

Member Cost S	Benefits and Coverage	ollee's out of pocket costs.	Platinu Coinsurance	e Plan	Platinu Copay P	Plan
	e - AV Calculator		88.5 <u>89.</u>	<u>/</u> %	89.5 <u>90.</u>	<u>3</u> %
	cludes a deductible? dividual deductible		No \$0		No \$0	
Integrated Fa	mily deductible	diaal / Dharmaay / Dantal	\$0	1 40	\$0	. ¢0
	ductible, NOT integrated: Me ctible, NOT integrated: Medic		\$0 / \$0 / \$0 / \$0 /		\$0 / \$0 / \$0 / \$0 /	
	-of-pocket maximum		\$4,00		\$4,00	
	pocket maximum -only coverage deductible		\$8,00 N/A	U	\$8,00 N/A	U
HSA family pla	n: Individual deductible		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 inj	ury, illness, or condition	\$20		\$20	
Health care provider's office or clinic	Other practitioner office visit		\$20		\$20	
visit	Specialist visit		\$40		\$40	
	Preventive care/ screening/ im	munization	No charge		No charge	
	Laboratory Tests		\$20		\$20	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs		\$40 10%		\$40 \$150	
)				
	Tier 1		\$5		\$5	
Drugs to treat illness or	Tier 2		\$15		\$15	
condition	Tier 3		\$25		\$25	
	Tier 4		10% up to \$250 per script		10% up to \$250 per script	
Outpatient	Surgery facility fee (e.g., ASC)		10%		\$250	
services	Physician/surgeon fees Outpatient visit		10% 10%		\$40 10%	
	Emergency room facility fee (w	aived if admitted)	\$150		\$150	
Need	Emergency room physician fee	· · ·	10% <u>No charge</u>		No charge	
immediate attention	Emergency medical transporta	tion	\$150		\$150	
attention	Urgent care		\$40 <u>\$15</u>		\$40	
	- Facility fee (e.g. hospital room)		10%		\$250 per day up	
Hospital stay	Physician/surgeon fee		10%		to 5 days \$40	
	Mental/Behavioral health outpa	atient office visits	\$20 <u>\$15</u>		\$20 <u>\$15</u>	
	Mental/Behavioral health other	outpatient items and services	\$20		\$20	
	Mental/Rehavioral health inpat	ent facility fee (e.g.hospital room)	10%		\$250 per day up	
Mental health,	· · · · · · · · · · · · · · · · · · ·		-		to 5 days	
behavioral health, or	Mental/Behavioral health inpat	ent physician /surgeon fee	10%		\$40	
substance abuse needs	Substance Use disorder outpa	tient office visits	\$20		\$20	
	Substance Use disorder other	outpatient items and services	\$20		\$20	
	Substance Use inpatient facilit	y fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpatie	ent physician /surgeon fee	10%		\$40	
	Prenatal care and preconcepti	on visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	10%		\$250 per day up to 5 days	
	services	Professional	10%		\$40	
	Home health care Outpatient Rehabilitation servio	ces	10% \$20		\$20 \$20	
Help recovering or	Outpatient Habilitation services		\$20 <u>\$15</u> \$20 <u>\$15</u>		\$20 <u>\$15</u>	
other special	Skilled nursing care		10%		\$150 per day up to 5 days	
health needs	Durable medical equipment		10%		10%	
	Hospice service Eye exam		No charge No charge		No charge No charge	
Child eye care	-	ontact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	- *	, ·			
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray					
and Preventive	Sealants per Tooth Topical Fluoride Application		Not Covered		Not Covered	
Child Dental	Space Maintainers - Fixed					
Basic Services	Amalgam Fill - 1 Surface <u>Resto</u> Periodontal Maintenance Serv		Not Covered		Not Covered	
	Root Canal-Molar Crowns and	l Casts	_		Not Covered	
Child Dental	Gingivectomy per Quad Endoo Extraction- Single Tooth Expos	<u>Iontics</u> sed Root or Erupted Periodontics	Not Occurry 1		Not Covered	
Major Services	(other than maintenance)	· · · · · · · · · · · · · · · · · · ·	Not Covered		Not Covered	
	Extraction- Complete Bony Pro Porcelain with Metal Crown Or				Not Covered Not Covered	
Child Orthodontics	Medically necessary orthodont	ics	Not Covered		Not Covered	

	hare amounts describe the En	rollee's out of pocket costs.	Gold Coinsurand	e Plan	Gold Copay P	lan
	e - AV Calculator		80.2 <u>80.</u> No	<u>3</u> 70	81.0 <u>81.</u> No	<u><</u> 70
Integrated Inc	cludes a deductible? dividual deductible		No \$0		No \$0	
	mily deductible ductible, NOT integrated: M	edical / Pharmacy / Dental	\$0 \$0 / \$0 /	\$0	\$0 \$0 / \$0 /	\$0
	tible, NOT integrated: Medi -of–pocket maximum	cal / Pharmacy / Dental	\$0 / \$0 / \$ 6,200 6		\$0 / \$0 / \$ 6,200 <u>6</u>	
amily Out-of-	oocket maximum		\$1 2,4 00 <u>1</u>		\$ 12,4 00 <u>1</u>	
	-only coverage deductible n: Individual deductible		N/A N/A		N/A N/A	
Common Medical Event	S	ervice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductibl Applies
	Primary care visit to treat an in	njury, illness, or condition	\$35		\$35	
Health care provider's office or clinic /isit	Other practitioner office visit		\$35		\$35	
	Specialist visit		\$55		\$55	
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge \$35		No charge \$35	
Fests	X-rays and Diagnostic Imagin	-	\$50 \$50 \$55		\$50 \$50 <u>\$55</u>	
	Imaging (CT/PET scans, MR	s)	20%		\$250 <u>\$275</u>	_
	Tier 1		\$15		\$15	
Drugs to treat Ilness or	Tier 2		\$50		\$50	
condition	Tier 3		\$70 <u>\$75</u>		\$70	
	Tier 4)	20% up to \$250 per script 20%		20% up to \$250 per script	
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	/	20%		\$600 \$55	
services	Outpatient visit		20%		20%	
	Emergency room facility fee (waived if admitted)	\$250 <u>\$325</u>		\$250 <u>\$325</u>	
veed mmediate	Emergency room facility fee (waived if admitted) \$250 \$325 Emergency room physician fee (waived if admitted) 20% No charge Emergency medical transportation \$250		No charge \$250			
attention	Urgent care		\$60		\$60	
Hospital stay	Facility fee (e.g. hospital roon	1)	20%		\$600 per day up to 5 days	
iospital stay	Physician/surgeon fee		20%		\$55	_
	Mental/Behavioral health outp	patient office visits	\$35		\$35	
	Mental/Behavioral health other outpatient items and services		\$35		\$35	
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%		\$600 per day up	
Mental health,			-		to 5 days	
pehavioral nealth, or	Mental/Behavioral health inpa	tient physician /surgeon iee	20%		\$55	
substance abuse needs	Substance Use disorder outp	atient office visits	\$35		\$35	
	Substance Use disorder other outpatient items and services		\$35		\$35	
	Substance Use inpatient facil	ity fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpat	ient physician /surgeon fee	20%		\$55	
	Prenatal care and preconcep		No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%		\$600 per day up to 5 days	
	services	Professional	20%		\$55	
lol-	Home health care Outpatient Rehabilitation serv	ices	20% \$35		\$30 \$35 <u>\$30</u>	
Help recovering or	Outpatient Habilitation service		\$35 <u>\$30</u>		\$35 <u>\$30</u>	
other special	Skilled nursing care		20%		\$300 per day up to 5 days	
nealth needs	Durable medical equipment Hospice service		20%		20%	_
	Eye exam		No charge No charge		No charge No charge	
Child eye care	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge		No charge	
Child Dontol	Oral Exam					
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		Not Covered		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed					
Child Dental Basic	Amalgam Fill - 1 Surface Res	torative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Ser Root Canal-Molar <u>Crowns ar</u>				Not Covered	
Child Dental	Gingivectomy per Quad Endo	odontics			Not Covered	
Major	Extraction- Single Tooth Expo (other than maintenance)	osed Root or Erupted Periodontics	Not Covered		Not Covered	
Services	Extraction- Complete Bony P Porcelain with Metal Crown C				Not Covered Not Covered	
					not covered	_
Child	Medically necessary orthodor		Not Covered		Not Covered	

Member Cost S	hare amounts describe the Enr	ollee's out of pocket costs.	Silver Plan	1
	e - AV Calculator		70.4 71.5%	
	cludes a deductible?			_
Integrated Inc	dividual deductible		Yes, Medical/Pha N/A	annacy
	mily deductible ductible, NOT integrated: Me	dical / Pharmacy / Dental	N/A \$ 2,250 <u>2.500</u> / \$2	50 / \$0
Family deduc	tible, NOT integrated: Medic		\$ 4,500 5,000/ \$5	00 / \$0
	-of–pocket maximum pocket maximum		\$ 6250 <u>6.80</u> \$ 12,500 <u>13.6</u>	
HSA plan: Self	-only coverage deductible		N/A	_
HSA family pla	n: Individual deductible		N/A	_
Common				Deductible
Medical Event	Se	rvice Type	Member Cost Share	Applies
	Primary care visit to treat an inj	jury, illness, or condition	\$45 \$35	
Health care provider's office or clinic	Other practitioner office visit		\$45	
visit	Specialist visit		\$70	
	Preventive care/ screening/ im	munization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging		\$35 \$65 \$70	
	Imaging (CT/PET scans, MRIs		\$250 <u>\$300</u>	
	Tier 1		\$15	
Drugs to treat illness or condition	Tier 2		\$50	Pharmacy deductible
	Tier 3		\$70	Pharmacy deductible
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees		20%	
services	Outpatient visit		20% 20%	
	Emergency room facility fee (w	vaived if admitted)	\$250 <u>\$350</u>	×
	Emergency room physician fee	e (waived if admitted)	\$50 <u>No charge</u>	×
Veed mmediate	Emergency medical transportation		\$250	X
attention				
	Urgent care		\$90 <u>\$35</u>	
Hospital stay	Facility fee (e.g. hospital room)		20%	х
	Physician/surgeon fee		20%	X
	Mental/Behavioral health outpa	atient office visits	\$45	
	Mental/Behavioral health other	outpatient items and services	\$45	
	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	20%	Х
Mental health,	· · · · · · · · · · · · · · · · · · ·			
pehavioral nealth, or	Mental/Behavioral health inpat	ient physician /surgeon fee	20%	Х
substance abuse needs	Substance Use disorder outpa	\$45		
	Substance Use disorder other	outpatient items and services	\$45	
	Substance Use inpatient facilit	y fee (e.g. hospital room)	20%	х
	Substance use disorder inpatie	ent physician /surgeon fee	20%	х
	Prenatal care and preconcepti		No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	х
	services	Professional	20%	Х
	Home health care Outpatient Rehabilitation servio	Ces	\$45 <u>\$45 \$35</u>	
Help recovering or	Outpatient Habilitation services		\$45 <u>\$35</u>	
other special	Skilled nursing care		20%	Х
health needs	Durable medical equipment		20%	
	Hospice service Eye exam		No charge No charge	
		ontact lenses in lieu of glasses)	No charge	
Child eye care	1 pair of glasses per year (or co			
	Oral Exam			
Child Dental			Not Covered	
Child Dental Diagnostic and	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth		Not Covered	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray		Not Covered	
Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	orative Procedures		
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		Not Covered	
Child Dental Diagnostic and Preventive Child Dental Basic Services	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Rester Periodontal Maintenance Serv Root Canal-Molar Crowns and	ices 1 Casts		
Child Dental Diagnostic and Preventive Child Dental Basic Services	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Rester Periodontal Maintenance Serv Root Canal- Molar Crowns and Gingivectomy per Quad Endoor Extraction- Single Tooth Expose	ices 1 Casts	Not Covered	
Child Dental Diagnostic and Preventive Child Dental Basic Services	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Restor Periodontal Maintenance Serv Root Canal- Molar Crowns and Gingivectomy per Quad Endoor Extraction - Single Tooth Expose (other than maintenance)	i <u>ces</u> <u>d Casts</u> <u>dontics</u> sed Root or Erupted Periodontics		
Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Rester Periodontal Maintenance Serv Root Canal- Molar Crowns and Gingivectomy per Quad Endoor Extraction- Single Tooth Expose	ices d Casts dontics sed Root or Erupted Periodontics osthodontics	Not Covered	

Member Cost Sl	Benefits and Coverage		SHOP <u>CCS</u> Silver Coinsurance	Plan	SHOP <u>CCS</u> Silver Copay Pla	n	
	e - AV Calculator		71.6 <u>71.6</u> %		71.3 71.3%		
	cludes a deductible?		Yes, Medical/Pha	armacy	Yes, Medical/Pharmacy N/A N/A \$ 1,500 <u>2.000</u> / \$250 / \$0		
Individual de	mily deductible ductible, NOT integrated: M		N/A \$ 1,500 <u>2.000</u> / \$2				
Individual Out-	tible, NOT integrated: Medi -of–pocket maximum	cal / Pharmacy / Dental	\$ 3,000 4 <u>,000</u> / \$5 \$6,500 <u>6.80</u>	<u>00</u>	\$ 3,000 4 <u>,000</u> / \$5 \$ 6,500 <u>6,80</u>	<u>)0</u>	
HSA plan: Self	pocket maximum -only coverage deductible		\$ 13,0 00 <u>13.6</u> N/A	<u>500</u>	\$ 13, 000 <u>13.6</u> N/A	<u>500</u>	
HSA family pla	n: Individual deductible		N/A	_	N/A	_	
Common				Deductible		Deductible	
Medical Event	S.	ervice Type	Member Cost Share	Applies	Member Cost Share	Applies	
	Primary care visit to treat an in	njury, illness, or condition	\$45		\$45		
Health care provider's office or clinic visit	Other practitioner office visit		\$45		\$45		
	Specialist visit		\$70 <u>\$75</u>		\$70 <u>\$75</u>		
	Preventive care/ screening/ in	nmunization	No charge		No charge		
Tests	Laboratory Tests X-rays and Diagnostic Imagin	a	\$35		\$35		
	Imaging (CT/PET scans, MR	-	20%	X	\$250 <u>\$300</u>		
	Tier 1		¢15		¢15		
			\$15		\$15		
Drugs to treat illness or	Tier 2		\$55	Pharmacy deductible	\$55	Pharmac deductibl	
condition	Tier 3		\$75	Pharmacy deductible	\$75	Pharmac deductibl	
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible	Pharmac deductibl	
	Surgery facility fee (e.g., ASC)	20%		20%		
Outpatient services	Physician/surgeon fees		20%		20%		
	Outpatient visit		20%		20%		
	Emergency room facility fee (waived if admitted)	\$250 <u>\$350</u>	X	\$250 <u>\$350</u>	×	
Need	Emergency room physician fe	e (waived if admitted)	\$50 <u>No charge</u>	×	\$50 <u>No charge</u>	×	
immediate	Emergency medical transport	ation	\$250	Х	\$250	Х	
attention	Urgent care		\$90		\$90		
Hospital stay	Facility fee (e.g. hospital roon))	20%	x	20%	x	
	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	Mental/Behavioral health inpa	tient physician/ surgeon fee	20%	х	20%	х	
health, or substance	Substance Use disorder outp		\$45	A	\$45	A	
abuse needs							
	Substance Use disorder othe	r outpatient items and services	\$45		\$45		
	Substance Use inpatient facil	ty fee (e.g. hospital room)	20%	х	20%	х	
	Substance use disorder inpat	ient physician /surgeon fee	20%	х	20%	Х	
	Prenatal care and preconcep	tion visits	No charge		No charge		
Pregnancy	Delivery and all inpatient	Hospital	20%	х	20%	х	
	services	Professional	20%	X	20%	X	
	Home health care Outpatient Rehabilitation serv	ices	20% \$45		\$45 \$45		
Help recovering or	Outpatient Habilitation service		\$45		\$45		
other special	Skilled nursing care		20%	х	20%	х	
health needs	Durable medical equipment		20%		20%		
	Hospice service Eye exam		No charge No charge		No charge No charge		
Child eye care	-	contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam						
	Preventive - Cleaning						
Diagnostic and Preventive	Preventive - X-ray Sealants per Tooth Topical Fluoride Application		Not Covered		Not Covered		
revenuve	Space Maintainers - Fixed						
Dasic	Amalgam Fill - 1 Surface Res	torative Procedures	Not Covered		Not Covered		
Services	Periodontal Maintenance Ser				Net On and		
	Root Canal-Molar Crowns an Gingivectomy per Quad Endo				Not Covered Not Covered		
		osed Root or Erupted Periodontics	Not Covered		Not Covered		
	v .		Not Covered				
Child Dental Major Services	(other than maintenance)	·			Not Covered		
Major	v .	rosthodontics					

-	Benefits and Coverage nare amounts describe the En	rollee's out of pocket costs.	SHOP <u>CC</u> Silver	_
	- AV Calculator		HSA HDHP 70.5 71.3	
	cludes a deductible?		Yes, integra	
Integrated Inc	lividual deductible		\$2,000 integ	rated
Individual dec	mily deductible ductible, NOT integrated: Me		\$4,000 integ	rated
	tible, NOT integrated: Medic of–pocket maximum	al / Pharmacy / Dental	N/A \$ 6,250 6.6	50
Family Out-of-p	oocket maximum		\$ 12,500 <u>13</u> ,	
	only coverage deductible n: Individual deductible		\$2,000 \$2,600	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applie
	Primary care visit to treat an in	jury, illness, or condition	20%	х
Health care provider's office or clinic	Other practitioner office visit		20%	х
visit	Specialist visit		20%	х
	Preventive care/ screening/ im	munization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	1	20% 20%	X X
	Imaging (CT/PET scans, MRI		20%	X
	Tier 1		20% <u>up to \$250 per script</u>	х
Drugs to treat illness or condition	Tier 2		20% <u>up to \$250 per script</u>	х
	Tier 3		20% <u>up to \$250 per script</u>	х
	Tier 4		20% up to \$250 per script	x
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees		20% 20%	X X
services	Outpatient visit		20%	Х
	Emergency room facility fee (v	vaived if admitted)	20%	Х
	Emergency room physician fe	e (waived if admitted)	20%	х
Need immediate	Emergency medical transportation		20%	Х
attention	Urgent care		20%	x
Hospital stay	Facility fee (e.g. hospital room)	20%	х
,	Physician/surgeon fee		20%	Х
	Mental/Behavioral health outp	atient office visits	20%	х
	Mental/Behavioral health othe	r outpatient items and services	20%	х
	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpat	ient physician /surgeon fee	20%	х
health, or substance abuse needs	Substance Use disorder outpatient office visits		20%	x
	Substance Use disorder other outpatient items and services		20%	х
	Substance Lise innetiont facili	tu foo (o a hoopital room)	20%	v
	Substance Use inpatient facilit		20%	X
	Substance use disorder inpati		20%	X
Drogness	Prenatal care and preconcept		No charge	
Pregnancy	Delivery and all inpatient services	Hospital Professional	20%	x
	Home health care		20%	Х
Help	Outpatient Rehabilitation servi Outpatient Habilitation service		20% 20%	X X
recovering or other special	Skilled nursing care		20%	x
health needs	Durable medical equipment		20%	X
	Hospice service		0%	X
Child eye care	Eye exam 1 pair of glasses per year (or c	ontact lenses in lique of closess)	No charge	
	1 pair of glasses per year (or c Oral Exam	ontaot ienses in lieu of glasses)	No charge	
Child Dental	Preventive - Cleaning			
Diagnostic and	Preventive - X-ray Sealants per Tooth		Not Covered	
Preventive	Topical Fluoride Application Space Maintainers - Fixed			
Child Dental		orative Dropodurop		
Basic Services	Amalgam Fill - 1 Surface Rest		Not Covered	
Jervices	Periodontal Maintenance Serverse Root Canal- Molar Crowns an			
Child Dental	Gingivectomy per Quad Endo	dontics		
	Extraction-Single Tooth Expo (other than maintenance)	sed Root or Erupted Periodontics	Not Covered	
	Extraction- Complete Bony Pr			
Major Services Child	. ,	ral Surgery	Not Covered	

Summary of Benefits and Coverage

Member Cost S	Benefits and Coverage hare amounts describe the Er - AV Calculator		Silver P 100%-150 ⁰ 93.8 <u>94.</u>	% FPL	Silver Plan 150%-200% FF 86.8 <u>87.5</u> %	Ľ
	cludes a deductible?		Yes, Medical/	Pharmacy	Yes, Medical/Phan	macy
	dividual deductible mily deductible		N/A N/A		N/A N/A	
Individual de	ductible, NOT integrated: M		\$75 / \$0		\$ 550 <u>650</u> / \$50 /	
	tible, NOT integrated: Medi	cal / Pharmacy / Dental	\$150 / \$0 \$ 2,250 2		\$1,100 <u>1.300</u> / \$10	
	-of–pocket maximum pocket maximum		\$ 2,250 <u>2</u> \$4,500 <u>4</u>		\$ 2,250 <u>2.350</u> \$ 4,500 <u>4,700</u>	
ISA plan: Self	-only coverage deductible		N/A		N/A	
ISA family pla	n: Individual deductible		N/A		N/A	
Common Medical Event	s	ervice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductibl Applies
	Primary care visit to treat an i	njury, illness, or condition	\$5		\$15	
Health care provider's office or clinic	Other practitioner office visit		\$5		\$15	
visit	Specialist visit		\$8		\$25	
	Preventive care/ screening/ in	nmunization	No charge		No charge	
	Laboratory Tests		\$8		\$15	
ests	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MR	-	\$8 \$50		\$25 \$100	
	Tier 1		\$3		\$5	
Drugs to treat llness or	Tier 2		\$10		\$20	Pharmao deductib
condition	Tier 3		\$15		\$35	Pharmac deductib
	Tier 4		10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmac deductib
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	;)	10% 10%		15% 15%	
services	Outpatient visit		10%		15%	
		(waived if admitted)		v		v
	Emergency room facility fee		\$30 <u>\$50</u>	×	\$75 <u>\$100</u>	¥
leed	Emergency room physician f	ee (waived if admitted)	\$25 <u>No charge</u>	×	\$40 <u>No charge</u>	X
mmediate	Emergency medical transpor	tation	\$30	Х	\$75	Х
ittention	Urgent care		\$6		\$30	
Hospital stay	Facility fee (e.g. hospital roor	n)	10%	х	15%	Х
	Physician/surgeon fee		10%	X	15%	Х
	Mental/Behavioral health out	patient office visits	\$5		\$15	
	Mental/Behavioral health oth	er outpatient items and services	\$5		\$15	
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	10%	х	15%	х
Mental health, behavioral	Mental/Behavioral health inpa	atient physician /surgeon fee	10%	х	15%	х
nealth, or substance	Substance Use disorder out		\$5		\$15 <u>\$10</u>	
abuse needs			Ψ3		φτο <u>φτο</u>	
	Substance Use disorder othe	er outpatient items and services	\$5		\$15	
	Substance Use inpatient faci	lity fee (e.g. hospital room)	10%	х	15%	Х
	Substance use disorder inpa	tient physician /surgeon fee	10%	Х	15%	Х
	Prenatal care and preconcep	tion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	10%	х	15%	Х
	services	Professional	10%	Х	15%	Х
	Home health care	ires	\$3 \$5		\$15 \$15 \$10	
lelp	Outpatient Rehabilitation service		\$5		\$15	
ecovering or other special	Skilled nursing care		10%	х	15%	х
nealth needs	Durable medical equipment		10%		15%	
	Hospice service		No charge		No charge	
bild our	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					
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray					
ind Preventive	Sealants per Tooth Topical Fluoride Application		Not Covered		Not Covered	
	Space Maintainers - Fixed				1	
Child Dental Basic Services	Amalgam Fill - 1 Surface <u>Res</u>		Not Covered		Not Covered	
Services	Periodontal Maintenance Se Root Canal- Molar Crowns a		-			
Child Dental	Gingivectomy per Quad End	odontics				
Child Dental Major Services	Extraction- Single Tooth Exp (other than maintenance) Extraction- Complete Bony F	osed Root or Erupted Periodontics Prosthodontics	Not Covered		Not Covered	
	Porcelain with Metal Crown					
Child	Medically necessary orthodo	ntics	Not Covered		Not Covered	
Orthodontics	, see any oranged					

Actuarial Mal	hare amounts describe the Enro	llee's out of pocket costs.	Silver Plan 200%-250% FP 72.8.73.7%	Ľ
	e - AV Calculator cludes a deductible?		72.8 73.7% Yes, Medical/Pham	nacy
Integrated Inc	lividual deductible		N/A	пасу
	mily deductible ductible, NOT integrated: Med	ical / Pharmacy / Dental	N/A \$ 1,900 2.200 / \$250	0 / \$0
Family deduc	tible, NOT integrated: Medica		\$ 3,800 <u>4,400</u> / \$500	
	-of–pocket maximum pocket maximum		\$ 5,450 <u>5.700</u> \$ 10,9 00 <u>11.40</u> (<u>0</u>
	-only coverage deductible n: Individual deductible		N/A N/A	
Common Medical Event	Sen	rice Туре	Member Cost Share	Deductibl Applies
	Primary care visit to treat an inju	ry, illness, or condition	\$40	
Health care provider's office or clinic	Other practitioner office visit		\$40	
visit	Specialist visit		\$55	
	Preventive care/ screening/ imm	unization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging		\$35 \$50 <u>\$65</u>	
	Imaging (CT/PET scans, MRIs)		\$250 <u>\$300</u>	
	Tier 1		\$15	
Drugs to treat illness or	Tier 2		\$45	Pharmac deductibl
condition	Tier 3		\$70	Pharmac deductibl
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmac deductibl
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees		20% 20%	
services	Outpatient visit		20%	
	Emergency room facility fee (wa	ived if admitted)	\$250 <u>\$350</u>	X
	Emergency room physician fee	(waived if admitted)	\$50 <u>No charge</u>	¥
Need immediate attention	Emergency medical transportation		\$250	Х
	Urgent care		\$80	
Hospital stay	Facility fee (e.g. hospital room)		20%	х
	Physician/surgeon fee		20%	Х
	Mental/Behavioral health outpat	ient office visits	\$40	
	Mental/Behavioral health other o	outpatient items and services	\$40	
	Mental/Behavioral health inpatie	nt facility fee (e.g.hospital room)	20%	Х
Mental health,	Mental/Behavioral health inpatie		20%	X
behavioral health, or			2070	~
substance abuse needs	Substance Use disorder outpati	ent office visits	\$40 <u>\$30</u>	
	Substance Use disorder other o	utpatient items and services	\$40	
	Substance Use inpatient facility	fee (e.g. hospital room)	20%	Х
	Substance use disorder inpatier	nt physician/surgeon fee	20%	х
	Prenatal care and preconceptio		No charge	~
Pregnancy		Hospital	20%	Х
	services	Professional	20%	X
	Home health care		\$40	
	Outpatient Rehabilitation service	75	\$40 <u>\$30</u>	
-	Outpatient Habilitation services		\$40 <u>\$30</u>	
recovering or other special			20%	Х
recovering or other special	Outpatient Habilitation services Skilled nursing care Durable medical equipment		20% 20%	X
recovering or other special	Outpatient Habilitation services Skilled nursing care		20%	X
recovering or other special health needs	Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service	tact lenses in lieu of glasses)	20% 20% No charge	X
Help recovering or other special health needs Child eye care	Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or con Oral Exam	tact lenses in lieu of glasses)	20% 20% No charge No charge	X
recovering or other special health needs	Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or con	tact lenses in lieu of glasses)	20% 20% No charge No charge No charge	X
recovering or other special health needs Child eye care Child Dental Diagnostic and	Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or con Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	tact lenses in lieu of glasses)	20% 20% No charge No charge	X
recovering or other special health needs Child eye care Child Dental Diagnostic and	Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or con Oral Exam Preventive - Cleaning Preventive - X-ray	tact lenses in lieu of glasses)	20% 20% No charge No charge No charge	X
recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental	Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or con Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application		20% 20% No charge No charge No charge No charge	X
recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or con Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	rative Procedures	20% 20% No charge No charge No charge	X
recovering or other special health needs Child eye care Child Dental	Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or con Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Restor Periodontal Maintenance Service Root Canal-Molar Crowns and	rative Procedures es Casts	20% 20% No charge No charge No charge No charge	X
recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental	Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or con Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Restor Periodontal Maintenance Servic Root Canal-Molar Crowns and Gingivectomy per Quad Endodo	rative Procedures es Casts	20% 20% 20% No charge No charge No charge No charge No charge Not Covered Not Covered	
recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services	Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or con Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Restor Periodontal Maintenance Service Root Canal-Molar Crowns and Gingivectomy per Quad Endodo	rative Procedures es Casts ontics ed Root or Erupted Periodontics sthodontics	20% 20% No charge No charge No charge No charge	

	hare amounts describe the Er	rollee's out of pocket costs.	Bronze Pla	n	Bronzo HSA HDHP	Plan	
	e - AV Calculator		61.9%		<u>61.06</u> <u>62.</u>	_	
	cludes a deductible?		Yes, Medical/Pha N/A	rmacy	Yes, integr \$4,500 integ		
	mily deductible	adiaal (Dharmaay (Dantal	N/A \$ 6.000 6.300 / \$500 / \$0		\$9,000 integrated		
	ductible, NOT integrated: M :tible, NOT integrated: Medi		\$ 12,0 00 <u>6.300</u> / \$5 \$1 2,0 00 <u>12.600</u> / \$1		N/A N/A		
	-of-pocket maximum		\$ 6,500 6.80	_	\$ 6,500 <u>6.</u>		
	pocket maximum -only coverage deductible		\$ 13,000 <u>13.6</u> N/A	00	\$1 3,000 <u>13</u> \$4,500		
HSA family pla	n: Individual deductible		N/A		\$4,500)	
Common					Member Cost	Deductible	
Medical Event		ervice Type	Member Cost Share	Deductible Applies		Applies	
Health care	Primary care visit to treat an i	ijury, liiness, or condition	\$70 <u>\$75</u>	non-preventive visits After 1st three	40%	X	
orovider's office or clinic ⁄isit	Other practitioner office visit		\$70 <u>\$75</u>	non-preventive visits After 1st three	40%	X	
	Specialist visit		\$90 <u>\$105</u>	non-preventive visits	40%	Х	
	Preventive care/ screening/ in Laboratory Tests	imunization	No charge \$40		No charge 40%	X	
Tests	X-rays and Diagnostic Imagin		100%	X	40%	Х	
	Imaging (CT/PET scans, MR	s)	100%	X	40%	X	
	Tier 1		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% <u>up to \$500</u> per script	х	
Drugs to treat Ilness or	Tier 2		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% <u>up to \$500</u> per script	х	
condition	Tier 3		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% <u>up to \$500</u> per script	х	
	Tier 4		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% <u>up to \$500</u> <u>per scrip</u> t	х	
Outpatient	Surgery facility fee (e.g., ASC)	100%	X	40%	X	
services	Physician/surgeon fees Outpatient visit		100% 100%	X X	40% 40%	X X	
	Emergency room facility fee (waived if admitted)	100%	X	40%	X	
	Emergency room physician fe	·	100% <u>No charge</u>	×	40% 0%	х	
veed mmediate	Emergency medical transport	. ,	100%	× X	40%	X	
attention	Urgent care		\$120	After 1st three non-preventive visits	40%	х	
Hospital stay	Facility fee (e.g. hospital roon	1)	100%	x	40%	Х	
	Physician/surgeon fee		100%	Х	40%	Х	
	Mental/Behavioral health outp	atient office visits	\$70 <u>\$75</u>	After 1st three non-preventive visits	40%	х	
	Mental/Behavioral health other outpatient items and services		\$70	After 1st three non-preventive visits	40%	х	
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	100%	Х	40%	Х	
Mental health,	Mental/Behavioral health inpa	tient physician /surgeon fee	100%	Х	40%	Х	
behavioral nealth, or substance	Substance Use disorder outp		\$70 <u>\$75</u>	After 1st three non-preventive	40%	x	
abuse needs				visits After 1st three			
	Substance Use disorder other outpatient items and services		\$70 <u>\$75</u>	non-preventive visits	40%	Х	
	Substance Use inpatient facil	ty fee (e.g. hospital room)	100%	х	40%	х	
	Substance use disorder inpat	ient physician /surgeon fee	100%	х	40%	Х	
	Prenatal care and preconcep	tion visits	No charge		No charge		
Pregnancy	Delivery and all inpatient	Hospital	100%	Х	40%	х	
	services	Professional	100%	Х	40%	Х	
	Home health care Outpatient Rehabilitation serv	ices	100% \$70 \$75	Х	40% 40%	X X	
Help recovering or	Outpatient Habilitation service		\$70 <u>\$75</u> \$70 <u>\$75</u>		40%	X	
other special	Skilled nursing care		100%	Х	40%	х	
nealth needs	Durable medical equipment		100%	Х	40%	Х	
	Hospice service Eye exam		No charge No charge		0% No charge	X	
Child eye care		contact lenses in lieu of alasses)	No charge		No charge		
	Oral Exam						
Child Dental	Preventive - Cleaning						
Diagnostic and Preventive	Preventive - X-ray Sealants per Tooth Topical Fluoride Application		Not Covered		Not Covered		
	Space Maintainers - Fixed						
Child Dental Basic Services	Amalgam Fill - 1 Surface <u>Res</u> Periodontal Maintenance Ser		Not Covered		Not Covered		
	Periodontal Maintenance Ser Root Canal-Molar Crowns and	nd Casts					
	Gingivectomy per Quad Endo	odontics					
Major	(other than maintenance)	osed Root or Erupted Periodontics	Not Covered		Not Covered		
Major	÷ .	rosthodontics	Not Covered		Not Covered		
Child Dental Major Services Child	(other than maintenance) Extraction- Complete Bony P	rosthodontics Dral Surgery	Not Covered		Not Covered		

Actuarial Value	e - AV Calculator		
Plan design ind	cludes a deductible?	Yes, inte	
	dividual deductible	\$ 6, 850 <u>7.15</u> \$ 13,700 <u>14,3</u>	
Individual de	ductible, NOT integrated: Medical / Pharmacy / Dental	N/	A
	tible, NOT integrated: Medical / Pharmacy / Dental -of–pocket maximum	N/ \$ 6,850	
Family Out-of-	oocket maximum	\$ 13,700	14.300
	-only coverage deductible n: Individual deductible	N/ N/	
Common Medical Event	Service Type	Member Cost Share	Deductibl Applies
	Primary care visit to treat an injury, illness, or condition	0%	After 1st the non-preven visits
Health care provider's office or clinic visit	Other practitioner office visit	0%	After 1st the non-preven visits
visit	Specialist visit	0%	х
	Preventive care/ screening/ immunization	No charge	Y
Tests	Laboratory Tests X-rays and Diagnostic Imaging	0% 0%	X X
	Imaging (CT/PET scans, MRIs)	0%	× X
	Tier 1	0%	х
Drugs to treat illness or	Tier 2	0%	х
condition	Tier 3	0%	х
	Tier 4	0%	х
Outpatient	Surgery facility fee (e.g., ASC)	0%	X
services	Physician/surgeon fees Outpatient visit	0% 0%	X
	Emergency room facility fee (waived if admitted)	0%	×
	Emergency room physician fee (waived if admitted)		×
Need	Emergency room physician fee (waived if admitted) Emergency medical transportation	0% <u>No charge</u>	×
immediate attention	Urgent care	0%	After 1st th non-preven visits
Hospital stay	Facility fee (e.g. hospital room)	0%	x
	Physician/surgeon fee	0%	X After 1st th
	Mental/Behavioral health outpatient office visits	0%	After 1st th non-preven visits
	Mental/Behavioral health other outpatient items and services	0%	After 1st the non-preven visits
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	0%	х
Mental health, behavioral	Mental/Behavioral health inpatient physician /surgeon fee	0%	х
health, or substance abuse needs	Substance Use disorder outpatient office visits	0%	After 1st th non-preven
	Substance Use disorder other outpatient items and services	0%	visits After 1st thi non-preven
			visits
	Substance Use inpatient facility fee (e.g. hospital room)	0%	X
	Substance use disorder inpatient physician/surgeon fee	0%	X
	Prenatal care and preconception visits	No charge	
Pregnancy	Delivery and all inpatient Hospital services	0%	Х
	Professional Home health care	0% 0%	X X
Help	Outpatient Rehabilitation services	0%	Х
recovering or	Outpatient Habilitation services	0%	Х
other special health needs	Skilled nursing care	0%	X
	Durable medical equipment Hospice service Eye exam	0% 0% No charge	X X
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X
Child Dental	Oral Exam Preventive - Cleaning		
Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Amalgam Fill - 1 Surface Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Root Canal- Molar Crowns and Casts		
Child Dental Major	Gingivectomy per Quad Endodontics Extraction-Single Tooth Exposed Root or Erupted Periodontics	Not Covered	
Services	(other than maintenance) Extraction- Complete Bony Prosthodontics Porcelain with Metal Crown Oral Surgery	NOT COVERED	
		1	
Child			