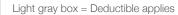
Family deductible and out-of-pocket maximum (OOPM) is 2x individual	Platinum 250	Platinum 500	Platinum 850		
In-network deductible / out-of-network deductible	<b>\$250</b> / \$3,000	<b>\$500</b> / \$3,000	<b>\$850</b> / \$3,000		
In-network OOPM / out-of-network OOPM	<b>\$4,000</b> / \$10,000 <b>\$4,000</b> / \$10,000 <b>\$850</b>		<b>\$850</b> / \$10,000		
Preventive care	Covered in full for in-network services				
Employee Assistance Program (4 counseling visits per incident)	Covered in full				
Behavioral health	\$20	\$20	0%		
Virtual care	\$10	\$10	0%		
Primary care provider	\$20	\$20	0%		
Specialist	\$30	\$30	0%		
Urgent care	\$30	\$30	0%		
Maternity	10%	10%	0%		
Inpatient hospital	10% 10%		0%		
Outpatient surgery and services	10% 10%		0%		
Outpatient lab and radiology	0%		0%		
Outpatient complex lab and imaging	10%		0%		
Outpatient rehab	\$20	\$20	0%		
Emergency room	\$250 plus 10% coinsurance	\$250 plus 10% coinsurance	0%		
Hearing aids and evaluation \$1,000 limit per calendar year, regardless of age	10%	10%	0%		
Pediatric vision up to age 19	Annual eye exam plus one pair of frames and lenses, or one pair of contacts per year				
Pediatric dental up to age 19	0% Preventive, 20% Basic, 50% Major				
Acupuncture / spinal manipulations (12 / 10 annual visit limit)	\$20 \$20		0%		
In-network coinsurance for other covered medical care	10%	10%	0%		
Out-of-network coinsurance for covered medical care	50% 50%		50%		
Optimum Value Medication List	N/A	N/A	Yes		
Rx Preferred generic	\$8	\$8	0%		
Rx Generic	\$30	\$35	0%		
Rx Preferred brand*	\$30	\$30	0%		
Rx Preferred specialty*	20%	20%	0%		

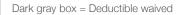


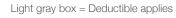


<sup>\*</sup>Non-preferred Rx brand and specialty may be available at a higher cost-share



Family deductible and out-of-pocket maximum (OOPM) is 2x individual	Gold 500	Gold 1000	Gold 1500	Gold 2000	Gold 2500
In-network deductible / out-of-network deductible	<b>\$500</b> / \$5,000	<b>\$1,000</b> / \$5,000	<b>\$1,500</b> / \$5,000	<b>\$2,000</b> / \$5,000	<b>\$2,500</b> / \$5,000
In-network OOPM / out-of-network OOPM	<b>\$7,500</b> / \$10,000	<b>\$7,000</b> / \$10,000	<b>\$8,550</b> / \$10,000	<b>\$5,750</b> / \$10,000	<b>\$7,350</b> / \$10,000
Preventive care		Covered i	n full for in-network	services	
Employee Assistance Program (4 counseling visits per incident)	Covered in full				
Behavioral health	\$30	\$30	\$30	\$30	\$30
Virtual care	\$10	\$10	\$10	\$10	\$10
Primary care provider	\$30	\$30	\$30	\$30	\$30
Specialist	\$50	\$50	\$50	\$50	\$50
Urgent care	\$50	\$50	\$50	\$50	\$50
Maternity	30%	30%	20%	25%	30%
Inpatient hospital	30%	30%	20%	25%	30%
Outpatient surgery and services	30%	30%	20%	25%	30%
Outpatient lab and radiology	30%	30%	20%	25%	30%
Outpatient complex lab and imaging	30%	30%	20%	25%	30%
Outpatient rehab	\$30	\$30	\$30	\$30	\$30
Emergency room	\$300 plus 30% coinsurance	\$300 plus 30% coinsurance	\$300 plus 20% coinsurance	\$300 plus 25% coinsurance	\$300 plus 30% coinsurance
Hearing aids and evaluation \$1,000 limit per calendar year, regardless of age	30%	30%	20%	25%	30%
Pediatric vision up to age 19	Annual eye e	xam plus one pair o	f frames and lenses	, or one pair of cont	acts per year
Pediatric dental up to age 19		0% Preve	entive, 20% Basic, 5	0% Major	
Acupuncture / spinal manipulations (12 / 10 annual visit limit)	\$30	\$30	\$30	\$30	\$30
In-network coinsurance for other covered medical care	30%	30%	20%	25%	30%
Out-of-network coinsurance for covered medical care	50%	50%	50%	50%	50%
Optimum Value Medication List	N/A	N/A	N/A	N/A	N/A
Rx Preferred generic	\$10	\$10	\$15	\$10	\$10
Rx Generic	\$35	\$35	\$35	\$35	\$35
Rx Preferred brand*	\$50	\$50	\$50	\$50	\$50
Rx Preferred specialty*	20%	20%	20%	20%	20%

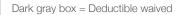


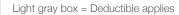


<sup>\*</sup>Non-preferred Rx brand and specialty may be available at a higher cost-share



Family deductible and out-of-pocket maximum (OOPM) is 2x individual	Silver 3000	Silver 5500	Bronze 8550		
In-network deductible / out-of-network deductible	<b>\$3,000</b> / \$5,000	<b>\$5,500</b> / \$7,500	<b>\$8,550</b> / \$10,000		
In-network OOPM / out-of-network OOPM	<b>\$8,550</b> / \$10,000	<b>\$8,550</b> / \$10,000 <b>\$7,500</b> / \$10,000 <b>\$8,550</b> /			
Preventive care	Covered in full for in-network services				
Employee Assistance Program (4 counseling visits per incident)	Covered in full				
Behavioral health	\$40	\$40	0%		
Virtual care	\$10	\$10	0%		
Primary care provider	\$40	\$40	0%		
Specialist	\$60	\$60	0%		
Urgent care	\$60	\$60	0%		
Maternity	35%	50%	0%		
Inpatient hospital	35%	35% 50%			
Outpatient surgery and services	35% 50%		0%		
Outpatient lab and radiology	35% 50%		0%		
Outpatient complex lab and imaging	35% 50%		0%		
Outpatient rehab	\$40	\$40	0%		
Emergency room	\$400 plus 35% coinsurance	\$400 plus 50% coinsurance	0%		
Hearing aids and evaluation \$1,000 limit per calendar year, regardless of age	35%	50%	0%		
Pediatric vision up to age 19	Annual eye exam plus one pair of frames and lenses, or one pair of contacts per year				
Pediatric dental up to age 19	0% Preventive, 20% Basic, 50% Major				
Acupuncture / spinal manipulations (12 / 10 annual visit limit)	\$40 \$40		0%		
In-network coinsurance for other covered medical care	35%	50%	0%		
Out-of-network coinsurance for covered medical care	50% 50%		50%		
Optimum Value Medication List	N/A	N/A	Yes		
Rx Preferred generic	\$20	\$20	0%		
Rx Generic	\$35	\$35	0%		
Rx Preferred brand*	\$60	\$60	0%		
Rx Preferred specialty*	20%	20%	0%		





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Family deductible and out-of-pocket maximum (OOPM) is 2x individual	Gold HSA 1500	Silver HSA 2500	Silver HSA Embedded 3000	Silver HSA 3500	Silver HSA 4850	Bronze HSA 5500
In-network deductible / out-of-network deductible	<b>\$1,500</b> / \$5,000	<b>\$2,500</b> / \$5,000	<b>\$3,000</b> / \$5,000	<b>\$3,500</b> / \$5,000	<b>\$4,850</b> / \$5,000	<b>\$5,500</b> / \$10,000
In-network OOPM / out-of-network OOPM	<b>\$4,500</b> / \$10,000	<b>\$6,900</b> / \$10,000	<b>\$6,000</b> / \$10,000	<b>\$6,900</b> / \$10,000	<b>\$4,850</b> / \$10,000	<b>\$7,000</b> / \$15,000
Preventive care		Co	vered in full for i	n-network servi	ces	
Employee Assistance Program (4 counseling visits per incident)	Covered in full					
Behavioral health	20%	30%	25%	20%	0%	50%
Virtual care	20%	30%	25%	20%	0%	50%
Primary care provider	20%	30%	25%	20%	0%	50%
Specialist	20%	30%	25%	20%	0%	50%
Urgent care	20%	30%	25%	20%	0%	50%
Maternity	20%	30%	25%	20%	0%	50%
Inpatient hospital	20%	30%	25%	20%	0%	50%
Outpatient surgery and services	20%	30%	25%	20%	0%	50%
Outpatient lab and radiology	20%	30%	25%	20%	0%	50%
Outpatient complex lab and imaging	20%	30%	25%	20%	0%	50%
Outpatient rehab	20%	30%	25%	20%	0%	50%
Emergency room	20%	30%	25%	20%	0%	50%
Hearing aids and evaluation \$1,000 limit per calendar year, regardless of age	20%	30%	25%	20%	0%	50%
Pediatric vision up to age 19	Annual ey	e exam plus one	pair of frames a	ınd lenses, or on	e pair of contac	ts per year
Pediatric dental up to age 19		0%	Preventive, 20%	% Basic, 50% Ma	ajor	
Acupuncture / spinal manipulations (12 / 10 annual visit limit)	20%	30%	25%	20%	0%	50%
In-network coinsurance for other covered medical care	20%	30%	25%	20%	0%	50%
Out-of-network coinsurance for covered medical care	50%	50%	50%	50%	50%	50%
Optimum Value Medication List	Yes	Yes	Yes	Yes	Yes	Yes
Rx Preferred generic	10%	10%	10%	10%	0%	50%
Rx Generic	25%	25%	25%	25%	0%	50%
Rx Preferred brand*	25%	35%	35%	35%	0%	50%
Rx Preferred specialty*	20%	20%	20%	20%	0%	20%

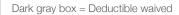


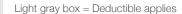


<sup>\*</sup>Non-preferred Rx brand and specialty may be available at a higher cost-share



Family deductible and out-of-pocket maximum (OOPM) is 2x individual	Silver Essential 2500	Silver Essential 4000	Bronze Essential 7500	
In-network deductible / out-of-network deductible	<b>\$2,500</b> / \$5,000	<b>\$4,000</b> / \$5,000	<b>\$7,500</b> / \$10,000	
In-network OOPM / out-of-network OOPM	<b>\$8,150</b> / \$10,000	<b>\$8,150</b> / \$10,000	<b>\$8,550</b> / \$15,000	
Preventive care	Covered in full for in-network services			
Employee Assistance Program (4 counseling visits per incident)	Covered in full			
Behavioral health	30%	30% 20% 30%		
Virtual care	Con	vered in full for in-network servi	ces	
Primary care provider	\$40 upfront limited	\$40 upfront limited		
Specialist	to 10 combined visits; deductible and coinsurance	to 4 combined visits; deductible and coinsurance	to 4 combined visits; deductible and coinsurance	
Urgent care	after visit limit is met	after visit limit is met	after visit limit is met	
Maternity	30%	20%	30%	
Inpatient hospital	30%	20%	30%	
Outpatient surgery and services	30%	20%	30%	
Outpatient lab and radiology	30%	20%	30%	
Outpatient complex lab and imaging	30%	20%	30%	
Outpatient rehab	30%	20%	30%	
Emergency room	30%	20%	30%	
Hearing aids and evaluation \$1,000 limit per calendar year, regardless of age	30%	30% 20%		
Pediatric vision up to age 19	Annual eye exam plus one pair of frames and lenses, or one pair of contacts per year			
Pediatric dental up to age 19	0% Preventive, 20% Basic, 50% Major			
Acupuncture / spinal manipulations (12 / 10 annual visit limit)	30%	20%	30%	
In-network coinsurance for other covered medical care	30% 20%		30%	
Out-of-network coinsurance for covered medical care	50% 50%		50%	
Optimum Value Medication List	N/A	N/A	N/A	
Rx Preferred generic	\$15	\$10	\$10	
Rx Generic	\$35	\$35	\$35	
Rx Preferred brand*	25%	25%	25%	
Rx Preferred specialty*	20%	20%	20%	





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