-OF-POCKET LIMIT <small>(OOP Limit does not include copays and Rx copays)</small>	\$5,500 Single / \$11,000 Family	\$6,000 Single / \$12,000 Family	\$6,850 Single / \$13,700 Family	\$10,000 Single / \$20,000 Family
ACA MAXIMUM OUT-OF-POCKET	\$7,900 Single / \$15,800 Family	\$7,900 Single / \$15,800 Family	\$7,900 Single / \$15,800 Family	ACA Compliant only with HRA integration

PREVENTIVE SERVICES

- 100% Coverage
- PHYSICIAN SERVICES** Office visit benefit includes all services provided during visit except lab services
 - Primary Care Office Visit \$30 Copay, then 100% to \$250 per visit, then Deductible / Co-insurance
 - Specialist Office Visit \$50 Copay, then 100% to \$250 per visit, then Deductible / Co-insurance
- Physician & Surgeon Professional Services Deductible / Co-insurance
- Anesthesia Services (Physician / CRNA) Deductible / Co-insurance

TELEPHONIC PHYSICIAN CONSULTATIONS

- \$0 Copay

OUTPATIENT LAB

- 100% Coverage if preferred vendor, otherwise Deductible / Co-insurance
- OUTPATIENT RADIOLOGY AND IMAGING** Pre-certification required prior to scheduling for MRI, CT, PET and Nuclear Imaging
 - Physician Office / Freestanding Imaging Ctr. Deductible / Co-insurance
 - Hospital Outpatient \$500 Copay, then Deductible / Co-insurance

DIABETIC SUPPLIES

- 100% Coverage if preferred vendor, otherwise 50% cost to member through Rx Benefit

ALLERGY TREATMENT

- \$25 Copay, then 100% to \$100 per visit

OUTPATIENT REHAB & THERAPY

- Deductible / Co-insurance

CHIROPRACTIC SERVICES

- Deductible / Co-insurance

EMERGENCY SERVICES

- Hospital ER (Facility Charge Only) \$250 Copay, then Deductible / Co-insurance (Copay waived if admitted)
- Urgent Care / ER Professional Services \$50 Copay, then 100% to \$500 per visit, then Deductible / Co-insurance
- Ambulance Deductible / Co-insurance
- Air Ambulance \$2,500 Copay, then Deductible / Co-insurance

OUTPATIENT SURGICAL PROCEDURES

- Pre-certification required prior to scheduling
- Physician Office / Freestanding Surgery Ctr. Deductible / Co-insurance
- Hospital Outpatient \$1,000 Copay per visit, then Deductible / Co-insurance
- Implant Device Deductible / Co-insurance (Benefit Max of 200% of manufacturer invoice. See Summary Plan Document for additional details.)

INPATIENT HOSPITALIZATION

- All non-emergency confinements must be pre-certified and emergency confinements must be reported within 48 hours of when confinement begins
- Medical Facility Services \$500 Copay per confinement, then Deductible / Co-insurance
- Anesthesiologist & Surgeon Fees Deductible / Co-insurance

INPATIENT SURGICAL PROCEDURES

- Deductible / Co-insurance
- Implant Device Deductible / Co-insurance (Benefit Max of 200% of manufacturer invoice. See Summary Plan Document for additional details.)

HOME HEALTH, SKILLED NURSING & HOSPICE CARE

- Deductible / Co-insurance

MENTAL HEALTH & SUBSTANCE ABUSE

- Deductible / Co-insurance

DURABLE MEDICAL EQUIPMENT

- Deductible / Co-insurance

PRESCRIPTION DRUG BENEFITS

- Refer to Preferred Formulary and Summary Plan Document (SPD) for additional details
- Generic \$1 Copay / \$15 Copay
- Brand / Non-Preferred Brand / Speciality \$50 Copay / \$80 Copay / 50%
- International Mail Order - Brand \$0 Copay if preferred vendor (voluntary participation)

NOTE: This outline is intended as a brief overview of the actual plan and represents In-network benefit levels. The In-network Out-of-Pocket Maximum (including deductible, co-insurance, copays and Rx copays) for each plan is \$7,900 Single / \$15,800 Family. Out-of-network deductibles are 2X In-network Deductible. Out-of-network Co-insurance percentage and out-of-pocket amounts vary by plan selection. Please refer to your Summary Plan Document (SPD) for the actual benefits, limitations, and exclusions. If there is any inconsistency between this outline and the SPD, the SPD shall govern. You may request a SPD from Lifestyle Health Plans or your sales representative. Certain procedures require pre-certification prior to scheduling in order to qualify for benefits. Failure to do so will result in penalties and/or non coverage of services.



Ded. met 100%

Healthy Consumer

	Healthy Consumer 3000	Healthy Consumer 3500	Healthy Consumer 5000	Healthy Consumer 6500
DEDUCTIBLE	\$3,000 Single / \$6,000 Family (Embedded Deductible)	\$3,500 Single / \$7,000 Family (Embedded Deductible)	\$5,000 Single / \$10,000 Family (Embedded Deductible)	\$6,500 Single / \$13,000 Family (Embedded Deductible)
LIFESTYLE DEDUCTIBLE <small>(Reduced Deductible based on wellness points earned)</small>	\$500 Single / \$1,000 Family	\$500 Single / \$1,000 Family	\$500 Single / \$1,000 Family	\$500 Single / \$1,000 Family
CO-INSURANCE	None	None	None	None
CO-INSURANCE MAXIMUM	No Co-insurance Responsibility	No Co-insurance Responsibility	No Co-insurance Responsibility	No Co-insurance Responsibility
OUT-OF-POCKET LIMIT <small>(OOP Limit does not include copays and Rx copays)</small>	\$3,000 Single / \$6,000 Family	\$3,500 Single / \$7,000 Family	\$5,000 Single / \$10,000 Family	\$6,500 Single / \$13,000 Family
ACA MAXIMUM OUT-OF-POCKET	\$6,750 Single / \$13,500 Family	\$6,750 Single / \$13,500 Family	\$6,750 Single / \$13,500 Family	\$6,750 Single / \$13,500 Family
PREVENTIVE SERVICES	100% Coverage			
PHYSICIAN SERVICES	<ul style="list-style-type: none"> - Primary Care Office Visit After Deductible, \$30 Copay - Specialist Office Visit After Deductible, \$50 Copay - Physician & Surgeon Professional Services Deductible / Co-insurance - Anesthesia Services (Physician / CRNA) Deductible / Co-insurance 			
TELEPHONIC PHYSICIAN CONSULTATIONS	\$0 Copay			
OUTPATIENT LAB	Deductible / Co-insurance			
OUTPATIENT RADIOLOGY AND IMAGING	<ul style="list-style-type: none"> - Physician Office / Freestanding Imaging Ctr. Deductible / Co-insurance - Hospital Outpatient Deductible / Co-insurance 			
DIABETIC SUPPLIES	Deductible / Co-insurance			
ALLERGY TREATMENT	Deductible / Co-insurance			
OUTPATIENT REHAB & THERAPY	Deductible / Co-insurance			
CHIROPRACTIC SERVICES	Deductible / Co-insurance			
EMERGENCY SERVICES	<ul style="list-style-type: none"> - Hospital ER (Facility Charge Only) Deductible / Co-insurance - Urgent Care / ER Professional Services Deductible / Co-insurance - Ambulance Deductible / Co-insurance - Air Ambulance Deductible / Co-insurance 			
OUTPATIENT SURGICAL PROCEDURES	<ul style="list-style-type: none"> - Physician Office / Freestanding Surgery Ctr. Deductible / Co-insurance - Hospital Outpatient Deductible / Co-insurance - Implant Device Deductible / Co-insurance (Benefit Max of 200% of manufacturer invoice. See Summary Plan Document for additional details.) 			
INPATIENT HOSPITALIZATION	<ul style="list-style-type: none"> - Medical Facility Services Deductible / Co-insurance - Anesthesiologist & Surgeon Fees Deductible / Co-insurance 			
INPATIENT SURGICAL PROCEDURES	<ul style="list-style-type: none"> - Implant Device Deductible / Co-insurance - Benefit Max of 200% of manufacturer invoice. See Summary Plan Document for additional details. 			
HOME HEALTH, SKILLED NURSING & HOSPICE CARE	<ul style="list-style-type: none"> - Mental Health & Substance Abuse Deductible / Co-insurance - Durable Medical Equipment Deductible / Co-insurance - Prescription Drug Benefits Refer to Preferred Formulary and Summary Plan Document (SPD) for additional details - Generic After Deductible, \$1 Copay / \$15 Copay - Brand / Non-Preferred Brand / Specialty After Deductible, \$50 Copay / \$80 Copay / 50% - International Mail Order - Brand After Deductible, \$0 Copay if preferred vendor (voluntary participation) 			

NOTE: This outline is intended as a brief overview of the actual plan and represents in-network benefit levels. The In-network Out-of-Pocket Maximum (including deductible, co-insurance, copays and Rx copays) for each plan is \$6,750 Single / \$13,500 Family. Out-of-network deductibles are 2x In-network Deductible. Out-of-network Co-insurance percentage and out-of-pocket amounts vary by plan selection. Please refer to your Summary Plan Document (SPD) for the actual benefits, limitations, and exclusions. If there is any inconsistency between this outline and the SPD, the SPD shall govern. You may request a SPD from Lifestyle Health Plans or your sales representative. Certain procedures require pre-certification prior to scheduling in order to qualify for benefits. Failure to do so will result in penalties and/or non coverage of services.