			Platinum-Coinsurance Plan		Platinum-Copay Plan	
			Participating Providers	Non- Participating Providers	Participating Providers	Non- Participating Providers
Estimated Actuaria	al Value		89%	N/A	88%	N/A
		ФО.	Ф ГОО	N1/A	N/A	
Overall deductibles	for specific servic	AC	\$0	\$500	N/A	IN/A
other deddenoies	Facility-related Se				\$0	\$500
	Brand Drugs		\$0	N/A	\$0	N/A
	Dental		TBD	TBD	TBD	N/A
Out-of-pocket lim	nit on expenses		\$1,250	\$2,500	\$1,250	N/A
Common Medical	Sarvina	Type	Member Cost	Member Cost	Member Cost	Member Cost
Event	Service		Share	Share	Share	Share
Visit to a health care provider's office or clinic	Primary care visit to or illness (deductib first 2 visits except Participating Provice plans)	le waived for Non-	\$20	30%	\$20	Not covered
	Specialist visit		\$20	30%	\$20	Not covered
	Other practitioner of Preventive care/ so		10% No cost share	30%	\$20	Not covered
	Preventive care/ sc	reening/	No cost share	Not covered	No cost share	Not covered
Tests	Diagnostic test (x-ra	,	10%	30%	\$20 10%	Not covered
	Imaging (CT/PET s Generic drugs	caris, ivikis)	\$5	Not covered	\$5	Not covered Not covered
Drugs to treat	Preferred brand dru	iue	\$15	Not covered	\$15	Not covered
illness or	Non-preferred brand drugs		\$25	Not covered	\$25	Not covered
condition	Specialty drugs		10%	Not covered	10%	Not covered
Outpatient	Facility fee (e.g. ambul		10%	30%	10%	Not covered
surgery	Physician/surgeon fees		10%	30%	\$100	Not covered
	Emergency room services		\$150	\$150	\$150	\$150
Need immediate attention	Emergency medical transportation		10%	30%	\$150	Not covered
	Urgent care		\$40	30%	\$40	Not covered
Hospital stay	Facility fee (e.g., ho		10%	30%	10%	Not covered
1100pital olay	Physician/surgeon		10%	30%	\$200	Not covered
	Mental/Behavioral I	nealth	\$20	30%	\$20	Not covered
Mental health,	outpatient services		,		-	
behavioral	Mental/Behavioral I	nealth inpatient	10%	30%	10%	Not covered
health, or	services					
substance abuse	Substance use disc services	order outpatient	\$20	30%	\$20	Not covered
needs	Substance use disc services	order inpatient	10%	30%	10%	Not covered
	Prenatal and postn	atal care	\$20	30%	\$20	Not covered
Pregnancy	Delivery and all	Professional	10%	30%	\$200	Not covered
	inpatient services	Hospital	10%	30%	10%	Not covered
	Home health care		10%	30%	\$20	Not covered
Help recovering	Rehabilitation servi		10%	30%	\$20	Not covered
or other special	Habilitation service		10%	30%	\$20	Not covered
health needs	Skilled nursing care		10%	30%	10%	Not covered
	Durable medical ed	uipment	10%	30%	10%	Not covered
	Hospice service	المعاقبة الم	No cost share	30%	No cost share	Not covered
	Eye exam (deduction	oie waived)	0%	Not covered	0%	Not covered
Child needs	Glasses Dental check-up - F Diagnostic Services		\$20 0%	Not covered	\$20 0%	Not covered
dental or eye care						
	Dental Basic Service		TBD	TBD	TBD	Not covered
	Dental Restorative Orthodontia Service		TBD	TBD	TBD	Not covered

- 1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.
- 2) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of \$250
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
- 4) "Other Practitioner Office Visits" includes Acupuncturist, Therapy Visits, and other office visits not related to Primary Care or Specialty Physicians
- 5) It is anticipated that high and low dental benefit options will be developed (cost sharing to be determined) and paired with the medical metal tier plans for pediatric oral care. Page 1 of 9

		Gold-Coins	d-Coinsurance Plan		Gold-Copay Plan	
		Participating Providers	Non- Participating Providers	Participating Providers	Non- Participating Providers	
Estimated Actuari	al Value	81% N/A 80%		N/A		
Overall deductible	1	\$500	\$1,000	N/A	N/A	
	for specific services	φοσσ	Ψ1,000	7477	14/71	
	Facility-related Services			\$500	\$1,000	
	Brand Drugs	\$100	N/A	\$100	N/A	
Out-of-pocket lim	Dental vit on expenses	TBD \$2,500	TBD \$5,000	TBD \$2,500	N/A N/A	
Out-oi-pocket iiii	iit on expenses	φ2,500	φ5,000	φ2,500	IN/A	
Common Medical		Member Cost	Member Cost	Member Cost	Member Cost	
Event	Service Type	Share	Share	Share	Share	
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (deductible waived for first 2 visits except Non- Participating Provides or HSA plans)	\$30	40%	\$30	Not covered	
Office of Chillic	Specialist visit	\$30	40%	\$30	Not covered	
	Other practitioner office visit	20%	40%	\$30	Not covered	
	Preventive care/ screening/	No cost share	Not covered	No cost share	Not covered	
Tests	Diagnostic test (x-ray, blood work)	20%	40%	\$30	Not covered	
	Imaging (CT/PET scans, MRIs)	20%	40%	20%	Not covered	
Drugs to treat	Generic drugs	\$10	Not covered	\$10	Not covered	
illness or	Preferred brand drugs	\$20	Not covered	\$20	Not covered	
condition	Non-preferred brand drugs	\$35 20%	Not covered	\$35 20%	Not covered	
	Specialty drugs Facility fee (e.g., ambulatory		Not covered		Not covered	
Outpatient	surgery center)	20%	40%	20%	Not covered	
surgery	Physician/surgeon fees	20%	40%	\$150	Not covered	
	Emergency room services	\$200	\$200	\$200	\$200	
Need immediate attention	Emergency medical transportation	20%	40%	\$150	Not covered	
	Urgent care	\$50	40%	\$50	Not covered	
Hospital stay	Facility fee (e.g., hospital room)	20%	40%	20%	Not covered	
	Physician/surgeon fee Mental/Behavioral health	20%	40%	\$250	Not covered	
	outpatient services	\$30	40%	\$30	Not covered	
Mental health, behavioral	Mental/Behavioral health inpatient	200/	400/	200/	Not covered	
health, or	services	20%	40%	20%	Not covered	
substance abuse needs	Substance use disorder outpatient services	\$30	40%	\$30	Not covered	
	Substance use disorder inpatient services	20%	40%	20%	Not covered	
Pregnancy	Prenatal and postnatal care Delivery and all Professional	\$30 20%	40% 40%	\$30 \$250	Not covered Not covered	
1 Tegriancy	inpatient services Hospital	20%	40%	20%	Not covered	
	Home health care	20%	40%	\$30	Not covered	
Help recovering	Rehabilitation services	20%	40%	\$30	Not covered	
or other special	Habilitation services	20%	40%	\$30	Not covered	
health needs	Skilled nursing care	20%	40%	20%	Not covered	
	Durable medical equipment	20%	40% 40%	20%	Not covered	
	Hospice service Eye exam (deductible waived)	No cost share 0%	Not covered	No cost share 0%	Not covered Not covered	
	Glasses	\$30	Not covered	\$30	Not covered	
Child needs dental or eye care	Dental check-up - Preventive and Diagnostic Services (deductible	0%	Not covered	0%	Not covered	
	Dental Basic Services	TBD	TBD	TBD	Not covered	
	Dental Restorative and Orthodontia Services	TBD	TBD	TBD	Not covered	
	C. In odd i tild Ooi vilood					

- 1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.
- 2) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of \$250
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
- 4) "Other Practitioner Office Visits" includes Acupuncturist, Therapy Visits, and other office visits not related to Primary Care or Specialty Physicians
- 5) It is anticipated that high and low dental benefit options will be developed (cost sharing to be determined) and paired with the medical metal tier plans for pediatric oral care. Page 2 of 9

•			urance Plan		lan-100%-150% PL
		Participating Providers	Non- Participating Providers	Participating Providers	Non- Participating Providers
Estimated Actuari	al Value	71% N/A 94%		N/A	
Overall deductible		\$1,000	\$2,000	\$0	\$100
	for specific services	ψ1,000	Ψ2,000	Ψ	Ψ.00
	Facility-related Services				
	Brand Drugs	\$250	\$500	\$0 TDD	\$0 TDD
Out-of-pocket lim	Dental vit on expenses	TBD \$5,500	TBD \$11,000	TBD \$1,833	TBD \$3,667
Out-or-pocket IIII	iit on expenses	φ3,300	φ11,000	φ1,000	φ3,007
Common Medical		Member Cost	Member Cost	Member Cost	Member Cost
Event	Service Type	Share	Share	Share	Share
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (deductible waived for first 2 visits except Non- Participating Provides or HSA plans)	\$40	50%	\$3	25%
office of chillic	Specialist visit	\$40	50%	\$3	25%
	Other practitioner office visit	30%	50%	5%	25%
	Preventive care/ screening/	No cost share	Not covered	No cost share	Not covered
Tests	Diagnostic test (x-ray, blood work)	30%	50%	5%	25%
	Imaging (CT/PET scans, MRIs)	30%	50%	5%	25%
Drugs to treat	Generic drugs	\$15	Not covered	\$3	Not covered
illness or	Preferred brand drugs	\$25	Not covered	\$5	Not covered
condition	Non-preferred brand drugs Specialty drugs	\$40 30%	Not covered Not covered	\$8 5%	Not covered Not covered
	Facility fee (e.g., ambulatory				
Outpatient	surgery center)	30%	50%	5%	25%
surgery	Physician/surgeon fees	30%	50%	5%	25%
	Emergency room services	\$250	\$250	\$25	\$25
Need immediate attention	Emergency medical transportation	30%	50%	5%	25%
	Urgent care	\$55	50%	\$5 50'	25%
Hospital stay	Facility fee (e.g., hospital room)	30%	50%	5%	25%
	Physician/surgeon fee Mental/Behavioral health	30%	50%	5%	25%
	outpatient services	\$40	50%	\$3	25%
Mental health, behavioral	Mental/Behavioral health inpatient	200/	E09/	E0/	250/
health, or	services	30%	50%	5%	25%
substance abuse needs	Substance use disorder outpatient services	\$40	50%	\$3	25%
	Substance use disorder inpatient services	30%	50%	5%	25%
Drognonov	Prenatal and postnatal care	\$40	50%	\$3	25%
Pregnancy	Delivery and all Professional inpatient services Hospital	30% 30%	50% 50%	5% 5%	25% 25%
	Home health care	30%	50%	5%	25%
Help recovering	Rehabilitation services	30%	50%	5%	25%
or other special	Habilitation services	30%	50%	5%	25%
health needs	Skilled nursing care	30%	50%	5%	25%
	Durable medical equipment	30%	50%	5%	25%
	Hospice service Eye exam (deductible waived)	No cost share 0%	50% Not covered	No cost share 0%	25% Not covered
	Glasses	\$40	Not covered	\$3	Not covered
Child needs dental or eye care	Dental check-up - Preventive and Diagnostic Services (deductible	0%	Not covered	0%	Not covered
dontal or eye care	Dental Basic Services	TBD	TBD	TBD	TBD
	Dental Restorative and Orthodontia Services	TBD	TBD	TBD	TBD

- 1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.
- 2) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of \$250
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
- 4) "Other Practitioner Office Visits" includes Acupuncturist, Therapy Visits, and other office visits not related to Primary Care or Specialty Physicians
- 5) It is anticipated that high and low dental benefit options will be developed (cost sharing to be determined) and paired with the medical metal tier plans for pediatric oral care. Page 3 of 9

			an-150%-200% PL	FPL	
		Participating Providers	Non- Participating Providers	Participating Providers	Non- Participating Providers
Estimated Actuaria	al Value	87%	N/A	79%	N/A
Overall deductible		\$250	\$500	\$1,000	\$2,000
	for specific services	ΨΣσσ	φοσσ	ψ1,000	Ψ2,000
	Facility-related Services	Φ.	00	0070	A-00
	Brand Drugs Dental	\$0 TBD	\$0 TBD	\$250 TBD	\$500 TBD
Out-of-pocket lim		\$1,833	\$3,667	\$2,750	\$5,500
респости		¥ 1,000	V 0,001	4 =,: 55	42,222
Common Medical		Member Cost	Member Cost	Member Cost	Member Cost
Event	Service Type	Share	Share	Share	Share
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (deductible waived for first 2 visits except Non- Participating Provides or HSA plans)	\$10	30%	\$40	50%
office of chilic	Specialist visit	\$10	30%	\$40	50%
	Other practitioner office visit	10%	30%	30%	50%
	Preventive care/ screening/	No cost share	Not covered	No cost share	Not covered
Tests	Diagnostic test (x-ray, blood work)	10%	30%	30%	50%
	Imaging (CT/PET scans, MRIs)	10%	30%	30%	50%
Drugs to treat	Generic drugs	\$10 \$15	Not covered	\$15 \$25	Not covered
illness or	Preferred brand drugs Non-preferred brand drugs	\$20	Not covered Not covered	\$40	Not covered Not covered
condition	Specialty drugs	10%	Not covered	30%	Not covered
Outpatient	Facility fee (e.g., ambulatory	10%	30%	30%	50%
surgery	surgery center)				
	Physician/surgeon fees Emergency room services	10% \$100	30% \$100	30% \$250	50% \$250
Need immediate attention	Emergency medical transportation	10%	30%	30%	50%
	Urgent care	\$15	30%	\$55	50%
Hospital stay	Facility fee (e.g., hospital room)	10%	30%	30%	50%
ricopital olay	Physician/surgeon fee	10%	30%	30%	50%
	Mental/Behavioral health outpatient services	\$10	30%	\$40	50%
Mental health,	Mental/Behavioral health inpatient	400/	000/	000/	500/
behavioral health, or	services	10%	30%	30%	50%
substance abuse needs	Substance use disorder outpatient services	\$10	30%	\$40	50%
	Substance use disorder inpatient services	10%	30%	30%	50%
Pregnancy	Prenatal and postnatal care Delivery and all Professional	\$10 10%	30% 30%	\$40 30%	50% 50%
regnancy	inpatient services Hospital	10%	30%	30%	50%
	Home health care	10%	30%	30%	50%
Help recovering	Rehabilitation services	10%	30%	30%	50%
or other special	Habilitation services	10%	30%	30%	50%
health needs	Skilled nursing care Durable medical equipment	10% 10%	30% 30%	30%	50% 50%
	Hospice service	No cost share	30%	No cost share	50%
	Eye exam (deductible waived)	0%	Not covered	0%	Not covered
	Glasses	\$10	Not covered	\$40	Not covered
Child needs dental or eye care	Dental check-up - Preventive and Diagnostic Services (<i>deductible</i> <i>waived</i>)	0%	Not covered	0%	Not covered
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Dental Basic Services	TBD	TBD	TBD	TBD
	Dental Restorative and Orthodontia Services	TBD	TBD	TBD	TBD

- 1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.
- 2) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of \$250
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
- 4) "Other Practitioner Office Visits" includes Acupuncturist, Therapy Visits, and other office visits not related to Primary Care or Specialty Physicians
- 5) It is anticipated that high and low dental benefit options will be developed (cost sharing to be determined) and paired with the medical metal tier plans for pediatric oral care. Page 4 of 9

		Silver-Co	ppay Plan	Silver Copay Plan 100%-15 FPL	
		Participating Providers	Non- Participating Providers	Participating Providers	Non- Participating Providers
Estimated Actuari	al Value	68%	N/A	93%	N/A
Overall deductible		N/A	N/A	N/A	N/A
	for specific services				
	Facility-related Services	\$1,000	N/A	\$0	N/A
	Brand Drugs Dental	\$250	N/A	\$0 TDD	N/A
Out-of-pocket lim		TBD \$5,500	N/A N/A	TBD \$1,833	N/A N/A
out or pooket init	int on expenses	ψο,σσσ	14// (ψ1,000	14// (
Common Medical		Member Cost	Member Cost	Member Cost	Member Cost
Event	Service Type	Share	Share	Share	Share
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (deductible waived for first 2 visits except Non- Participating Provides or HSA plans)	\$40	Not covered	\$3	Not covered
	Specialist visit	\$40	Not covered	\$3	Not covered
	Other practitioner office visit Preventive care/ screening/	\$40 No cost share	Not covered Not covered	\$3 No cost share	Not covered Not covered
	•				
Tests	Diagnostic test (x-ray, blood work)	\$40	Not covered	\$3	Not covered
	Imaging (CT/PET scans, MRIs)	30%	Not covered	5%	Not covered
Drugs to treat	Generic drugs	\$15	Not covered	\$3	Not covered
illness or	Preferred brand drugs	\$25	Not covered	\$5 ***	Not covered
condition	Non-preferred brand drugs Specialty drugs	\$40 30%	Not covered Not covered	\$8 5%	Not covered Not covered
	Facility fee (e.g., ambulatory				
Outpatient	surgery center)	30%	Not covered	5%	Not covered
surgery	Physician/surgeon fees	\$200	Not covered	\$25	Not covered
	Emergency room services	\$250	\$250	\$25	\$25
Need immediate attention	Emergency medical transportation	\$150	Not covered	\$25	Not covered
	Urgent care	\$55	Not covered	\$5 50/	Not covered
Hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fee	30% \$350	Not covered Not covered	5% \$40	Not covered Not covered
	Mental/Behavioral health		Not covered		
Mantal baskb	outpatient services	\$40	Not covered	\$3	Not covered
Mental health, behavioral	Mental/Behavioral health inpatient	30%	Not covered	5%	Not covered
health, or	services	30 /6	Not covered	370	Not covered
substance abuse needs	Substance use disorder outpatient services	\$40	Not covered	\$3	Not covered
	Substance use disorder inpatient services	30%	Not covered	5%	Not covered
Pregnancy	Prenatal and postnatal care Delivery and all Professional	\$40 \$350	Not covered Not covered	\$3 \$40	Not covered Not covered
regnancy	inpatient services Hospital	30%	Not covered	5%	Not covered
	Home health care	\$40	Not covered	\$3	Not covered
Help recovering	Rehabilitation services	\$40	Not covered	\$3	Not covered
or other special	Habilitation services	\$40	Not covered	\$3	Not covered
health needs	Skilled nursing care	30%	Not covered	5%	Not covered
	Durable medical equipment	30%	Not covered	5%	Not covered
	Hospice service Eye exam (deductible waived)	No cost share 0%	Not covered Not covered	No cost share 0%	Not covered Not covered
	Glasses	\$40	Not covered	\$3	Not covered
Child needs dental or eye care	Dental check-up - Preventive and Diagnostic Services (deductible	0%	Not covered	0%	Not covered
	Dental Basic Services	TBD	Not covered	TBD	Not covered
	Dental Restorative and Orthodontia Services	TBD	Not covered	TBD	Not covered
	Orthodonida Services				

- 1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.
- 2) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of \$250
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
- 4) "Other Practitioner Office Visits" includes Acupuncturist, Therapy Visits, and other office visits not related to Primary Care or Specialty Physicians
- 5) It is anticipated that high and low dental benefit options will be developed (cost sharing to be determined) and paired with the medical metal tier plans for pediatric oral care. Page 5 of 9

		Silver Copay P	lan 150%-200% PL	FPL	
		Participating Providers	Non- Participating Providers	Participating Providers	Non- Participating Providers
Estimated Actuaria	al Value	87% N/A 79%		N/A	
Overall deductible	1	N/A	N/A	N/A	N/A
	for specific services	14/7	14/73	14/14	14/71
	Facility-related Services	\$250	N/A	\$1,000	N/A
	Brand Drugs Dental	\$0 TBD	N/A N/A	\$250 TBD	N/A N/A
Out-of-pocket lim		\$1,833	N/A	\$2,750	N/A
респист		¥ 1,000	- 41 -	4 =,: 55	
Common Medical		Member Cost	Member Cost	Member Cost	Member Cost
Event	Service Type	Share	Share	Share	Share
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (deductible waived for first 2 visits except Non- Participating Provides or HSA plans)	\$10	Not covered	\$40	Not covered
office of chillic	Specialist visit	\$10	Not covered	\$40	Not covered
	Other practitioner office visit Preventive care/ screening/	\$10 No cost share	Not covered	\$40 No cost share	Not covered
	•		Not covered		Not covered
Tests	Diagnostic test (x-ray, blood work)	\$10	Not covered	\$40	Not covered
	Imaging (CT/PET scans, MRIs)	10%	Not covered	30%	Not covered
Drugs to treat	Generic drugs	\$10	Not covered	\$15	Not covered
illness or	Preferred brand drugs	\$15	Not covered	\$25 \$40	Not covered
condition	Non-preferred brand drugs Specialty drugs	\$20 10%	Not covered Not covered	30%	Not covered Not covered
Outpotions	Facility fee (e.g., ambulatory				
Outpatient surgery	surgery center)	10%	Not covered	30%	Not covered
Surgery	Physician/surgeon fees	\$25	Not covered	\$200	Not covered
Need immediate	Emergency room services	\$100	\$100	\$250	\$250
attention	Emergency medical transportation	\$50	Not covered	\$150	Not covered
	Urgent care Facility fee (e.g., hospital room)	\$15 10%	Not covered	\$55 30%	Not covered Not covered
Hospital stay	Physician/surgeon fee	\$50	Not covered	\$350	Not covered
	Mental/Behavioral health	\$10	Not covered	\$40	Not covered
Mental health,	outpatient services	φισ	Not covered	Ψ40	Not covered
behavioral	Mental/Behavioral health inpatient	10%	Not covered	30%	Not covered
health, or	services Substance use disorder outpatient				
substance abuse needs	services	\$10	Not covered	\$40	Not covered
neeas	Substance use disorder inpatient services	10%	Not covered	30%	Not covered
	Prenatal and postnatal care	\$10	Not covered	\$40	Not covered
Pregnancy	Delivery and all Professional	\$50	Not covered	\$350	Not covered
	inpatient services Hospital Home health care	10% \$10	Not covered Not covered	30% \$40	Not covered Not covered
	Rehabilitation services	\$10	Not covered	\$40	Not covered
Help recovering	Habilitation services	\$10	Not covered	\$40	Not covered
or other special health needs	Skilled nursing care	10%	Not covered	30%	Not covered
nealth needs	Durable medical equipment	10%	Not covered	30%	Not covered
	Hospice service	No cost share	Not covered	No cost share	Not covered
	Eye exam (deductible waived) Glasses	0% \$10	Not covered Not covered	0% \$40	Not covered Not covered
	Dental check-up - Preventive and	φιυ	INOL COVERED	⊅ 4 ∪	INUL CUVELEU
Child needs dental or eye care	Diagnostic Services (deductible	0%	Not covered	0%	Not covered
, , , , , ,	Dental Basic Services	TBD	Not covered	TBD	Not covered
	Dental Restorative and Orthodontia Services	TBD	Not covered	TBD	Not covered

- 1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.
- 2) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of \$250
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
- 4) "Other Practitioner Office Visits" includes Acupuncturist, Therapy Visits, and other office visits not related to Primary Care or Specialty Physicians
- 5) It is anticipated that high and low dental benefit options will be developed (cost sharing to be determined) and paired with the medical metal tier plans for pediatric oral care. Page 6 of 9

		Silver-H	SA Plan			
			Participating Providers	Non- Participating Providers		
Estimated Actuari	al Value		70%	N/A		
			¢1 200	\$2,600		
Overall deductibles	for specific service	26	\$1,300	\$2,600		
Other acadombies	Facility-related Se					
	Brand Drugs		\$0	\$0		
	Dental		TBD	TBD		
Out-of-pocket lim	it on expenses		\$5,000	\$10,000		
Common Medical Event	Service Type		Member Cost Share	Member Cost Share		
Visit to a health care provider's office or clinic	Primary care visit to or illness (deductibl first 2 visits except Participating Provid plans)	treat an injury e waived for Non-	20%	40%		
office of clinic	Specialist visit		20%	40%		
	Other practitioner of		20%	40%		
	Preventive care/ screening/ Diagnostic test (x-ray, blood work)		No cost share	Not covered		
Tests			20%	40%		
	Imaging (CT/PET so Generic drugs	cans, MRIS)	20%	40% Not covered		
Drugs to treat	Preferred brand drugs		20%	Not covered		
illness or	Non-preferred brand		20%	Not covered		
condition	Specialty drugs		20%	Not covered		
Outpatient	Facility fee (e.g., an surgery center)	nbulatory	20%	40%		
surgery	Physician/surgeon fees		20%	40%		
	Emergency room services		Emergency room services		20%	20%
Need immediate attention	Emergency medical	I transportation	20%	40%		
	Urgent care		20%	40%		
Hospital stay	Facility fee (e.g., ho		20%	40%		
1100pital Stay	Physician/surgeon f		20%	40%		
Mental health,	Mental/Behavioral health outpatient services		20%	40%		
behavioral health, or	Mental/Behavioral h services	·	20%	40%		
substance abuse	Substance use diso services		20%	40%		
	Substance use diso services	·	20%	40%		
Dura was a same a s	Prenatal and postna		20%	40%		
Pregnancy	Delivery and all	Professional	20%	40%		
	inpatient services Home health care	Hospital	20%	40%		
	Rehabilitation service	200	20%	40% 40%		
Help recovering	Habilitation services		20%	40%		
or other special	Skilled nursing care		20%	40%		
health needs	Durable medical eq		20%	40%		
	Hospice service		No cost share	40%		
	Eye exam (deductil	ole waived)	20%	Not covered		
Child needs dental or eye care	Glasses Dental check-up - P Diagnostic Services waived)		20%	Not covered		
domai or cyc care	Dental Basic Service	es	TBD	TBD		
	Dental Restorative		TBD	TBD		
	Orthodontia Service	es	טפו	טסו		

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- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
- 4) "Other Practitioner Office Visits" includes Acupuncturist, Therapy Visits, and other office visits not related to Primary Care or Specialty Physicians
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			Bronze-Coinsurance Plan		Bronze-Copay Plan	
			Participating Providers	Non- Participating Providers	Participating Providers	Non- Participating Providers
Estimated Actuaria	al Value		64%	N/A	63%	N/A
		Ф0.000	# 4.000	N1/0	NI/A	
Overall deductibles	for specific servic	95	\$2,000	\$4,000	N/A	N/A
Other deductibles	Facility-related Se				\$2,000	N/A
	Brand Drugs		\$750	\$1,500	\$500	N/A
	Dental		TBD	TBD	TBD	N/A
Out-of-pocket lim	nit on expenses		\$6,350	\$12,700	\$6,350	N/A
Common Medical			Member Cost	Member Cost	Member Cost	Member Cost
Event	Service	Туре	Share	Share	Share	Share
Visit to a health care provider's office or clinic	Primary care visit to or illness (deductib first 2 visits except Participating Provice plans)	le waived for Non-	\$60	50%	\$70	Not covered
	Specialist visit	***	\$60	50%	\$70	Not covered
	Other practitioner of		40%	50%	\$70	Not covered
	Preventive care/ so	reening/	No cost share	Not covered	No cost share	Not covered
Tests	Diagnostic test (x-ra	,	40%	50%	\$70	Not covered
	Imaging (CT/PET s	cans, MRIs)	40%	50%	40%	Not covered
Drugs to treat	Generic drugs	100	\$20	Not covered	\$20	Not covered
illness or	Preferred brand drugs Non-preferred brand drugs		\$45	Not covered	\$45	Not covered
condition	Specialty drugs	a arugs	\$60 40%	Not covered	\$60 40%	Not covered Not covered
Outpatient	Facility fee (e.g., ambulatory surgery center)		40%	Not covered 50%	40%	Not covered
surgery	Physician/surgeon fees		40%	50%	\$500	Not covered
	Emergency room services		\$250	\$250	\$250	\$250
Need immediate attention	Emergency medical transportation		40%	50%	\$300	Not covered
attention	Urgent care		\$75	50%	\$75	Not covered
	Facility fee (e.g., ho	spital room)	40%	50%	40%	Not covered
Hospital stay	Physician/surgeon		40%	50%	\$750	Not covered
	Mental/Behavioral I outpatient services		\$60	50%	\$70	Not covered
Mental health,	Mental/Behavioral I	nealth innatient				
behavioral	services	ioditi iiipationt	40%	50%	40%	Not covered
health, or substance abuse	Substance use disc	order outpatient	\$60	50%	\$70	Not covered
needs	services	rder innetient	φοσ	3070	ψ. σ	1101 0010104
	Substance use disc services	·	40%	50%	40%	Not covered
	Prenatal and postn		\$60	50%	\$70	Not covered
Pregnancy	Delivery and all	Professional	40%	50%	\$750	Not covered
	inpatient services	Hospital	40%	50%	40%	Not covered
	Home health care	200	40%	50%	\$70	Not covered
Help recovering	Rehabilitation service		40% 40%	50% 50%	\$70 \$70	Not covered Not covered
or other special			40%			
health needs	Skilled nursing care Durable medical ed		40%	50% 50%	40% 40%	Not covered Not covered
	Hospice service	ыртнетт	No cost share	50%	No cost share	Not covered
	Eye exam (deductil	ole waived)	0%	Not covered	0%	Not covered
	Glasses		\$60	Not covered	\$70	Not covered
Child needs dental or eye care	Dental check-up - F Diagnostic Services		0%	Not covered	0%	Not covered
	Dental Basic Service	es	TBD	TBD	TBD	Not covered
	Dental Restorative Orthodontia Service	and	TBD	TBD	TBD	Not covered
	Chinodonila Oct vice					

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			Bronze-HSA Plan		Catastrophic Plan	
			Participating Providers	Non- Participating Providers	Participating Providers	Non- Participating Providers
Estimated Actuaria	al Value		61%	N/A	64%	N/A
Overall deductible		\$2,000	\$4,000	\$6,350	\$12,700	
	for specific service	es	φ=,σσσ	Ψ 1,000	ψο,σσσ	ψ : <u>=</u> ,: σσ
	Facility-related Se	rvices				
	Brand Drugs		\$0	\$0	\$0	\$0
	Dental		TBD	TBD	TBD	TBD
Out-of-pocket lim	nit on expenses		\$6,350 \$12,700 \$6,350		\$12,700	
Common Medical		Member Cost Member Cost M		Member Cost	Member Cost	
Event	Service [·]	Гуре	Share	Share	Share	Share
Visit to a health care provider's office or clinic	Primary care visit to or illness (deductibl first 2 visits except Participating Provid plans)	e waived for Non-	30%	50%	0%	20%
	Specialist visit		30%	50%	0%	20%
	Other practitioner of		30%	50%	0%	20%
	Preventive care/ sc	_	No cost share	Not covered	No cost share	Not covered
Tests	Diagnostic test (x-ra		30%	50%	0%	20%
	Imaging (CT/PET scans, MRIs)		30%	50% Not covered	0% 0%	20% Not covered
Drugs to treat	Generic drugs Preferred brand dru	ne	30%	Not covered	0%	Not covered
illness or	Non-preferred brand drugs		30%	Not covered	0%	Not covered
condition	Specialty drugs		30%	Not covered	0%	Not covered
Outpatient	Facility fee (e.g., ambulatory surgery center)		30%	50%	0%	20%
surgery	Physician/surgeon fees		30%	50%	0%	20%
	Emergency room services		30%	30%	0%	0%
Need immediate attention	Emergency medical transportation		30%	50%	0%	20%
	Urgent care		30%	50%	0%	20%
Hospital stay	Facility fee (e.g., ho	spital room)	30%	50%	0%	20%
nospital stay	Physician/surgeon f	ee	30%	50%	0%	20%
	Mental/Behavioral health		30%	50%	0%	20%
Mental health,	outpatient services		3070	3070	0,0	2070
behavioral	Mental/Behavioral health inpatient		30%	50%	0%	20%
health, or	services					
substance abuse needs	Substance use disorder outpatient services		30%	50%	0%	20%
neeus	Substance use diso services	rder inpatient	30%	50%	0%	20%
	Prenatal and postna		30%	50%	0%	20%
Pregnancy	Delivery and all	Professional	30%	50%	0%	20%
	inpatient services	Hospital	30%	50%	0%	20%
	Home health care Rehabilitation service	200	30%	50%	0%	20%
Help recovering	Habilitation services		30%	50% 50%	0% 0%	20%
or other special	Skilled nursing care		30%	50%	0%	20%
health needs	Durable medical eq		30%	50%	0%	20%
	Hospice service		No cost share	50%	No cost share	20%
	Eye exam (deductik	ole waived)	30%	Not covered	0%	Not covered
	Glasses		30%	Not covered	0%	Not covered
Child needs dental or eye care		(deductible	0%	Not covered	0%	Not covered
	Dental Basic Service		TBD	TBD	TBD	TBD
	Dental Restorative		TBD	TBD	TBD	TBD
	Orthodontia Service	3				

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