

Platinum

Platinum

Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

OUT OF POCK	ET COSTS	Coinsurance	ce Plan	Copay P	
Actuarial Value	e - AV Calculator	88.10	%	88.00%	6
Overall deduct	ible	\$0		\$0	
	bles for specific services	ψυ		ψ	
	Medical	\$0		\$0	
	Brand Drugs	\$0		\$0	
	Dental	Not Cove		Not Cove	
Out-of-pocket	t limit	\$4,00	0	\$4,000)
Common		Member Cost	Deductible	Member Cost	Deductible
Medical Event	Service Type	Share	Applies	Share	Applies
Health care	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$20		\$20	
provider's	visit to treat an injury of liness				
office or	Specialist visit	\$40		\$40	
clinic visit					
	Preventive care/ screening/ immunization	No cost share		No cost share	
	Laboratory Tests	\$20		\$20	
Tests	X-rays and Diagnostic Imaging	\$40		\$40	
	Imaging (CT/PET scans, MRIs)	10%		\$150	
Drugs to treat	Generic drugs	\$5		\$5	
illness or	Preferred brand drugs	\$15		\$15	
condition	Non-preferred brand drugs	\$25		\$25	
contaition	Specialty drugs	10%		10%	
Outpatient	Facility fee (e.g., ASC)	10%		\$250	
surgery	Physician/surgeon fees	10%		φ200	
	Emergency room services (waived if admitted)	\$150		\$150	
Need	Emergency medical transportation	\$150		\$150	
immediate					
attention	Urgent care	\$40		\$40	
	ů,	• •		• -	
	Facility fee (e.g. hospital room)	10%		\$250 per day up	
Hospital stay	Physician/surgeon fee	10%		to 5 days	
				· · · ·	
	Mantal/Rahaviaral haalth autratiant aan jaga	¢ao		\$ 20	
	Mental/Behavioral health outpatient services	\$20		\$20	
Mental health,					
behavioral	Mental/Behavioral health inpatient services	10%		\$250 per day up	
health, or	······································			to 5 days	
substance					
abuse needs	Substance use disorder outpatient services	\$20		\$20	
		1007		\$250 per day up	
	Substance use disorder inpatient services	10%		to 5 days	
	Prenatal care and preconception visits	No cost share		No cost share	
Pregnancy	Delivery and all inpatient Hospital	10%		\$250 per day up	
	services Professional	10%		to 5 days	
	Home health care	10%		\$20	
	Outpatient Rehabilitation services	\$20		\$20	
Help	Outpatient Habilitation services	\$20		\$20	
recovering or				\$150 per day up	
other special	Skilled nursing care	10%		to 5 days	
health needs	Durable medical equipment	10%		10%	
	Hospice service	No cost share		No cost share	
Child eve care	Eye exam 1 pair of glasses per year (or contact lenses in lieu	No cost share		No cost share	
child eye care	of glasses)	No cost share		No cost share	
	Dental check-up - Preventive and Diagnostic				
Child dental	Dental Basic Services				
care	Dental Major Services	Not Cove	erea	Not Cove	erea
	Orthodontics (medically necessary)	1			
		e			

Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S Gold Gold

COST SHARIN OUT OF POCK	G AMOUNTS DESCRIBE THE	ENROLLEE'S	Gold	e Dien	Gold	lan
			Coinsuranc		Copay P	
Actuarial Value	e - AV Calculator		78.80%	6	78.60%	
Overall deduct	ible		\$0		\$0	
Other deductib	bles for specific services					
	Medical		\$0		\$0	
	Brand Drugs		\$0		\$0	
	Dental		Not Cove	ered	Not Cove	red
Out-of-pocket	t limit		\$6,250)	\$6,250)
Common			Member Cost	Deductible	Member Cost	Deductible
Medical Event	Service Type	•	Share	Applies	Share	Applies
Health care provider's office or	Primary care visit or non-speci visit to treat an injury or illness	alist practitioner	\$30		\$30	
clinic visit	Specialist visit		\$50		\$50	
	Preventive care/ screening/ im	munization	No cost share		No cost share	
	Laboratory Tests		\$30		\$30	
Tests	X-rays and Diagnostic Imaging		\$50		\$50	
	Imaging (CT/PET scans, MRIs		20%		\$250	
Druge to to t	Generic drugs		\$15		\$15	
Drugs to treat	Preferred brand drugs		\$50		\$50	
illness or condition	Non-preferred brand drugs		\$70		\$70	
condition	Specialty drugs		20%		20%	
Outpatient	Facility fee (e.g., ASC)		20%		¢c00	
surgery	Physician/surgeon fees		20%		\$600	
	Emergency room services (wai	ved if admitted)	\$250		\$250	
Need	Emergency medical transporta		\$250		\$250	
immediate attention	Urgent care		\$60		\$60	
Hospital stay	Facility fee (e.g. hospital room))	20%		\$600 per day up	
nospital stay	Physician/surgeon fee		20%		to 5 days	
Mental health.	Mental/Behavioral health outpa	atient services	\$30		\$30	
behavioral health, or	Mental/Behavioral health inpat	ient services	20%		\$600 per day up to 5 days	
substance abuse needs	Substance use disorder outpat	ient services	\$30		\$30	
	Substance use disorder inpatie	ent services	20%		\$600 per day up to 5 days	
Pregnancy	Prenatal care and preconception	on visits	No cost share		No cost share	
. egnanøy		Hospital	20%		\$600 per day up	
		Professional	20%		to 5 days	
	Home health care		20%		\$30	
	Outpatient Rehabilitation service		\$30		\$30	
Help	Outpatient Habilitation services	3	\$30		\$30	
recovering or	Skilled nursing care		20%		\$300 per day up	
other special health needs	-				to 5 days	
neath needs	Durable medical equipment Hospice service		20% No cost share		20% No cost share	
Child	Eye exam	and and the second state	No cost share		No cost share	
child eye care	1 pair of glasses per year (or co of glasses)		No cost share		No cost share	
Child dental care	Dental check-up - Preventive a Dental Basic Services Dental Major Services		Not Cove	ered	Not Cove	red
	Orthodontics (medically necess	sary)				

Child dental

care

Dental Basic Services

Dental Major Services

Orthodontics (medically necessary)

Summary of Benefits and Coverage Individual Individual COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S Silver Silver OUT OF POCKET COSTS **Coinsurance Plan** Copay Plan 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 Not Covered Not Covered Dental Out-of-pocket limit \$6,250 \$6,250 Member Cost Deductible **Member Cost** Common Deductible Medical Event Share Share Service Type Applies Applies Primary care visit or non-specialist practitioner Health care \$45 \$45 visit to treat an injury or illness provider's office or Specialist visit \$65 \$65 clinic visit Preventive care/ screening/ immunization No cost share No cost share Laboratory Tests \$45 \$45 Tests X-rays and Diagnostic Imaging \$65 \$65 Imaging (CT/PET scans, MRIs) 20% Х \$250 Generic drugs \$15 \$15 Drugs to treat Preferred brand drugs \$50 Х \$50 Х illness or Non-preferred brand drugs \$70 Х \$70 Х condition Specialty drugs 20% Х 20% Х Outpatient Facility fee (e.g., ASC) 20% 20% surgery Physician/surgeon fees 20% 20% \$250 Emergency room services (waived if admitted) \$250 Х Х Emergency medical transportation \$250 Х \$250 Х Need immediate attention Urgent care \$90 \$90 Facility fee (e.g. hospital room) 20% Х **Hospital stay** 20% Х Physician/surgeon fee 20% Mental/Behavioral health outpatient services \$45 \$45 Mental health, behavioral Mental/Behavioral health inpatient services 20% Х 20% Х health, or substance abuse needs Substance use disorder outpatient services \$45 \$45 Substance use disorder inpatient services 20% Х 20% Х Prenatal care and preconception visits No cost share No cost share Pregnancy 20% Delivery and all inpatient Hospital Х 20% Х services Professional 20% Home health care 20% \$45 Outpatient Rehabilitation services \$45 \$45 **Outpatient Habilitation services** Help \$45 \$45 recovering or Skilled nursing care 20% Х 20% Х other special health needs Durable medical equipment 20% 20% Hospice service No cost share No cost share Eye exam No cost share No cost share Child eye care 1 pair of glasses per year (or contact lenses in lieu No cost share No cost share of glasses) Dental check-up - Preventive and Diagnostic

Not Covered

Not Covered

Summary of Benefits and Coverage

Summary of Benefits and Coverage	SHOP	SHOP
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Coinsurance Plan	Silver Copay Plan
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

out of pooned			. ,			
Common Medical Event	Service Typ)e	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's	Primary care visit or non-spec visit to treat an injury or illnes		\$45		\$45	
office or	Specialist visit		\$65		\$65	
clinic visit	Preventive care/ screening/ ir	nmunization	No cost share		No cost share	
	Laboratory Tests		\$45		\$45	
Tests	X-rays and Diagnostic Imagin	-	\$65		\$65	
	Imaging (CT/PET scans, MRI	s)	20%	Х	\$250	
Drugs to treat	Generic drugs		\$15		\$15	
illness or	Preferred brand drugs		\$50	Х	\$50	Х
condition	Non-preferred brand drugs		\$70	Х	\$70	Х
contaition	Specialty drugs		20%	Х	20%	Х
Outpatient	Facility fee (e.g., ASC)		20%		20%	
surgery	Physician/surgeon fees		20%		20%	
	Emergency room services (wa	aived if admitted)	\$250	Х	\$250	Х
Need	Emergency medical transport	ation	\$250	Х	\$250	Х
immediate attention	Urgent care		\$90		\$90	
	Facility fee (e.g. hospital room) Physician/surgeon fee		20%	Х	200%	Y
Hospital stay			20%		20%	х
Mental health,	Mental/Behavioral health outp	patient services	\$45		\$45	
behavioral health, or	Mental/Behavioral health inpa	tient services	20%	х	20%	Х
substance abuse needs	Substance use disorder outpa	atient services	\$45		\$45	
	Substance use disorder inpat	ient services	20%	х	20%	х
Pregnancy	Prenatal care and preconcept	ion visits	No cost share		No cost share	
regnancy	Delivery and all inpatient	Hospital	20%	Х	20%	Х
	services	Professional	20%			~
	Home health care		20%		\$45	
	Outpatient Rehabilitation serv		\$45		\$45	
Help	Outpatient Habilitation service	es	\$45		\$45	
recovering or other special	Skilled nursing care		20%	Х	20%	х
health needs	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
	Eye exam		No cost share		No cost share	
Child eye care	1 pair of glasses per year (or of glasses)	contact lenses in lieu	No cost share		No cost share	
Child dental care	Dental check-up - Preventive Dental Basic Services Dental Major Services		Not Co	vered	Not C	covered
	Orthodontics (medically neces	ssary)				

	Benefits and Coverage	5	SH		
COST SHARIN OUT OF POCK	G AMOUNTS DESCRIBE T	HE ENROLLEE'S	Silv HSA		
	e - AV Calculator		71.6		
Overall deduct	bles for specific services		\$1,500 integrate	ed Med/Rx Ded	
	Medical		N/	A	
	Brand Drugs		N/		
	Dental		Not Co		
Out-of-pocket	t limit		\$6,2	250	
Common Medical Event	Service T	уре	Member Cost Share	Deductible Applies	
Health care provider's	Primary care visit or non-sp visit to treat an injury or illne		20%	х	
office or clinic visit	Specialist visit		20%	Х	
	Preventive care/ screening	/ immunization	No cost share		
	Laboratory Tests		20%	Х	
Tests	X-rays and Diagnostic Imag		20%	X	
	Imaging (CT/PET scans, M	RIs)	20%	X	
Drugs to treat	Generic drugs Preferred brand drugs		20% 20%	X	
illness or	Non-preferred brand drugs		20%	× X	
condition	Specialty drugs		20%	X	
Outpatient	Facility fee (e.g., ASC)		20%	Х	
surgery	Physician/surgeon fees		20%	Х	
	Emergency room services		20%	Х	
Need	Emergency medical transpo	ortation	20%	X	
immediate attention	Urgent care		20%	х	
	Facility fee (e.g. hospital ro	om)	20%	Х	
Hospital stay	Physician/surgeon fee	,	20%	Х	
Mental health.	Mental/Behavioral health o	utpatient services	20%	x	
behavioral	Mental/Behavioral health in	patient services	20%	х	
health, or substance abuse needs	Substance use disorder ou	tpatient services	20%	х	
	Substance use disorder inp	atient services	20%	х	
Brognancy	Prenatal care and preconce	eption visits	No cost share		
Pregnancy	Delivery and all inpatient	Hospital	20%	X	
	services	Professional	20%	<u> </u>	
	Home health care	nuicoc	20%	X	
Help	Outpatient Rehabilitation service Outpatient Habilitation Serv		20% 20%	X	
recovering or	Skilled nursing care		20%	X	
other special health needs	Durable medical equipment	t	20%	Х	
	Hospice service		No cost share	Х	
	Eye exam		No cost share		
Child eye care	1 pair of glasses per year (of glasses)	or contact lenses in lieu	No cost share		
Child dental care	Dental check-up - Preventiv Dental Basic Services Dental Major Services	ve and Diagnostic	Not Covered		
	Orthodontics (medically nee	cessary)			

Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S Silver Coinsurance Plan Silver Coinsurance Plan 150%-200% EPI

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S DUT OF POCKET COSTS		Silver Coinsurance Plan 100%-150% FPL		Silver Coinsurance Plan 150%-200% FPL		
Actuarial Value	e - AV Calculator	94.80		88.00%		
Overall deduct	iibla	\$0		N/A		
	bles for specific services	φ υ		IN/A		
	Medical	\$0		\$500		
	Brand Drugs	\$0		\$50		
	Dental	Not Cove	ered	Not Cove	ered	
Out-of-pocket	t limit	\$2,25	0	\$2,25)	
Common		Member Cost	Deductible	Member Cost	Deductible	
Medical Event	Service Type	Share	Applies	Share	Applies	
Health care provider's office or	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$3		\$15		
linic visit	Specialist visit	\$5		\$20		
	Preventive care/ screening/ immunization	No cost share		No cost share		
	Laboratory Tests	\$3		\$15		
Fests	X-rays and Diagnostic Imaging	\$5		\$20		
	Imaging (CT/PET scans, MRIs)	10%		15%	Х	
	Generic drugs	\$3		\$5		
Drugs to treat	Preferred brand drugs	\$5		\$15	Х	
liness or	Non-preferred brand drugs	\$10		\$25	X	
condition	Specialty drugs	10%		15%	X	
Dutpatient	Facility fee (e.g., ASC)	10%		15%		
surgery	Physician/surgeon fees	10%		15%		
J J	Emergency room services (waived if admitted)	\$25		\$75	Х	
	Emergency medical transportation	\$25		\$75	X	
Need mmediate attention	Urgent care	\$6		\$30		
Hospital stay	Facility fee (e.g. hospital room)	10%		15%	Х	
lospital stay	Physician/surgeon fee	10%		15%		
Mental health,	Mental/Behavioral health outpatient services	\$3		\$15		
oehavioral	Mental/Behavioral health inpatient services	10%		15%	х	
nealth, or substance abuse needs	Substance use disorder outpatient services	\$3		\$15		
	Substance use disorder inpatient services	10%		15%	х	
	Prenatal care and preconception visits	No cost share		No cost share		
Pregnancy	Delivery and all inpatient Hospital	10%		15%	Х	
	services Professional	10%		15%		
	Home health care	10%		15%		
	Outpatient Rehabilitation services	\$3		\$15		
lelp	Outpatient Habilitation services	\$3		\$15		
ecovering or	Skilled nursing care	10%		15%	х	
other special nealth needs	Durable medical equipment	10%		15%		
	Hospice service	No cost share		No cost share		
	Eye exam					
Child eve care	1 pair of glasses per year (or contact lenses in lieu	No cost share		No cost share		
onna eye care	of glasses)	No cost share		No cost share		
	Dental check-up - Preventive and Diagnostic					
		Not Covered		Not Covered		
Child dental care	Dental Basic Services Dental Major Services	Not Cove	ered	Not Cove	red	

Summary of Benefits and Coverage

COST SHARIN	G AMOUNTS DESCRIBE THE	E ENROLLEE'S	Silver Coinsur	
OUT OF POCK			200%-2509	
Actuarial Value	e - AV Calculator		73.50	%
Overall deduct			N/A	
Other deductil	bles for specific services		¢4 50	0
	Medical Brand Drugo		\$1,50	
	Brand Drugs Dental		\$250 Not Cove	
Out-of-pocket			\$5,20	
out of poone			¢0, <u>=</u> 0	
Common Medical Event	Service Typ	e	Member Cost Share	Deductible Applies
Health care provider's	ider's visit to treat an injury or illness		\$40	
office or clinic visit	Specialist visit		\$50	
	Preventive care/ screening/ in	nmunization	No cost share	
	Laboratory Tests		\$40	
Tests	X-rays and Diagnostic Imagin		\$50	
	Imaging (CT/PET scans, MRI	s)	30%	Х
Drugs to treat	Generic drugs		\$15	
illness or	Preferred brand drugs		\$30	Х
condition	Non-preferred brand drugs		\$50	Х
	Specialty drugs		20%	X
Outpatient	Facility fee (e.g., ASC)		20%	
surgery	Physician/surgeon fees		20%	
	Emergency room services (wa		\$250	Х
Need	Emergency medical transporta	ation	\$250	X
immediate attention	Urgent care		\$80	
	Facility fee (e.g. hospital room	ו)	20%	Х
Hospital stay	Physician/surgeon fee		20%	
	Mental/Behavioral health outp	atient services	\$40	
Mental health, behavioral	Mental/Behavioral health inpa	20%	Х	
health, or substance abuse needs	Substance use disorder outpa	\$40		
	Substance use disorder inpati	ent services	20%	х
Pregnancy	Prenatal care and preconcept	ion visits	No cost share	
regnancy	Delivery and all inpatient	Hospital	20%	X
	services	Professional	20%	
	Home health care Outpatient Rehabilitation serv	icos	20% \$40	
Help	Outpatient Habilitation service		\$40	
recovering or				
other special	Skilled nursing care		20%	Х
health needs	Durable medical equipment		20%	
	Hospice service		No cost share	
	Eye exam		No cost share	
Child eye care	1 pair of glasses per year (or of glasses)	contact lenses in lieu	No cost share	
Child dental care	Dental check-up - Preventive Dental Basic Services Dental Major Services		Not Covered	
	Orthodontics (medically neces	ssary)		

Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S
OUT OF POCKET COSTSSilver Copay Plan
100%-150% FPLSilver Copay Plan
150%-200% FPL

OUT OF POCKET COSTS		100%-150% FPL		Silver Copay Plan 150%-200% FPL	
Actuarial Value	e - AV Calculator	94.90	%	88.00%	
Overall deduct	ihle	\$0		N/A	
	bles for specific services	ψυ			
	Medical	\$0		\$500)
	Brand Drugs	\$0		\$50	
	Dental	Not Cove	ered	Not Cov	ered
Out–of–pocket	limit	\$2,25	0	\$2,25	0
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Service Type	onare	Applies	Onare	Applies
	Primary care visit or non-specialist practitioner			• • •	
Health care	visit to treat an injury or illness	\$3		\$15	
provider's office or					
clinic visit	Specialist visit	\$5		\$20	
	Preventive care/ screening/ immunization	No cost share		No cost share	
	-				
	Laboratory Tests	\$3		\$15	
	X-rays and Diagnostic Imaging	\$5 \$5		\$20 \$100	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
Drugs to treat	Generic drugs	\$3		\$5 \$15	V
liness or	Preferred brand drugs	\$5		\$15	X
condition	Non-preferred brand drugs	\$10		\$25	X
	Specialty drugs	10%		15%	Х
Dutpatient	Facility fee (e.g., ASC)	10%		15%	
surgery	Physician/surgeon fees	10%		15%	
	Emergency room services (waived if admitted)	\$25		\$75	Х
Veed	Emergency medical transportation	\$25		\$75	Х
mmediate					
attention	Urgent care	\$6		\$30	
	Facility fee (e.g. hospital room)				
Hospital stay	Physician/surgeon fee	10%		15%	Х
	Mental/Behavioral health outpatient services	¢o		¢1E	
		\$3		\$15	
Mental health,					
	Mental/Behavioral health inpatient services	10%		15%	х
nealth, or		1070		1070	~
substance					
	Substance use disorder outpatient services	\$3		\$15	
				4	
	Substance use disorder inpatient services	10%		15%	Х
	Prenatal care and preconception visits	No cost share		No cost share	
Pregnancy	Delivery and all inpatient Hospital				
	services Professional	10%		15%	Х
	Home health care	\$3		\$15	
	Outpatient Rehabilitation services	\$3		\$15 \$15	
lelp	Outpatient Habilitation services	\$3		\$15	
ecovering or					
other special	Skilled nursing care	10%		15%	Х
-	Durable medical equipment	10%		15%	
	Hospice service	No cost share		No cost share	
	· · · · · · · · · · · · · · · · · · ·				
Child eve care	Eye exam 1 pair of glasses per year (or contact lenses in lieu	No cost share		No cost share	
	of glasses)	No cost share		No cost share	
	Dental check-up - Preventive and Diagnostic				
Child dental	Dental Basic Services	Nation	arad	Net O	متمعا
child dental		Not Covered		Not Covered	
care	Dental Major Services	NOL COV	eieu		ereu

Summary of Benefits and Coverage

COST SHARIN	G AMOUNTS DESCRIBE TH		Silver Copa	-
OUT OF POCK			200%-2509	-
	e - AV Calculator		74.009	/o
Overall deduct			N/A	
Other deductib	bles for specific services		.	
	Medical Brend Druge		\$1,60	
	Brand Drugs Dental		\$250 Not Cove	
Out-of-pocket			\$5,20	
out of poone			¢0,±0	-
Common Medical Event	Service Typ)e	Member Cost Share	Deductible Applies
Health care provider's	Visit to treat an injury or illness		\$40	
office or clinic visit	Specialist visit		\$50	
CITIIC VISIC	Preventive care/ screening/ ir	nmunization	No cost share	
	Laboratory Tests		\$40	
Tests	X-rays and Diagnostic Imagin		\$50	
	Imaging (CT/PET scans, MRIs)		\$250	
Drugs to treat	Generic drugs		\$15	
illness or	Preferred brand drugs		\$30	X
condition	Non-preferred brand drugs		\$50	X
	Specialty drugs	20%	X	
Outpatient	Facility fee (e.g., ASC)		20%	
surgery	Physician/surgeon fees		20%	X
	Emergency room services (wa Emergency medical transport		\$250 \$250	X X
Need immediate attention	Urgent care		\$80	~~~
Hospital stay	Facility fee (e.g. hospital roon	ו)	20%	Х
nospital stay	Physician/surgeon fee		2076	^
Mental health,	Mental/Behavioral health outp	patient services	\$40	
behavioral health, or	Mental/Behavioral health inpa	tient services	20%	Х
substance abuse needs	Substance use disorder outpa	\$40		
	Substance use disorder inpat	ient services	20%	х
Pregnancy	Prenatal care and preconcept		No cost share	
	Delivery and all inpatient services	Hospital Professional	20%	X
	Home health care	•	\$40	
Liele	Outpatient Rehabilitation serv		\$40	
Help	Outpatient Habilitation service	25	\$40	
recovering or other special	Skilled nursing care		20%	Х
health needs	Durable medical equipment		20%	
	Hospice service		No cost share	
	Eye exam		No cost share	
Child eye care	of glasses)		No cost share	
Child dental care	Dental check-up - Preventive Dental Basic Services Dental Major Services		Not Cove	ered
	Orthodontics (medically neces	ssary)		

Summary of Benefits and Coverage

Overall deduct	ible		60.6	00/			
		Actuarial Value - AV Calculator		60.60%		59.40%	
Other deductik	Diverall deductible Diver deductibles for specific services		\$5,000 integrate	d Med/Rx Ded	\$4,500 integrated Med/F		
	oles for specific services Medical						
Brand Drugs			N//		N/A		
	Dental		N// Not Co		N/A Not Cov		
Out-of-pocket			\$6,2		\$6,25		
out of poole			+-;-		÷-;	-	
Common Medical Event	Service Typ	be	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Health care provider's	Primary care visit or non-spective visit to treat an injury or illnes		\$60	See Note 4	40%	х	
office or clinic visit	Specialist visit		\$70	Х	40%	Х	
	Preventive care/ screening/ ir	nmunization	No cost share		No cost share		
	Laboratory Tests		30%	Х	40%	Х	
Tests	X-rays and Diagnostic Imagin	-	30%	X	40%	Х	
	Imaging (CT/PET scans, MRI	s)	30%	X	40%	<u>X</u>	
Drugs to treat	Generic drugs		\$15 \$50	X	40%	X	
illness or	Preferred brand drugs		\$50	X	40%	X	
condition	Non-preferred brand drugs		\$75	X	40%	X	
Outractic at	Specialty drugs Facility fee (e.g., ASC)		30%	X X	40%	X	
Outpatient	Physician/surgeon fees		30% 30%	X	40% 40%		
surgery	Emergency room services (w	aived if admitted)	\$300	<u>х</u>	40%	X X	
	Emergency medical transport		\$300	X	40%	X	
Need immediate attention	Urgent care		\$120	See Note 4	40%	X	
	Facility fee (e.g. hospital roon	n)	30%	Х	40%	Х	
Hospital stay	Physician/surgeon fee		30%	Х	40%	Х	
Mandal haakk	Mental/Behavioral health outp	patient services	\$60	See Note 4	40%	х	
Mental health, behavioral health, or	Mental/Behavioral health inpa	atient services	30%	х	40%	Х	
substance abuse needs	Substance use disorder outpatient services		\$60	See Note 4	40%	х	
	Substance use disorder inpat	ient services	30%	х	40%	х	
Pregnancy	Prenatal care and preconcept		No cost share		No cost share		
	Delivery and all inpatient	Hospital	30%	X	40%	X	
	services	Professional	30%	X	40%	<u>X</u>	
	Home health care Outpatient Rehabilitation serv	vices	30% \$60	X X	40% 40%	X X	
Help	Outpatient Renabilitation service		\$60	X	40%	X	
recovering or		,,,					
other special	Skilled nursing care		30%	Х	40%	Х	
health needs	Durable medical equipment		30%	Х	40%	Х	
	Hospice service		No cost share	х	No cost share	х	
	Eye exam		No cost share		No cost share		
Child eye care	1 pair of glasses per year (or of glasses)		No cost share		No cost share		
Child dental care	Dental check-up - Preventive Dental Basic Services Dental Major Services Orthodontics (medically nece		Not Co	vered	Not Covered		

Summary of Benefits and Coverage

-	Benefits and Coverage			
OUT OF POCK		E ENROLLEE 5	Catastroph	ic Plan
Actuarial Value	e - AV Calculator			
Overall deduct	tible		\$6,600 integrat	ed Med/Ry
	bles for specific services			
	Medical		N/A	
	Brand Drugs		N/A	
	Dental		Not Cove	
Out-of-pocke	t limit		\$6,60	0
Common Medical Event	Service Typ		Member Cost Share	Deductible Applies
	Service Typ	e	onaro	After 1st
	Primary care visit or non-spec	alist practitioner		non-
Health care	visit to treat an injury or illness		0%	preventive
provider's office or				visits
clinic visit	Specialist visit		0%	Х
	Preventive care/ screening/ in	nmunization	No cost share	
Toots	Laboratory Tests	~	0%	X
Tests	X-rays and Diagnostic Imaging	-	0%	X
	Imaging (CT/PET scans, MRI Generic drugs	>/	0% 0%	X
Drugs to treat	Preferred brand drugs		0%	X
illness or	Non-preferred brand drugs		0%	X
condition	Specialty drugs		0%	X
Outpatient	Facility fee (e.g., ASC)		0%	X
surgery	Physician/surgeon fees		0%	X
Surgery	Emergency room services (wa	aived if admitted)	0%	X
	Emergency medical transporta		0%	X
Need		0,0	After 1st	
immediate	Lingant core		00/	non-
attention	Urgent care	0%	preventive	
				visits
Hospital stay	Facility fee (e.g. hospital room	n)	0%	X
,	Physician/surgeon fee		0%	X
				After 1st
	Mental/Behavioral health outp	atient services	0%	non-
				preventive visits
Mental health,				
behavioral	Mental/Behavioral health inpa	tient services	0%	Х
health, or substance				After 1st
abuse needs	Substance use disorder outpa	tient services	0%	non-
			070	preventive
				visits
	Substance use disorder inpati	ent services	0%	Х
	Prenatal care and preconcept	ion visite	No cost share	
Pregnancy				
, sinally	Delivery and all inpatient	Hospital	0%	X
	services	Professional	0%	<u>X</u>
	Home health care	icos	0%	X
Help	Outpatient Rehabilitation serv Outpatient Habilitation service		0% 0%	X
recovering or				
other special	Skilled nursing care		0%	Х
health needs	Durable medical equipment		0%	Х
	Hospice service		No cost share	X
Child ave acre	Eye exam	ontost longes in lin	No cost share	
Child eye care	Eye exam 1 pair of glasses per year (or o	contact lenses in lieu	No cost share No cost share	x
Child eye care	Eye exam			x
Child eye care Child dental	Eye exam 1 pair of glasses per year (or o of glasses)		No cost share	
	Eye exam 1 pair of glasses per year (or of of glasses) Dental check-up - Preventive			

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-ofpocket 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-ofpocket 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.