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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Platinum Coinsurance Plan	Platinum Copay Plan
Actuarial Value - AV Calculator	88.10%	88.00%
Overall deductible	$0	$0
Other deductibles for specific services		
Medical	$0	$0
Brand Drugs	$0	$0
Dental	Not Covered	Not Covered
Out–of–pocket limit	$4,000	$4,000

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$20		$20	
	Specialist visit		$40		$40	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$20		$20	
	X-rays and Diagnostic Imaging		$40		$40	
	Imaging (CT/PET scans, MRIs)		10%		$150	
Drugs to treat illness or condition	Generic drugs		$5		$5	
	Preferred brand drugs		$15		$15	
	Non-preferred brand drugs		$25		$25	
	Specialty drugs		10%		10%	
Outpatient surgery	Facility fee (e.g., ASC)		10%		$250	
	Physician/surgeon fees		10%			
Need immediate attention	Emergency room services (waived if admitted)		$150		$150	
	Emergency medical transportation		$150		$150	
	Urgent care		$40		$40	
Hospital stay	Facility fee (e.g. hospital room)		10%		$250 per day up to 5 days	
	Physician/surgeon fee		10%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$20		$20	
	Mental/Behavioral health inpatient services		10%		$250 per day up to 5 days	
	Substance use disorder outpatient services		$20		$20	
	Substance use disorder inpatient services		10%		$250 per day up to 5 days	
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	10%		$250 per day up to 5 days	
		Professional	10%			
Help recovering or other special health needs	Home health care		10%		$20	
	Outpatient Rehabilitation services		$20		$20	
	Outpatient Habilitation services		$20		$20	
	Skilled nursing care		10%		$150 per day up to 5 days	
	Durable medical equipment		10%		10%	
	Hospice service		No cost share		No cost share	
Child eye care	Eye exam		No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share		No cost share	
Child dental care	Dental check-up - Preventive and Diagnostic		Not Covered		Not Covered	
	Dental Basic Services					
	Dental Major Services					
	Orthodontics (medically necessary)					

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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator	78.80%	78.60%
Overall deductible	$0	$0
Other deductibles for specific services		
Medical	$0	$0
Brand Drugs	$0	$0
Dental	Not Covered	Not Covered
Out–of–pocket limit	$6,250	$6,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$30		$30	
	Specialist visit		$50		$50	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$30		$30	
	X-rays and Diagnostic Imaging		$50		$50	
	Imaging (CT/PET scans, MRIs)		20%		$250	
Drugs to treat illness or condition	Generic drugs		$15		$15	
	Preferred brand drugs		$50		$50	
	Non-preferred brand drugs		$70		$70	
	Specialty drugs		20%		20%	
Outpatient surgery	Facility fee (e.g., ASC)		20%		$600	
	Physician/surgeon fees		20%			
Need immediate attention	Emergency room services (waived if admitted)		$250		$250	
	Emergency medical transportation		$250		$250	
	Urgent care		$60		$60	
Hospital stay	Facility fee (e.g. hospital room)		20%		$600 per day up to 5 days	
	Physician/surgeon fee		20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$30		$30	
	Mental/Behavioral health inpatient services		20%		$600 per day up to 5 days	
	Substance use disorder outpatient services		$30		$30	
	Substance use disorder inpatient services		20%		$600 per day up to 5 days	
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	20%		$600 per day up to 5 days	
		Professional	20%			
Help recovering or other special health needs	Home health care		20%		$30	
	Outpatient Rehabilitation services		$30		$30	
	Outpatient Habilitation services		$30		$30	
	Skilled nursing care		20%		$300 per day up to 5 days	
	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
Child eye care	Eye exam		No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share		No cost share	
Child dental care	Dental check-up - Preventive and Diagnostic		Not Covered		Not Covered	
	Dental Basic Services					
	Dental Major Services					
	Orthodontics (medically necessary)					

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Actuarial Value - AV Calculator	70.30%	69.90%
Overall deductible	N/A	N/A
Other deductibles for specific services		
Medical	$2,000	$2,000
Brand Drugs	$250	$250
Dental	Not Covered	Not Covered
Out–of–pocket limit	$6,250	$6,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$45		$45	
	Specialist visit		$65		$65	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$45		$45	
	X-rays and Diagnostic Imaging		$65		$65	
	Imaging (CT/PET scans, MRIs)		20%	X	$250	
Drugs to treat illness or condition	Generic drugs		$15		$15	
	Preferred brand drugs		$50	X	$50	X
	Non-preferred brand drugs		$70	X	$70	X
	Specialty drugs		20%	X	20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%		20%	
	Physician/surgeon fees		20%		20%	
Need immediate attention	Emergency room services (waived if admitted)		$250	X	$250	X
	Emergency medical transportation		$250	X	$250	X
	Urgent care		$90		$90	
Hospital stay	Facility fee (e.g. hospital room)		20%	X	20%	X
	Physician/surgeon fee		20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$45		$45	
	Mental/Behavioral health inpatient services		20%	X	20%	X
	Substance use disorder outpatient services		$45		$45	
	Substance use disorder inpatient services		20%	X	20%	X
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%			
Help recovering or other special health needs	Home health care		20%		$45	
	Outpatient Rehabilitation services		$45		$45	
	Outpatient Habilitation services		$45		$45	
	Skilled nursing care		20%	X	20%	X
	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
Child eye care	Eye exam		No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share		No cost share	
Child dental care	Dental check-up - Preventive and Diagnostic		Not Covered		Not Covered	
	Dental Basic Services					
	Dental Major Services					
	Orthodontics (medically necessary)					

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Actuarial Value - AV Calculator		71.50%		71.00%	
Overall deductible		N/A		N/A	
Other deductibles for specific services					
	Medical	$1,500		$1,500	
	Brand Drugs	$500		$500	
	Dental	Not Covered		Not Covered	
Out–of–pocket limit		$6,250		$6,250	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies**	**Member Cost Share**	**Deductible Applies**
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$45		$45	
	Specialist visit	$65		$65	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	$45		$45	
	X-rays and Diagnostic Imaging	$65		$65	
	Imaging (CT/PET scans, MRIs)	20%	X	$250	
Drugs to treat illness or condition	Generic drugs	$15		$15	
	Preferred brand drugs	$50	X	$50	X
	Non-preferred brand drugs	$70	X	$70	X
	Specialty drugs	20%	X	20%	X
Outpatient surgery	Facility fee (e.g., ASC)	20%		20%	
	Physician/surgeon fees	20%		20%	
Need immediate attention	Emergency room services (waived if admitted)	$250	X	$250	X
	Emergency medical transportation	$250	X	$250	X
	Urgent care	$90		$90	
Hospital stay	Facility fee (e.g. hospital room)	20%	X	20%	X
	Physician/surgeon fee	20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$45		$45	
	Mental/Behavioral health inpatient services	20%	X	20%	X
	Substance use disorder outpatient services	$45		$45	
	Substance use disorder inpatient services	20%	X	20%	X
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services — Hospital	20%	X	20%	X
	Delivery and all inpatient services — Professional	20%			
Help recovering or other special health needs	Home health care	20%		$45	
	Outpatient Rehabilitation services	$45		$45	
	Outpatient Habilitation services	$45		$45	
	Skilled nursing care	20%	X	20%	X
	Durable medical equipment	20%		20%	
	Hospice service	No cost share		No cost share	
Child eye care	Eye exam	No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share	
Child dental care	Dental check-up - Preventive and Diagnostic	Not Covered		Not Covered	
	Dental Basic Services				
	Dental Major Services				
	Orthodontics (medically necessary)				

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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver HSA Plan
Actuarial Value - AV Calculator	71.60%
Overall deductible	$1,500 integrated Med/Rx Ded
Other deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	Not Covered
Out–of–pocket limit	$6,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		20%	X
	Specialist visit		20%	X
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		20%	X
	X-rays and Diagnostic Imaging		20%	X
	Imaging (CT/PET scans, MRIs)		20%	X
Drugs to treat illness or condition	Generic drugs		20%	X
	Preferred brand drugs		20%	X
	Non-preferred brand drugs		20%	X
	Specialty drugs		20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%	X
	Physician/surgeon fees		20%	X
Need immediate attention	Emergency room services (waived if admitted)		20%	X
	Emergency medical transportation		20%	X
	Urgent care		20%	X
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		20%	X
	Mental/Behavioral health inpatient services		20%	X
	Substance use disorder outpatient services		20%	X
	Substance use disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		20%	X
	Outpatient Rehabilitation services		20%	X
	Outpatient Habilitation services		20%	X
	Skilled nursing care		20%	X
	Durable medical equipment		20%	X
	Hospice service		No cost share	X
Child eye care	Eye exam		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share	
Child dental care	Dental check-up - Preventive and Diagnostic		Not Covered	
	Dental Basic Services			
	Dental Major Services			
	Orthodontics (medically necessary)			

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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Coinsurance Plan 100%-150% FPL	Silver Coinsurance Plan 150%-200% FPL
Actuarial Value - AV Calculator	94.80%	88.00%
Overall deductible	$0	N/A
Other deductibles for specific services		
Medical	$0	$500
Brand Drugs	$0	$50
Dental	Not Covered	Not Covered
Out–of–pocket limit	$2,250	$2,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$3		$15	
	Specialist visit		$5		$20	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$3		$15	
	X-rays and Diagnostic Imaging		$5		$20	
	Imaging (CT/PET scans, MRIs)		10%		15%	X
Drugs to treat illness or condition	Generic drugs		$3		$5	
	Preferred brand drugs		$5		$15	X
	Non-preferred brand drugs		$10		$25	X
	Specialty drugs		10%		15%	X
Outpatient surgery	Facility fee (e.g., ASC)		10%		15%	
	Physician/surgeon fees		10%		15%	
Need immediate attention	Emergency room services (waived if admitted)		$25		$75	X
	Emergency medical transportation		$25		$75	X
	Urgent care		$6		$30	
Hospital stay	Facility fee (e.g. hospital room)		10%		15%	X
	Physician/surgeon fee		10%		15%	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$3		$15	
	Mental/Behavioral health inpatient services		10%		15%	X
	Substance use disorder outpatient services		$3		$15	
	Substance use disorder inpatient services		10%		15%	X
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	10%		15%	X
		Professional	10%		15%	
Help recovering or other special health needs	Home health care		10%		15%	
	Outpatient Rehabilitation services		$3		$15	
	Outpatient Habilitation services		$3		$15	
	Skilled nursing care		10%		15%	X
	Durable medical equipment		10%		15%	
	Hospice service		No cost share		No cost share	
Child eye care	Eye exam		No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share		No cost share	
Child dental care	Dental check-up - Preventive and Diagnostic		Not Covered		Not Covered	
	Dental Basic Services					
	Dental Major Services					
	Orthodontics (medically necessary)					

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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Coinsurance Plan 200%-250% FPL
Actuarial Value - AV Calculator	73.50%
Overall deductible	N/A
Other deductibles for specific services	
Medical	$1,500
Brand Drugs	$250
Dental	Not Covered
Out–of–pocket limit	$5,200

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$40	
	Specialist visit		$50	
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		$40	
	X-rays and Diagnostic Imaging		$50	
	Imaging (CT/PET scans, MRIs)		30%	X
Drugs to treat illness or condition	Generic drugs		$15	
	Preferred brand drugs		$30	X
	Non-preferred brand drugs		$50	X
	Specialty drugs		20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
Need immediate attention	Emergency room services (waived if admitted)		$250	X
	Emergency medical transportation		$250	X
	Urgent care		$80	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$40	
	Mental/Behavioral health inpatient services		20%	X
	Substance use disorder outpatient services		$40	
	Substance use disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	
Help recovering or other special health needs	Home health care		20%	
	Outpatient Rehabilitation services		$40	
	Outpatient Habilitation services		$40	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No cost share	
Child eye care	Eye exam		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share	
Child dental care	Dental check-up - Preventive and Diagnostic		Not Covered	
	Dental Basic Services			
	Dental Major Services			
	Orthodontics (medically necessary)			

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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Copay Plan 100%-150% FPL	Silver Copay Plan 150%-200% FPL
Actuarial Value - AV Calculator	94.90%	88.00%
Overall deductible	$0	N/A
Other deductibles for specific services		
Medical	$0	$500
Brand Drugs	$0	$50
Dental	Not Covered	Not Covered
Out–of–pocket limit	$2,250	$2,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$3		$15	
	Specialist visit		$5		$20	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$3		$15	
	X-rays and Diagnostic Imaging		$5		$20	
	Imaging (CT/PET scans, MRIs)		$50		$100	
Drugs to treat illness or condition	Generic drugs		$3		$5	
	Preferred brand drugs		$5		$15	X
	Non-preferred brand drugs		$10		$25	X
	Specialty drugs		10%		15%	X
Outpatient surgery	Facility fee (e.g., ASC)		10%		15%	
	Physician/surgeon fees		10%		15%	
Need immediate attention	Emergency room services (waived if admitted)		$25		$75	X
	Emergency medical transportation		$25		$75	X
	Urgent care		$6		$30	
Hospital stay	Facility fee (e.g. hospital room)		10%		15%	X
	Physician/surgeon fee					
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$3		$15	
	Mental/Behavioral health inpatient services		10%		15%	X
	Substance use disorder outpatient services		$3		$15	
	Substance use disorder inpatient services		10%		15%	X
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	10%		15%	X
		Professional				
Help recovering or other special health needs	Home health care		$3		$15	
	Outpatient Rehabilitation services		$3		$15	
	Outpatient Habilitation services		$3		$15	
	Skilled nursing care		10%		15%	X
	Durable medical equipment		10%		15%	
	Hospice service		No cost share		No cost share	
Child eye care	Eye exam		No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share		No cost share	
Child dental care	Dental check-up - Preventive and Diagnostic		Not Covered		Not Covered	
	Dental Basic Services					
	Dental Major Services					
	Orthodontics (medically necessary)					

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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Copay Plan 200%-250% FPL
Actuarial Value - AV Calculator	74.00%
Overall deductible	N/A
Other deductibles for specific services	
Medical	$1,600
Brand Drugs	$250
Dental	Not Covered
Out–of–pocket limit	$5,200

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$40	
	Specialist visit		$50	
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		$40	
	X-rays and Diagnostic Imaging		$50	
	Imaging (CT/PET scans, MRIs)		$250	
Drugs to treat illness or condition	Generic drugs		$15	
	Preferred brand drugs		$30	X
	Non-preferred brand drugs		$50	X
	Specialty drugs		20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
Need immediate attention	Emergency room services (waived if admitted)		$250	X
	Emergency medical transportation		$250	X
	Urgent care		$80	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$40	
	Mental/Behavioral health inpatient services		20%	X
	Substance use disorder outpatient services		$40	
	Substance use disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	20%	X
		Professional		
Help recovering or other special health needs	Home health care		$40	
	Outpatient Rehabilitation services		$40	
	Outpatient Habilitation services		$40	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No cost share	
Child eye care	Eye exam		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share	
Child dental care	Dental check-up - Preventive and Diagnostic		Not Covered	
	Dental Basic Services			
	Dental Major Services			
	Orthodontics (medically necessary)			

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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Bronze Plan	Bronze HSA Plan
Actuarial Value - AV Calculator	60.60%	59.40%
Overall deductible	$5,000 integrated Med/Rx Ded	$4,500 integrated Med/Rx
Other deductibles for specific services		
Medical	N/A	N/A
Brand Drugs	N/A	N/A
Dental	Not Covered	Not Covered
Out–of–pocket limit	$6,250	$6,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$60	See Note 4	40%	X
	Specialist visit		$70	X	40%	X
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		30%	X	40%	X
	X-rays and Diagnostic Imaging		30%	X	40%	X
	Imaging (CT/PET scans, MRIs)		30%	X	40%	X
Drugs to treat illness or condition	Generic drugs		$15	X	40%	X
	Preferred brand drugs		$50	X	40%	X
	Non-preferred brand drugs		$75	X	40%	X
	Specialty drugs		30%	X	40%	X
Outpatient surgery	Facility fee (e.g., ASC)		30%	X	40%	X
	Physician/surgeon fees		30%	X	40%	X
Need immediate attention	Emergency room services (waived if admitted)		$300	X	40%	X
	Emergency medical transportation		$300	X	40%	X
	Urgent care		$120	See Note 4	40%	X
Hospital stay	Facility fee (e.g. hospital room)		30%	X	40%	X
	Physician/surgeon fee		30%	X	40%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$60	See Note 4	40%	X
	Mental/Behavioral health inpatient services		30%	X	40%	X
	Substance use disorder outpatient services		$60	See Note 4	40%	X
	Substance use disorder inpatient services		30%	X	40%	X
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	30%	X	40%	X
		Professional	30%	X	40%	X
Help recovering or other special health needs	Home health care		30%	X	40%	X
	Outpatient Rehabilitation services		$60	X	40%	X
	Outpatient Habilitation services		$60	X	40%	X
	Skilled nursing care		30%	X	40%	X
	Durable medical equipment		30%	X	40%	X
	Hospice service		No cost share	X	No cost share	X
Child eye care	Eye exam		No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share		No cost share	
Child dental care	Dental check-up - Preventive and Diagnostic		Not Covered		Not Covered	
	Dental Basic Services					
	Dental Major Services					
	Orthodontics (medically necessary)					

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Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Catastrophic Plan
Actuarial Value - AV Calculator	
Overall deductible	$6,600 integrated Med/Rx
Other deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	Not Covered
Out–of–pocket limit	$6,600

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		0%	After 1st non-preventive visits
	Specialist visit		0%	X
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		0%	X
	X-rays and Diagnostic Imaging		0%	X
	Imaging (CT/PET scans, MRIs)		0%	X
Drugs to treat illness or condition	Generic drugs		0%	X
	Preferred brand drugs		0%	X
	Non-preferred brand drugs		0%	X
	Specialty drugs		0%	X
Outpatient surgery	Facility fee (e.g., ASC)		0%	X
	Physician/surgeon fees		0%	X
Need immediate attention	Emergency room services (waived if admitted)		0%	X
	Emergency medical transportation		0%	X
	Urgent care		0%	After 1st non-preventive visits
Hospital stay	Facility fee (e.g. hospital room)		0%	X
	Physician/surgeon fee		0%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		0%	After 1st non-preventive visits
	Mental/Behavioral health inpatient services		0%	X
	Substance use disorder outpatient services		0%	After 1st non-preventive visits
	Substance use disorder inpatient services		0%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	0%	X
		Professional	0%	X
Help recovering or other special health needs	Home health care		0%	X
	Outpatient Rehabilitation services		0%	X
	Outpatient Habilitation services		0%	X
	Skilled nursing care		0%	X
	Durable medical equipment		0%	X
	Hospice service		No cost share	X
Child eye care	Eye exam		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share	x
Child dental care	Dental check-up - Preventive and Diagnostic		Not Covered	
	Dental Basic Services			
	Dental Major Services			
	Orthodontics (medically necessary)			

End Notes:

1) The family deductible and out-of-pocket maximum are equal to 2 times the individual values. In a family plan, an individual is responsible only for the individual out-of-pocket deductible and the individual out-of-pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out-of-pocket maximum. Once the family deductible amount is satisfied, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members.

2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
4) For Bronze and Catastrophic plans, the deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
5) Member cost-share for oral anti-cancer drugs shall not exceed $200 per month.
6) The in-patient stay for Platinum and Gold Copay Plans has no additional cost share after 5 days.
7) For drugs to treat an illness or condition, the copay applies to the term of prescription.

8) The member cost share for a generic drug is the copay specified or the retail cost of the generic drug, whichever is less.