



Member Cost Share amounts describe the Enrollee's out of pocket costs.			Platinum Platinum		
	e - AV Calculator	Coinsurance 89.7%91		Copay P 90.3%88	
Plan design inc	cludes a deductible?	No		No	
	dividual deductible mily deductible	\$0 \$0		\$0 \$0	
	ductible, NOT integrated: Medical / Pharmacy / Dental ctible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0 / \$0 /		\$0 / \$0 / \$0 / \$0 /	
Individual Out-	-of-pocket maximum	\$4,000 <u>\$3</u> \$8,000 <u>\$6</u>	<u>,350</u>	\$4,000 <u>\$3</u> \$8,000\$6	<u>,350</u>
HSA plan: Self-	only coverage deductible	N/A	<u>,700</u>	N/A	,700
HSA family pla	n: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care provider's office or clinic	Other practitioner office visit	\$15		\$15	
visit	Specialist visit	\$40 <u>\$30</u>		\$40 <u>\$30</u>	
	Preventive care/ screening/ immunization Laboratory Tests	No charge \$20\$15		No charge \$20\$15	
Tests	X-rays and Diagnostic Imaging	\$40 <u>\$30</u>		\$40 <u>\$30</u> \$150\$75	
	,				
Drugs to treat illness or condition		·			
	Tier 3	\$25		\$25	
	Tier 4 Surgery facility fee (e.g., ASC)	10% up to \$250 per script		10% up to \$250 per script \$250\$100	
Outpatient services	Physician/surgeon fees	10%		\$40 <u>\$25</u>	
	•				
Need	<u> </u>				
immediate attention	Primary care visit to treat an injury, illness, or condition				
	Facility fee (e.g. hospital room)	10%		\$250 per day up	
Hospital stay				-	
	Mental/Behavioral health other outpatient items and services	\$15		\$15	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%			
Mental health, behavioral	Mental/Behavioral health inpatient physician fee	10%		•	
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$15		\$15	
	Substance Use disorder other outpatient items and services	\$15		\$15	
	Substance Use inpatient facility fee (e.g. hospital room)	10%			
	Substance use disorder inpatient physician fee	10%			
	<u> </u>				
Pregnancy	Delivery and all inpatient Hospital			\$250 per day up	
	Professional			\$40No charge	
				· ·	
Help recovering or	Outpatient Habilitation services	\$15			
other special health needs	Skilled nursing care	10%			
neutii needs					
Child eye care					
Ciliu eye care		No charge		No charge	
Child Dental Diagnostic	Oral Exam Preventive - Cleaning Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services Crowns and Casts			Not Covered	
Child Dental	Endodontics			Not Covered	
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
3.7.003	Prosthodontics Oral Surgery			Not Covered Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

Integrated Indiv Integrated Famil Individual dedu Family deductik Individual Out-of Family Out-of-po HSA plan: Self-or HSA family plan: Common Medical Event Pr Health care provider's office or clinic visit Sp Pr La X- Im Drugs to treat illness or condition Ti	udes a deductible? vidual deductible nily deductible uctible, NOT integrated: Medical / Pharmacy / Dental ble, NOT integrated: Medical / Pharmacy / Dental f-pocket maximum	80.9%81 No \$0 \$0 \$0 / \$0 / \$0 / \$0 / \$0 / \$0 / \$6,750\$6 \$13,500\$1 N/A N/A Member Cost Share \$30\$25 \$55 No charge \$35 \$55 20% \$15	(\$0 (\$0 (\$0 (,000	81.2% <u>78</u> No \$0 \$0 \$0 / \$0 / \$0 / \$0 / \$0 / \$0 / \$6,750\$6 \$13,500\$1: N/A N/A Member Cost Share \$30\$25 \$55 No charge \$35 \$55 \$275 \$15	\$0 \$0 ,000
Integrated Indiv Integrated Famil Individual dedu Family deductik Individual Out-of Family Out-of-po HSA plan: Self-or HSA family plan: Common Medical Event Pr Health care provider's office or clinic visit Sp Pr Tests Ti Drugs to treat illness or condition Ti	vidual deductible hily deductible uctible, NOT integrated: Medical / Pharmacy / Dental ble, NOT integrated: Medical / Pharmacy / Dental of-pocket maximum ble coverage deductible Individual deductible Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization aboratory Tests Grays and Diagnostic Imaging maging (CT/PET scans, MRIs) Fier 1	\$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	7 \$0 5,000 2,000 Deductible	\$0 \$0 \$0 \$0 / \$0 / \$0 / \$0 / \$6,750 <u>\$6</u> \$13,500 <u>\$11</u> N/A N/A Member Cost Share \$30 <u>\$25</u> \$55 \$55 \$55 \$275	\$0 ,000 2,000
Individual dedu Family deductite Individual Out-of Family Out-of-po HSA plan: Self-or HSA family plan: Common Medical Event Press Office or clinic visit Specifical Event Tight Drugs to treat illness or condition Tight	Detailed, NOT integrated: Medical / Pharmacy / Dental ble, NOT integrated: Medical / Pharmacy / Dental of-pocket maximum ocket maximum only coverage deductible: Individual deductible Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Preventive care/ screening/ immunization aboratory Tests (-rays and Diagnostic Imaging maging (CT/PET scans, MRIs) Tier 1 Tier 2	\$0 / \$0 / \$0 / \$0 / \$6,750\$6 \$13,500\$1 N/A N/A Member Cost Share \$30\$25 \$55 No charge \$35 \$55 20%	7 \$0 5,000 2,000 Deductible	\$0 / \$0 / \$0 / \$0 / \$6,750 <u>\$6</u> \$13,500 <u>\$11</u> N/A N/A Member Cost Share \$30 <u>\$25</u> \$55 \$55 No charge \$35 \$55 \$275	\$0 ,000 2,000
Individual Out-of Family Out-of-po HSA plan: Self-or HSA family plan: Common Medical Event Pr Health care provider's office or clinic visit Sp Pr Tests Ti Drugs to treat illness or condition Ti	Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Preventive care/ screening/ immunization aboratory Tests C-rays and Diagnostic Imaging maging (CT/PET scans, MRIs) Fier 2	\$6,750\$6 \$13,500\$1 N/A N/A Member Cost Share \$30\$25 \$55 No charge \$35 \$55 20% \$15	2,000 2,000 Deductible	\$6,750 <u>\$6</u> \$13,500 <u>\$1</u> N/A N/A Member Cost Share \$30 <u>\$25</u> \$55 No charge \$35 \$55 \$275	,000 2,000 Deductible
Family Out-of-po HSA plan: Self-or HSA family plan: Common Medical Event Pr Health care provider's office or clinic visit Sp Pr La X- Im Ti Drugs to treat illness or condition Ti	Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Preventive care/ screening/ immunization aboratory Tests (-rays and Diagnostic Imaging maging (CT/PET scans, MRIs) Fier 1	\$13,500 <u>\$1</u> N/A N/A Member Cost Share \$30 <u>\$25</u> \$55 No charge \$35 \$55 20% \$15	2,000 Deductible	\$13,500 <u>\$1</u> ; N/A N/A Member Cost Share \$30 <u>\$25</u> \$55 No charge \$35 \$55 \$275	2,000 Deductible
Common Medical Event Present Service or clinic visit Tests X-Im Drugs to treat illness or condition Time Service Service or condition Time Service Servic	Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization aboratory Tests (-rays and Diagnostic Imaging maging (CT/PET scans, MRIs) Tier 1	N/A Member Cost Share \$30 <u>\$25</u> \$30 <u>\$25</u> \$55 No charge \$35 \$55 20% \$15		N/A Member Cost Share \$30\$25 \$30\$25 \$55 No charge \$35 \$55 \$275	
Health care provider's office or clinic visit Tests Drugs to treat illness or condition	Primary care visit to treat an injury, illness, or condition Other practitioner office visit Preventive care/ screening/ immunization aboratory Tests (-rays and Diagnostic Imaging maging (CT/PET scans, MRIs) Tier 1	\$30 <u>\$25</u> \$30 <u>\$25</u> \$30 <u>\$25</u> \$55 No charge \$35 \$55 20% \$15		\$30\\$25 \$30\\$25 \$30\\$25 \$55 No charge \$35 \$55 \$275	
Health care provider's office or clinic visit Tests Drugs to treat illness or condition	Primary care visit to treat an injury, illness, or condition Other practitioner office visit Preventive care/ screening/ immunization aboratory Tests (-rays and Diagnostic Imaging maging (CT/PET scans, MRIs) Tier 1	\$30 <u>\$25</u> \$30 <u>\$25</u> \$30 <u>\$25</u> \$55 No charge \$35 \$55 20% \$15		\$30\\$25 \$30\\$25 \$30\\$25 \$55 No charge \$35 \$55 \$275	
Health care provider's office or clinic visit Tests Crugs to treat illness or condition Time of the care of the	Other practitioner office visit Specialist visit Preventive care/ screening/ immunization aboratory Tests (-rays and Diagnostic Imaging maging (CT/PET scans, MRIs) Tier 1	\$30 <u>\$25</u> \$55 No charge \$35 \$55 20% \$15		\$30 <u>\$25</u> \$55 No charge \$35 \$55 \$275	
provider's Office or clinic visit Span Example 1 Tests X-Im Tile Drugs to treat illness or condition Tile	Preventive care/ screening/ immunization aboratory Tests (-rays and Diagnostic Imaging maging (CT/PET scans, MRIs) Tier 1 Tier 2	\$55 No charge \$35 \$55 20% \$15		\$55 No charge \$35 \$55 \$275	
Property Later Time Trugs to treat illness or condition	Preventive care/ screening/ immunization aboratory Tests (-rays and Diagnostic Imaging maging (CT/PET scans, MRIs) Tier 1 Tier 2	No charge \$35 \$55 20% \$15		No charge \$35 \$55 \$275	
Tests X- Im Ti Drugs to treat illness or condition Ti	aboratory Tests (-rays and Diagnostic Imaging maging (CT/PET scans, MRIs) Tier 1 Tier 2	\$35 \$55 20% \$15		\$35 \$55 \$275	
Tests X- Im Ti Drugs to treat illness or condition Ti	ier 2	\$55 20% \$15		\$55 \$275	
Drugs to treat illness or condition	ier 2	\$15			
Drugs to treat illness or condition	ier 2 ier 3			\$15	
illness or condition	ïer 3	\$55			
11				\$55	
Ti	ier 4	\$75		\$75	
		20% up to \$250 per script		20% up to \$250 per script	
Outpatient Ph	Surgery facility fee (e.g., ASC) Physician/surgeon fees	20% 20%		\$600 <u>\$300</u> \$55 <u>\$40</u>	
services	Outpatient visit	20%		20%	
Er	mergency room facility fee (waived if admitted)	\$325		\$325	
	mergency room physician fee (waived if admitted)	No charge		No charge	
Need Er	mergency medical transportation	\$250		\$250	
attention Ui	Irgent care	\$30		\$30	
F:	acility fee (e.g. hospital room)	20%		\$600 per day up	
Hospital Stay	Physician/surgeon fee	20%		to 5 days \$55No charge	
М	Mental/Behavioral health outpatient office visits	\$30 <u>\$25</u>		\$30 <u>\$25</u>	
M	Mental/Behavioral health other outpatient items and services	\$ 30 <u>\$25</u>		\$30 <u>\$25</u>	
М	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%		\$600 per day up to 5 days	
Mental health, Mehavioral	Mental/Behavioral health inpatient physician fee	20%		\$55No charge	
health, or substance	Substance Use disorder outpatient office visits	\$ 30 \$25		\$30 <u>\$25</u>	
Sı	Substance Use disorder other outpatient items and services	\$ 30 \$25		\$ 30 \$25	
Sı	Substance Use inpatient facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
Sı	Substance use disorder inpatient physician fee	20%		\$55No charge	
	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient Hospital	20%		\$600 per day up	
se	ervices Professional	20%		to 5 days \$55No charge	
	Home health care (cost share per visit) Outpatient Rehabilitation services	20% \$30\$25		\$30 \$30\$25	
Hein	Outpatient Habilitation services	\$30 <u>\$25</u>		\$30 <u>\$25</u>	
other special SI	skilled nursing care	20%		\$300 per day up to 5 days	
	Durable medical equipment	20%		20%	
	lospice service iye exam	No charge No charge		No charge No charge	
Child eye care	pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Diagnostic Pr	Preventive - Cleaning Preventive - X-ray	Not Covered		Not Covered	
Preventive To	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not covered		Not Govered	
Child Dental	Restorative Procedures	N . C		NI . C	
Services Pe	Periodontal Maintenance Services Crowns and Casts	Not Covered		Not Covered Not Covered	
_	Endodontics			Not Covered	
Major Pe	Periodontics (other than maintenance)	Not Covered		Not Covered	
Pr	Prosthodontics Oral Surgery			Not Covered Not Covered	
Child	Medically necessary orthodontics	Not Covered		Not Covered	

Plan design includes a d Integrated Individual de Integrated Family deductible, Not Individual Out-of-pocket mathematical Event Individual Out-of-pocket mathematical Individual	nte describe the F	prollee's out of pocket costs	Silver Plan	1
Plan design includes a dintegrated Individual design integrated Individual design integrated Individual design integrated Family deductible, NoT individual Out-of-pocket man individual Out-o		nrollee's out of pocket costs.		
Integrated Individual des Integrated Family dedu Individual deductible, No Family deductible, No Family deductible, No Family Out-of-pocket mand the Individual Out-of-pocket ma	culator		71.5% 71.99	<u>%</u>
Integrated Family deductible, Namily deductible, Namily deductible, Normalized Family deductible, Normalized Family Out-of-pocket mand HSA plan: Self-only covered HSA family plan: Individual Out-of-pocket mand HSA plan: Self-only covered HSA family plan: Individual Out-of-pocket mand HSA plan: Self-only covered HSA family plan: Individual Out-of-pocket mand HSA plan: Self-only covered HSA family plan: Individual Out-of-pocket mand HSA plan: Self-only covered HSA family plan: Individual Out-of-pocket mand HSA plan: Self-only covered HSA family plan: Individual Out-of-pocket mand HSA plan: Individual			Yes, Medical/Pha	armacy
Family deductible, NOT Individual Out-of-pocket Family Dut-of-pocket ma HSA plan: Self-only cove HSA family plan: Individual Common Medical Event Common Medical Event Primary ca Specialist Specialist Specialist Specialist Specialist Specialist Specialist Freventive Laboratory X-rays and Imaging (Company) Tier 1 Condition Tier 2 Tier 3 Tier 4 Coutpatient Services Need Immediate Surgery fa Physician/ Outpatient Services Mental health, Dehavioral Hospital stay Physician/ Outpatient Surgery fa Physician/ Outpatient Services Mental/Be Mental/Be Mental/Be Mental/Be Substance Sub			N/A N/A	
Individual Out-of-pocket mail ou		edical / Pharmacy / Dental	\$2,500/ \$250 <u>\$10</u>	
Family Out-of-pocket mands and Self-only covered and Self-only cov		cal / Pharmacy / Dental	\$5,000/ \$500 <u>\$20</u> \$6800\$7,00	
Common Medical Event	ximum		\$13,600 <u>\$14,</u> 0	
Common Medical Event Primary can be dealth care of fice or clinic visit Specialist Preventive Laboratory Laboratory Menditon Tier 1 Crugs to treat Ilness or condition Tier 3 Tier 4 Coutpatient Services Need Mendal Health Physician/ Outpatient Emergence Entre In a part of good Emergence Entre In a pair of good Entre In Emergence Entre In a pair of good Entre In Emergence Entre In a pair of good Entre In Emergence Entre In a pair of good Entre In Emergence Entre In a pair of good Entre In Emergence Entre In a pair of good Entre In Emergence Entre In a pair of good Entre In Emergence Entre In Emergence Entre In a pair of good Entre In Emergence Entre In a pair of good Entre In Emergence Entre In a pair of good Entre In Emergence Entre In a pair of good Entre In Emergence Entre In Emergence Entre In a pair of good Entre In Emergence Entre In a pair of good Entre In Emergence Entre In a pair of good Entre In Emergence Entre In a pair of good Entre In Emergence Entre In a pair of good Entre In Emergence Entre In a pair of good Entre In Emergence Entre In a pair of good Entre In Emergence Entre In Emergence Entre In a pair of good Entre In Emergence Entre In a pair of good Entre In Emergence Entre In a pair of good Entre In			N/A N/A	
Health care provider's poffice or clinic visit Preventive Laboratory X-rays and Imaging (Condition) Tier 1 Drugs to treat condition Tier 3 Tier 4 Dutpatient Services Need Immediate attention N	iai deductible		IV/A	
Health care provider's poffice or clinic visit Preventive Laboratory X-rays and Imaging (Condition) Tier 1 Drugs to treat cliness or condition Preventive Emergence Emergence Emergence Emergence Emergence Entention Hospital stay Hospital stay Pregnancy Pregnancy Pregnancy Pregnancy Pregnancy Pregnancy Pregnancy Preventive Entert E				Deductible
Health care provider's office or clinic visit Preventive Laboratory X-rays and Imaging (Condition) Tier 1 Drugs to treat cliness or Condition Need Emergence Emerg	S	ervice Type	Member Cost Share	Applies
orovider's office or clinic visit Specialist Specialist Preventive Laboratory X-rays and Imaging (Condition) Tier 1 Orugs to treat Illness or Condition Tier 3 Tier 4 Outpatient Services Need Services Surgery far Physician/ Outpatient Services Emergence Services Mental/Be Mental/Be Mental/Be Mental/Be Mental/Be Substance Su	are visit to treat an	injury, illness, or condition	\$35	
Visit Preventive Laboratory X-rays and Imaging (C Preudition Tier 1 Preventive Laboratory X-rays and Imaging (C Tier 1 Tier 2 Illness or Condition Tier 3 Tier 4 Physician/ Outpatient Services Physician/ Outpatient Emergence E	ctitioner office visit		\$35	
Preventive Laboratory X-rays and Imaging (C Drugs to treat Illness or Condition Tier 3 Tier 4 Dutpatient Services Physician/ Outpatient Services Phospital stay Hospital stay Physician/ Physician/ Outpatient Services Mental health, or Substance Pregnancy Substance Subst	visit		\$70	
Tests Laboratory X-rays and Imaging (C Tier 1 Tier 1 Tier 2 Tier 3 Tier 4 Outpatient Services Need immediate attention Need immediate attention Hospital stay Mental/Be Mental health, or substance abuse needs Pregnancy Pregnancy Child bertal health needs Child Dental Diagnostic and health needs Child Dental Diagnostic and preventive grown and preventive and preventive and preventive grown are forward and preventive grown and preventive grown are forward and preventive grown a			ψ. σ	
Tier 1 Drugs to treat Illness or condition Tier 3 Tier 4 Dutpatient Services Need Emergence attention Need Physician/ Outpatient Emergence attention Wental health, or substance abuse needs Pregnancy Substance abuse needs Pregnancy Delivery a services Child Dental Preventive Seventive Services Child Dental Durable melton Dur	e care/ screening/ i	mmunization	No charge	
Imaging (Condition Tier 1 Drugs to treat liness or condition Tier 3 Tier 4 Dutpatient Services Physician/ Outpatient Emergence attention Urgent can be attention Urgent can be attention Urgent can be attention Emergence attention Urgent can be attention Urgent can be attention Emergence attention Urgent can be attention Urgent can be attention Emergence attention Urgent can be attention Urgent can be attention Emergence attention Emergence Emergence Emergence Emergence Emergence Emergence Emergence Emergence Endeavioral Mental/Be Emergence Endeavioral Emergence Endeavioral	y Tests d Diagnostic Imagir	na	\$35 \$70	
Crugs to treat Illness or condition Tier 3 Tier 4 Dutpatient Services Outpatient Services Outpatient Services Outpatient Emergence	CT/PET scans, MR		\$300	
Condition Tier 2 Tier 3 Tier 4 Coutpatient Surgery far Physician/ Outpatient Emergence Entry Employee Experiment Emergence Experiment Emergence Experiment Emergence Experiment Emergence Experiment Emergence Experiment Employee Experiment Employee Experiment Employee Experiment Experiment Employee Experiment Exp			\$15	<u>Pharmac</u>
Tier 3 Tier 4 Dutpatient Services Need Physician/Outpatient Services Need Emergence Emergence Emergence Emergence Emergence Emergence Emergence Physician/ Mental/Be Mental/Be Mental/Be Mental/Be Mental/Be Mental/Be Substance				deductible
Tier 4 Dutpatient Services Outpatient Emergence Emerge	Tier 2		\$55	deductible
Dutpatient Services Dutpatient Services Dutpatient Services Dutpatient Services Emergence Em			\$80 20% up to \$250 per	Pharmacy deductible
Need Emergence E	icility fee (c. a. ACC		script after pharmacy deductible	Pharmacy deductible
Need mmediate attention Need mmediate attention Hospital stay Mental health, or substance abuse needs Pregnancy Pregnancy Pregnancy Pregnancy Prenatal control belivery a services Home head Outpatient Outpatient Outpatient Outpatient Outpatient Outpatient Outpatient Outpatient Durable mealth needs Child bental Durable mealth needs Child Dental Durable me	cility fee (e.g., ASC surgeon fees	·)	20% 20%	
Need mmediate attention Urgent can be provided by the provide			20%	
Mental health, behavioral health, or substance abuse needs Pregnancy Prenatal control of the special health needs Pregnancy Pregnancy Pregnancy Pregnancy Prenatal control of the special health needs Preventive	y room facility fee	(waived if admitted)	\$350	
Mental health, behavioral health, or substance abuse needs Pregnancy Prenatal control of the precedent of the prec	Emergency room physician fee (waived if admitted)		No charge	
Hospital stay Hospital stay Hospital stay Hontal/Be Mental/Be Mental/Be Mental/Be Mental/Be Mental/Be Mental/Be Mental/Be Mental/Be Mental/Be Substance Subs	Emergency medical transportation		\$250	X
Mental health, behavioral health, or substance abuse needs Pregnancy Pregnancy Pregnancy Precovering or other special health needs Child Dental Diagnostic and Preventive Sealants propical Flus Space Ma Child Dental Dental Diagnostic Services Child Dental Dental Dental Diagnostic Services Child Dental D	re		\$35	
Mental/Be Substance Skilled nur Durable m Hospice si Eye exam 1 pair of g Oral Exam Preventive Sealants p Topical Flu Space Ma Child Dental Basic Services Periodonta Crowns ar Endedonti	e (e.g. hospital rooi	m)	20%	Х
Mental health, behavioral health, or substance abuse needs Substance Substa	surgeon fee		20%	Х
Mental health, or substance abuse needs Pregnancy Pregnancy Pregnancy Pregnancy Prenatal control below the special nealth needs Child bental Diagnostic and Preventive and Child Dental Diagnostic and Child Dental Basic Services Mental/Be Mental/Be Mental/Be and Substance Substanc	havioral health out	patient office visits	\$35	
Mental health, behavioral health, or substance abuse needs Substance Substa	havioral health oth	er outpatient items and services	\$35	
Mental health, behavioral health, or substance abuse needs Substance Substa	havioral health inn	atient facility fee (e.g.hospital room)	20%	Х
Substance Skilled nur Durable metospice Substance Substance Skilled nur Durable metospice Substance Substance Skilled nur Durable metospice Substance Substa			2076	^
Substance Substa	havioral health inp	atient physician fee	20%	Х
Substance Substance Pregnancy Prenatal control Delivery a services Home head Outpatient Outpatient Outpatient Skilled nur Durable mealth needs Child eye care Child Dental Diagnostic And Sealants preventive Derived Sealants preventive Child Dental Diagnostic Deriver Sealants preventive Deriver Sealants prevent	Substance Use disorder outpatient office visits		\$35	
Pregnancy Pregnancy Pregnancy Pregnancy Delivery a services Home hea Outpatient Outpatient Outpatient Skilled nur Durable m Hospice s Eye exam 1 pair of g Oral Exam Preventive Child Dental Diagnostic And Preventive Sealants p Topical Flu Space Ma Child Dental Basic Child Dental Basic Child Dental Child	e Use disorder other	er outpatient items and services	\$35	
Pregnancy Pregnancy Delivery a services Home hea Outpatient Outpatient Skilled number of the special health needs Child eye care Child Dental Diagnostic And Sealants preventive Space Ma Child Dental Basic Services Prevence Prevence Preventive Space Ma Child Dental Child Dental Space Ma Child Dental Child Dental Space Ma Child Dental Child Dental Space Ma Child Dental Crowns are Endodontic Crowns are Endodontic Services	e Use inpatient faci	lity fee (e.g. hospital room)	20%	X
Pregnancy Pregnancy Delivery a services Home hea Outpatient Outpatient Skilled number of the special health needs Child eye care Child Dental Diagnostic And Sealants preventive Space Ma Child Dental Basic Services Prevence Prevence Preventive Space Ma Child Dental Child Dental Space Ma Child Dental Child Dental Space Ma Child Dental Child Dental Space Ma Child Dental Crowns are Endodontic Crowns are Endodontic Services	e use disorder inpa	tient physician fee	20%	Х
Pregnancy Delivery a services Home hea Outpatient Outpatient Skilled nur Durable mealth needs Child eye care Child Dental Diagnostic and Preventive Sealants propical Fluspace Ma Child Dental Diagnostic Preventive Space Ma Child Dental Basic Periodontal Crowns are Endodontic Services	are and preconcep		No charge	
Help ecovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Space Ma Crowns ar	nd all inpatient	Hospital	20%	Х
Child Dental Diagnostic and Preventive Child Dental Diagnostic and Child Dental Dental Diagnostic and Child Dental Dental Dental Diagnostic Space Mark Preventive	1	Professional	20%	X
Child eye care Child Dental Diagnostic and Child Dental Diagnostic and Child Dental Diagnostic Areventive Diagnostic	lth care (cost shar	e per visit)	\$45	
Child Dental Child	t Rehabilitation service		\$35 \$35	
Durable m Hospice s Eye exam 1 pair of g Oral Exam Preventive Ind Preventive Sealants p Topical Flo Space Ma Child Dental Basic Child Dental Child D	t Habilitation servic	63	\$35	V
Child eye care Child Dental Diagnostic and Preventive Child Dental Diagnostic Child Dental Diagnostic Cond Child Dental Diagnostic Cond Child Dental Cond Cond Cond Cond Cond Cond Cond Cond			20%	Х
Child eye care 1 pair of g Oral Exam Preventive Preventive Sealants p Topical Flo Space Ma Child Dental Basic Child Dental Child Denta	edical equipment ervice		20% No charge	
Oral Exam Preventive Preventive Sealants p Topical Flu Space Ma Child Dental Basic Crowns ar Endodonti			No charge	
Child Dental Preventive Preventive Sealants proping Topical Flus Space Matter Space Matter Services Periodontal Crowns are Endodonticed Preventive Sealants proping Topical Flus Space Matter Space Matt	lasses per year (or	contact lenses in lieu of glasses)	No charge	L
Preventive Sealants preventive Topical Flustration Space Ma Child Dental Basic Services Periodontal Crowns are				
Preventive Sealants proping Topical Flus Space Ma Child Dental Basic Restorative Periodontal Crowns an Endodontic				
Space Ma Child Dental Basic Bervices Periodonta Crowns ar	er Tooth		Not Covered	
Child Dental Basic Services Periodonta Crowns ar	uoride Application intainers - Fixed			
Restorativ Restorativ Periodonta Crowns ar				
Crowns ar	e Procedures		Not Covered	
Endodonti	al Maintenance Ser	rvices		
Jillo Dental				
	cs (other than mair	ntenance)	Not Covered	
Services Prosthodo	<u> </u>		1131 337 3134	
Oral Surge				
Child Medically	necessary orthodo	ntics	Not Covered	

	70, 2010 <u>0anaary 20</u>	2011				
Summary of	Benefits and Coverage		CCSB Silver		CCSB Silver	
Member Cost S	Share amounts describe the En	rollee's out of pocket costs.	Coinsurance	Plan	Copay Pla	n
Actuarial Value	e - AV Calculator		71.6% 71.8°	<u>%</u>	71.3% 71.4%	
	cludes a deductible?		Yes, Medical/Pha	armacy	Yes, Medical/Pha	armacy
	dividual deductible amily deductible		N/A N/A		N/A N/A	
	eductible, NOT integrated: Me ctible, NOT integrated: Medic		\$2,000/ \$250 <u>\$1</u> \$4,000 / \$500 \$2		\$2,000/ \$250 <u>\$10</u> \$4,000 / \$500	
Individual Out-	of-pocket maximum	ai / Pharmacy / Dentai	\$4,000 / \$500 <u>\$2</u> \$6,800	<u>00</u> / φυ	\$4,000 / \$300 <u>\$2</u> \$6,800	<u>00</u> / ֆ0
	pocket maximum -only coverage deductible		\$13,600 N/A		\$13,600 N/A	
	n: Individual deductible		N/A N/A		N/A N/A	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an i	njury, illness, or condition	\$45		\$45	
Health care provider's office or clinic visit	Other practitioner office visit		\$45		\$45	
Violi	Specialist visit		\$75		\$75	
	Preventive care/ screening/ in	nmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin	g	\$40 \$70		\$40 \$70	
	Imaging (CT/PET scans, MRI		20%		\$300	
	Tier 1		\$15	Pharmacy deductible	\$15	Pharmacy deductible
Drugs to treat illness or	Tier 2		\$55	Pharmacy deductible	\$55	Pharmacy deductible
condition	Tier 3		\$85	Pharmacy deductible	\$85	Pharmacy deductible
	Tier 4		20% up to \$250 per script after pharmacy deductible 20%	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible 20%	Pharmacy deductible
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees)	20%		20%	
services	Outpatient visit		20%		20%	
	Emergency room facility fee (vaived if admitted)	\$350		\$350	
	Emergency room physician fe	e (waived if admitted)	No charge		No charge	
Need immediate	Emergency medical transport	<u> </u>	\$250	X	\$250	X
attention	Urgent care		\$45		\$45	
	Facility fee (e.g. hospital room))	20%	Х	20%	X
Hospital stay	Physician/surgeon fee	,	20%	X	20%	X
	Mental/Behavioral health outp	atient office visits	\$45		\$45	
	Mental/Behavioral health othe	r outpatient items and services	\$45		\$45	
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	Х	20%	Х
Mental health,	·					
behavioral health, or	Mental/Behavioral health inpa	tient physician fee	20%	X	20%	X
substance abuse needs	Substance Use disorder outpo	atient office visits	\$45		\$45	
	Substance Use disorder other	outpatient items and services	\$45		\$45	
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	Х	20%	Х
	Substance use disorder inpat	ent physician fee	20%	Х	20%	Х
	Prenatal care and preconcept		No charge		No charge	
Pregnancy	Delivery and all inpatient services	Hospital Professional	20% 20%	X	20%	X
	Home health care (cost share	1	20%	^	20% \$45	^
Help	Outpatient Rehabilitation serv	ices	\$45		\$45	
recovering or other special	Outpatient Habilitation service	25	\$45	V	\$45	X
health needs	Skilled nursing care Durable medical equipment		20%	Х	20%	^
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
a byc care	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Oral Exam Preventive - Cleaning					
Diagnostic and Preventive	Preventive - X-ray Sealants per Tooth Topical Fluoride Application		Not Covered		Not Covered	
Child Dontal	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures	ilooo	Not Covered		Not Covered	
JUI VIUES	Periodontal Maintenance Service Crowns and Casts	vices			Not Covered	
Child Dental	Endodontics				Not Covered	
Major Services	Periodontics (other than main	tenance)	Not Covered		Not Covered	
Oci Vices	Prosthodontics Oral Surgery				Not Covered Not Covered	
Child						
Orthodontics	Medically necessary orthodor	tics	Not Covered		Not Covered	

Date. June	: 16, 2016 <u>January 26</u> ,	2017		
Summary of	Benefits and Coverage		CCSB	
Member Cost S	hare amounts describe the En	rollee's out of pocket costs.	Silver HDHP PI	
Actuarial Value	e - AV Calculator		71.3% 71.	<u>7%</u>
	cludes a deductible?		Yes, integr	
	dividual deductible mily deductible		\$2,000 integ \$4,000 integ	
	ductible, NOT integrated: Me ctible, NOT integrated: Medic		N/A N/A	
Individual Out-	-of-pocket maximum	ai / Filailliacy / Delitai	\$6,550	
	pocket maximum -only coverage deductible		\$13,100 \$2,000	
	n: Individual deductible		\$2,600	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an i	njury, illness, or condition	20%	X
Health care				
provider's office or clinic	Other practitioner office visit		20%	Х
visit				
	Specialist visit		20%	X
	Preventive care/ screening/ ir	nmunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin	2	20% 20%	X
16313	Imaging (CT/PET scans, MRI		20%	X
	Tier 1		20% up to \$250 per	Х
			script	^
Druge to treat	Tier 2		20% up to \$250 per	X
Drugs to treat illness or			script	
condition	Tier 3		20% up to \$250 per script	Х
	Tier 4		20% up to \$250 per script	Х
Outpotions	Surgery facility fee (e.g., ASC		20%	X
Outpatient services	Physician/surgeon fees		20%	X
	Outpatient visit Emergency room facility fee (waived if admitted)	20%	X
		·		
Need	Emergency room physician fe	<u> </u>	0%	X
immediate attention	Emergency medical transport	ation	20%	X
	Urgent care		20%	X
	Facility fee (e.g. hospital room	n)	20%	Х
Hospital stay	Physician/surgeon fee	•	20%	X
	Mental/Behavioral health outp	atient office visits	20%	Х
	Mental/Behavioral health other	r outpatient items and services	20%	X
Mental health,	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	Х
behavioral	Mental/Behavioral health inpa	tient physician fee	20%	X
health, or substance				
abuse needs	Substance Use disorder outpo	atient office visits	20%	Х
	Substance Use disorder othe	outpatient items and services	20%	X
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	X
	Substance use disorder inpat	ent physician fee	20%	Х
	Prenatal care and preconcept	ion visits	No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
	services	Professional	20%	X
Uels	Home health care (cost share Outpatient Rehabilitation serv		20% 20%	X
Help recovering or	Outpatient Habilitation service		20%	X
other special health needs	Skilled nursing care		20%	Х
nountil fleeus	Durable medical equipment Hospice service		20% 0%	X
	Eye exam		No charge	
Child eye care	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge	
Child Dental	Oral Exam Preventive - Cleaning			
Diagnostic	Preventive - X-ray		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application			
Child Dental	Space Maintainers - Fixed			
Basic	Restorative Procedures		Not Covered	
Services	Periodontal Maintenance Service Crowns and Casts	vices		
Child Dental	Endodontics			
Major	Periodontics (other than main	tenance)	Not Covered	
Services	Prosthodontics Oral Surgery			
Child				
Orthodontics	Medically necessary orthodor	tics	Not Covered	

Date: June 16, 2016 January 26, 2017

Member Cost S	Benefits and Coverage hare amounts describe the Er		Silver F 100%-150 94.1%93	% FPL	Silver Plan 150%-200% F 87.5%87.9%	PL	
	cludes a deductible?		Yes, Medical/		Yes, Medical/Pharmacy		
Integrated Inc	dividual deductible mily deductible		N/A N/A		N/A N/A	,	
Individual de	ductible, NOT integrated: M		\$75 / \$0	7 \$0	\$650 / \$50 / \$		
	ctible, NOT integrated: Medi -of-pocket maximum	cal / Pharmacy / Dental	\$150 / \$0 \$2,350 \$1		\$1,300 / \$100 / \$2,350 \$2,45		
Family Out-of-	pocket maximum		\$4,700 <u>\$2</u>	2,000	\$4,700 <u>\$4,90</u>		
	-only coverage deductible n: Individual deductible		N/A N/A		N/A N/A		
Common Medical Event	Se	ervice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Primary care visit to treat an	injury, illness, or condition	\$5		\$10		
Health care provider's office or clinic visit	Other practitioner office visit		\$5		\$10		
Violi	Specialist visit		\$8		\$25		
	Preventive care/ screening/ i	mmunization	No charge		No charge		
Tests	Laboratory Tests X-rays and Diagnostic Imagir	ng	\$8 \$8		\$15 \$25		
	Imaging (CT/PET scans, MR		\$50		\$100		
	Tier 1		\$3		\$5		
Drugs to treat	Tier 2		\$10		\$20	Pharmacy deductible	
condition	Tier 3		\$15		\$35	Pharmacy deductible	
	Tier 4		10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmacy deductible	
Outpatient	Surgery facility fee (e.g., ASC	0)	10%		15%		
services	Physician/surgeon fees Outpatient visit		10% 10%		15% 15%		
	Emergency room facility fee (waived if admitted)	\$50		\$100		
	Emergency room physician fo	ee (waived if admitted)	No charge		No charge		
Need	Emergency medical transpor	<u> </u>	\$30	X	\$75	X	
immediate attention	Zinergeney inicalcal danoper		φου		ψ. σ		
	Urgent care		\$5		\$10		
Hospital stay	Facility fee (e.g. hospital roor	n)	10%	Х	15%	Х	
	Physician/surgeon fee		10%	X	15%	X	
	Mental/Behavioral health out	patient office visits	\$5		\$10		
	Mental/Behavioral health oth	er outpatient items and services	\$5		\$10		
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	10%	Х	15%	Х	
Mental health, behavioral	Mental/Behavioral health inpa	atient physician fee	10%	Х	15%	Х	
health, or substance abuse needs	Substance Use disorder outp		\$5		\$10		
	Substance Use disorder other	er outpatient items and services	\$5		\$10		
		·					
	Substance Use inpatient facil		10%	X	15%	X	
	Substance use disorder inpa		10%	X	15%	X	
Pregnancy	Prenatal care and preconcep Delivery and all inpatient	Hospital	No charge 10%	Х	No charge 15%	Х	
J	services	Professional	10%	X	15%	X	
	Home health care (cost share	e per visit)	\$3		\$15		
Help	Outpatient Rehabilitation service Outpatient Habilitation service		\$5 \$5		\$10 \$10		
recovering or other special	Skilled nursing care		10%	Х	15%	Х	
health needs	Durable medical equipment		10%		15%		
	Hospice service		No charge		No charge		
Child eye care	Eye exam 1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge		No charge No charge		
	Oral Exam	oontdot tendes in neu or glasses)	ivo ciiaige		ino charge		
Child Dental	Preventive - Cleaning						
Diagnostic and	Preventive - X-ray Sealants per Tooth		Not Covered		Not Covered		
Preventive	Topical Fluoride Application						
Child Dental	Space Maintainers - Fixed						
Basic	Restorative Procedures		Not Covered		Not Covered		
Services	Periodontal Maintenance Ser Crowns and Casts	vices					
Child Dental	Endodontics						
	Periodontics (other than main	ntenance)	Not Covered		Not Covered		
Major							
	Prosthodontics						
Major	Prosthodontics Oral Surgery Medically necessary orthodo		Not Covered		Not Covered		

Date: June 16, 2016 January 26, 2017

Oral Surgery

Medically necessary orthodontics

Not Covered

Child

Orthodontics

Member Cost S	nare amounts describe the En	rollee's out of pocket costs.	Silver Plan 200%-250% FP	L
Actuarial Value	- AV Calculator		73.7% <u>73.9%</u>	
Plan design inc	cludes a deductible?		Yes, Medical/Phari	macy
	dividual deductible mily deductible		N/A N/A	
Individual de	ductible, NOT integrated: Me		\$2,200 / \$250 <u>\$100</u>	
	tible, NOT integrated: Medic	al / Pharmacy / Dental	\$4,400 / \$500 <u>\$200</u> \$5,700 <u>\$5,850</u>	
Family Out-of- _l	oocket maximum		\$11,400 <u>\$11,70</u>	
	only coverage deductible n: Individual deductible		N/A N/A	
rioz ranny pia			14/74	
Common				Deductibl
Medical Event	Se	rvice Type	Member Cost Share	Applies
	Primary care visit to treat an i	niury, illness, or condition	\$30	
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	400	
Health care provider's	Other prostitioner office visit		#20	
office or clinic	Other practitioner office visit		\$30	
visit				
	Specialist visit		\$55 <u>\$65</u>	
	Preventive care/ screening/ ir	nmunization	No charge	
Tooto	Laboratory Tests	~	\$35 \$65\$70	
Tests	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MRI:		\$65 <u>\$70</u> \$300	
	Tier 1		\$15	Pharmac
	Tier i		\$15	deductible
	Tier 2		\$50	Pharmac
Drugs to treat	1101 2		φυυ	deductibl
condition	Tier 3	\$ 75	Pharmac	
			ΨΙΟ	deductibl
	Tier 4		20% up to \$250 per script	Pharmac
			after pharmacy deductible	deductibl
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees		20%	
services	Outpatient visit		20%	
	Emergency room facility fee (vaived if admitted)	\$350	
	Emergency room physician fe	e (waived if admitted)	No charge	
Need immediate	Emergency medical transport	<u> </u>	\$250	X
attention				
	Urgent care		\$30	
Hospital stay	Facility fee (e.g. hospital room)	20%	Х
nospitai stay	Physician/surgeon fee		20%	Х
	Mental/Behavioral health outp	atient office visits	\$30	
	Mental/Behavioral health other	r outpatient items and services	\$30	
Mental health,	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	Х
behavioral	Mental/Behavioral health inpa	tient physician fee	20%	Х
health, or substance				
abuse needs	Substance Use disorder outpatient office visits		\$30	
	Substance Use disorder other outpatient items and services		\$30	
		outpations from and convisco	φου	
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	Х
	•			
	Substance use disorder inpat		20%	Х
Ducasa	Prenatal care and preconcept		No charge	.,
Pregnancy	Delivery and all inpatient services	Hospital	20%	X
	Home health care (cost share	Professional per visit)	20% \$40	Х
Help	Outpatient Rehabilitation serv	ices	\$30	
recovering or	Outpatient Habilitation service	S	\$30	.,
other special health needs	Skilled nursing care		20%	Х
	Durable medical equipment Hospice service		20% No charge	
Child eve care	Eye exam		No charge	
Child eye care	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge	
Child Dental	Oral Exam Preventive - Cleaning			
Diagnostic	Preventive - X-ray		Not Covered	
and	Sealants per Tooth		INUL COVERED	
Preventive	Topical Fluoride Application Space Maintainers - Fixed			
Child Dental	Restorative Procedures		Not O	
Basic Services	Periodontal Maintenance Serv	vices	Not Covered	
	Crowns and Casts	1000		
Child Dental	Endodontics		N. C.	
Major Services	Periodontics (other than main	renance)	Not Covered	
	Prosthodontics Oral Surgery			
	Oral Surgery		<u> </u>	

Date: June 16, 2016 January 26, 2017

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Bronze Plan	Bronze HDHP Plan
Actuarial Value - AV Calculator	61.9% <u>60.8%</u>	62.0% 61.4%
)	
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, integrated
Integrated Individual deductible	N/A	\$4,800 integrated
Integrated Family deductible	N/A	\$9,600 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 / \$0	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / \$1,000 / \$0	N/A
Individual Out-of-pocket maximum	\$6,800 <u>\$7,000</u>	\$6,550
Family Out-of-pocket maximum	\$13,600 <u>\$14,000</u>	\$13,100
HSA plan: Self-only coverage deductible	N/A	\$4,800
HSA family plan: Individual deductible	N/A	\$4,800

amily Out-of-pocket maximum		\$6,800 <u>\$7,000</u> \$13,600\$14,000		\$6,550 \$13,100	
HSA plan: Self-	-only coverage deductible	N/A		\$4,800	0
HSA family plai	n: Individual deductible	N/A		\$4,800	0
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$75	After 1st three non-preventive visits	40%	Х
Health care provider's office or clinic	Other practitioner office visit	\$75	After 1st three non-preventive visits	40%	Х
visit	Specialist visit	\$105	After 1st three non-preventive visits	40%	Х
	Preventive care/ screening/ immunization	No charge		No charge	
Tooto	Laboratory Tests	\$40	V	40%	X
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	100%	X	40% 40%	X
	Tier 1	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х
Drugs to treat	Tier 2	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х
illness or condition	Tier 3	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х
	Tier 4	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х
Outpotions	Surgery facility fee (e.g., ASC)	100%	Х	40%	X
Outpatient services	Physician/surgeon fees	100%	X	40%	X
	Outpatient visit	100%	X	40%	X
	Emergency room facility fee (waived if admitted)	100%	Х	40%	Х
	Emergency room physician fee (waived if admitted)	No charge		0%	Х
Need immediate	Emergency medical transportation	100%	Х	40%	X
attention	Urgent care	\$75	After 1st three non-preventive visits	40%	Х
	Facility fee (e.g. hospital room)	100%	Х	40%	Х
Hospital stay	Physician/surgeon fee	100%	X	40%	Х
	Mental/Behavioral health outpatient office visits	\$75	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health other outpatient items and services	\$75	After 1st three non-preventive visits X	40%	Х
Mental health,	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	100%	Х	40%	Х
Donavioral	Mental/Behavioral health inpatient physician fee	100%	Х	40%	Х
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$75	After 1st three non-preventive visits	40%	Х
	Substance Use disorder other outpatient items and services	\$75	After 1st three non-preventive visits X	40%	Х
	Substance Use inpatient facility fee (e.g. hospital room)	100%	Х	40%	Х
	Substance use disorder inpatient physician fee	100%	Х	40%	Х
	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient Hospital	100%	Х	40%	Х
	services Professional	100%	X	40%	Х
	Home health care (cost share per visit)	100% \$75	X	40%	X
Help	Outpatient Rehabilitation services Outpatient Habilitation services	\$75 \$75		40% 40%	X
recovering or	Skilled nursing care	100%	Х	40%	X
health needs	Durable medical equipment	100%	X	40%	X
	Hospice service	No charge		0%	X
	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning Preventive - X-ray				
and	Sealants per Tooth	Not Covered		Not Covered	
	Topical Fluoride Application Space Maintainers - Fixed				
	Opado Mainamoro i IAGU				
		Nation		Not Covered	
Child Dental Basic	Restorative Procedures	Not Covered			
Child Dental Basic Services	Periodontal Maintenance Services	Not Covered			
Child Dental Basic Services		Not Covered			
Child Dental Basic Services Child Dental	Periodontal Maintenance Services Crowns and Casts Endodontics			Not Covered	
Child Dental Basic Services Child Dental Major	Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)	Not Covered Not Covered		Not Covered	
Child Dental Basic Services Child Dental Major Services	Periodontal Maintenance Services Crowns and Casts Endodontics			Not Covered	

Plan design in Integrated In Integrated Fa	hare amounts describe the Enr	ollee's out of pocket costs.	Catastro	phic Plan
Integrated In Integrated Fa	e - AV Calculator			
Integrated Fa	cludes a deductible?		Yes, int	egrated
	dividual deductible			0 integrated
	imily deductible ductible, NOT integrated: Me	dical / Pharmacy / Dental		<u>'00</u> integrated /A
	ctible, NOT integrated: Medic			/A
	-of-pocket maximum			<u>\$7.350</u>
	pocket maximum -only coverage deductible		\$14,300 N	\$14.700
	n: Individual deductible		N.	
Common		2.2.	Member Cost	Deductible
Medical Event	Ser	rvice Type	Share	Applies After 1st three
	Primary care visit to treat an in	jury, illness, or condition	0%	non-preventiv
dealth care provider's office or clinic	Other practitioner office visit		0%	After 1st thre non-preventive visits
visit	Specialist visit		0%	Х
	Preventive care/ screening/ im	munization	No charge	
	Laboratory Tests		0%	Х
ests	X-rays and Diagnostic Imaging		0%	X
	Imaging (CT/PET scans, MRIs)	0%	X
	Tier 1		0%	Х
rugs to treat	Tier 2		0%	Х
ondition	Tier 3		0%	Х
	Tier 4		0%	Х
	Surgery facility fee (e.g., ASC)		0%	Х
Outpatient ervices	Physician/surgeon fees		0%	Х
ei vices	Outpatient visit		0%	X
	Emergency room facility fee (waived if admitted)		0%	Х
leed mmediate attention	Emergency room physician fee (waived if admitted)		No charge	
	Emergency medical transporta	·	0%	X
	Urgent care		0%	After 1st three non-preventi visits
	Facility fee (e.g. hospital room		0%	X
lospital stay	Physician/surgeon fee		0%	X
	Mental/Behavioral health outpa	atient office visits	0%	After 1st three non-preventi visits
	Mental/Behavioral health other	outpatient items and services	0%	After 1st three
	Mental/Behavioral health innat	ient facility fee (e.g.hospital room)	0%	Х
lental health,				
ehavioral	Mental/Behavioral health inpat	ient physician fee	0%	Х
ealth, or ubstance buse needs	Substance Use disorder outpatient office visits		0%	After 1st three non-preventi visits
	Substance Use disorder other	outpatient items and services	0%	After 1st thre
	Substance Use inpatient facilit	y fee (e.g. hospital room)	0%	х
	Substance use disorder inpation	ent physician fee	0%	Х
		<u> </u>		^
	Prenatal care and preconcepti		No charge	
regnancy	Delivery and all inpatient services	Hospital	0%	Х
		Professional	0%	X
	Home health care (cost share Outpatient Rehabilitation servi	· · · · · · · · · · · · · · · · · · ·	0% 0%	X
	Outpatient Habilitation service		0%	X
	Skilled nursing care		0%	Х
ecovering or	Durable medical equipment		0%	X
ecovering or ther special			0%	X
ecovering or ther special	Hospice service		No charge	
ecovering or ther special ealth needs	Eye exam			
ecovering or ther special ealth needs		ontact lenses in lieu of glasses)	0%	Х
ecovering or ther special ealth needs hild eye care	Eye exam 1 pair of glasses per year (or c Oral Exam	ontact lenses in lieu of glasses)	0%	X
ecovering or ther special ealth needs hild eye care hild Dental	Eye exam 1 pair of glasses per year (or c Oral Exam Preventive - Cleaning	ontact lenses in lieu of glasses)	0%	X
ecovering or ther special ealth needs thild eye care thild Dental iagnostic	Eye exam 1 pair of glasses per year (or c Oral Exam Preventive - Cleaning Preventive - X-ray	ontact lenses in lieu of glasses)	0% Not Covered	X
ecovering or ther special ealth needs hild eye care hild Dental iagnostic nd	Eye exam 1 pair of glasses per year (or c Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	ontact lenses in lieu of glasses)		X
covering or ther special ealth needs child eye care child Dental plagnostic and	Eye exam 1 pair of glasses per year (or c Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	ontact lenses in lieu of glasses)		X
ecovering or ther special ealth needs thild eye care thild Dental plagnostic and reventive	Eye exam 1 pair of glasses per year (or c Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	ontact lenses in lieu of glasses)	Not Covered	X
covering or ther special ealth needs thild eye care thild Dental iagnostic and reventive	Eye exam 1 pair of glasses per year (or c Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures			X
child Dental reventive	Eye exam 1 pair of glasses per year (or c Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Serv		Not Covered	X
covering or ther special ealth needs child eye care child Dental pagnostic nd reventive child Dental casic ervices	Eye exam 1 pair of glasses per year (or c Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures		Not Covered	X
child Dental lasic ervices	Eye exam 1 pair of glasses per year (or concord Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Serve	ices	Not Covered	X
covering or ther special ealth needs hild eye care hild Dental iagnostic nd reventive hild Dental asic ervices	Eye exam 1 pair of glasses per year (or control of con	ices	Not Covered Not Covered	X
covering or other special lealth needs Child eye care Child Dental liagnostic and Preventive Child Dental liasic lervices Child Dental liasic lervices	Eye exam 1 pair of glasses per year (or control of con	ices	Not Covered Not Covered	X
lelp ecovering or other special health needs Child eye care Child Dental Diagnostic hild Dental Sasic Services Child Dental Gasic Services Child Dental	Eye exam 1 pair of glasses per year (or concord Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Serve Crowns and Casts Endodontics Periodontics (other than maintenance)	ices enance)	Not Covered Not Covered	X