

Standard Plans, PY2024*****		Platinum		Gold		Silver		Bronze Copay		Bronze HSA	
Actuarial Value		91.72%		81.87%		70.46%		64.95%		64.92%	
Individual Overall Deductible		\$0		\$500		\$5,200		\$8,350		\$6,350	
<b>Other Individual Deductibles for Specific Services</b>											
Medical		\$0		\$500		\$4,850		\$7,500		\$6,350	
Prescription Drugs		\$0		\$0		\$350		\$850		Integrated with Medical	
Dental		\$0		\$0		\$0		\$0		\$0	
Individual Out-of-Pocket Maximum		\$2,000		\$5,800		\$8,850		\$9,150		\$7,200	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health Care Provider's Office or Clinic visit*	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$20		\$25		\$40		\$45		20%	X
	Specialist visit	\$40		\$50		\$80		\$105		20%	X
	Preventive care/screening/immunization	\$0		\$0		\$0		\$0		\$0	
Tests	Laboratory tests**	\$20		\$30		\$60		\$55	X	20%	X
	X-rays and diagnostic imaging	\$40		\$50		\$80		\$80	X	20%	X
	Imaging (CT/PET scans, MRIs)	\$150		\$250		\$400		\$500	X	20%	X
Drugs to treat Illness or Condition***	Generic	\$5		\$15		\$20		\$25		20%	X
	Preferred brand	\$15		\$50		\$50	X	\$75	X	20%	X
	Non-preferred Brand	\$25		\$70		\$70	X	\$100	X	20%	X
	Specialty	\$100		\$150		\$150	X	\$150	X	20%	X
Outpatient Surgery	Facility fee (e.g. hospital room)	\$250		\$375		20%	X	40%	X	20%	X
	Physician/Surgeon fee	\$0		\$125		20%	X	40%	X	20%	X
Outpatient Non-surgical Clinic Visit****	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	\$75		\$75		20%	X	40%	X	20%	X
Need Immediate Attention	Emergency room services (waived if admitted)	\$150		\$300		\$400	X	40%	X	20%	X
	Emergency medical transportation	\$150		\$300		\$400	X	40%	X	20%	X
	Urgent Care	\$40		\$60		\$90		\$100		20%	X

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Hospital Stay	Facility fee (e.g. hospital room)		\$250 per day up to 5 days		\$600 per day up to 5 days	X	20%	X	40%	X	20%	X
	Physician/surgeon fee		\$0		\$0	X	20%	X	40%	X	20%	X
Mental/Behavioral Health	M/B office visits		\$20		\$25			\$40		\$45		20% X
	M/B outpatient services		\$20		\$25			\$0		\$0		20% X
	M/B inpatient services	Hospital	\$250 per day up to 5 days		\$600 per day up to 5 days	X	20%	X	40%	X	20%	X
		Professional	\$0		\$0	X	20%	X	40%	X	20%	X
Substance Abuse needs	Substance abuse disorder office visits		\$20		\$25			\$40		\$45		20% X
	Substance abuse disorder outpatient services		\$20		\$25			\$0		\$0		20% X
	Substance abuse disorder inpatient services	Hospital	\$250 per day up to 5 days		\$600 per day up to 5 days	X	20%	X	40%	X	20%	X
		Professional	\$0		\$0	X	20%	X	40%	X	20%	X
Pregnancy	Prenatal care and preconception services		\$0		\$0			\$0		\$0		\$0 X
	Delivery and all inpatient services	Hospital	\$250 per day up to 5 days		\$600 per day up to 5 days	X	20%	X	40%	X	20%	X
		Professional	\$0		\$0	X	20%	X	40%	X	20%	X
Help recovering or other special health needs	Home health care		\$20		\$30			\$50		\$50	X	20% X
	Outpatient rehabilitation services		\$20		\$30			\$65		\$50	X	20% X
	Outpatient habilitation services		\$20		\$30			\$65		\$50	X	20% X
	Skilled nursing care		\$150 per day up to 5 days		\$300 per day up to 5 days			20%	X	40%	X	20% X
	Durable medical equipment		10%		20%			20%		40%	X	20% X
	Hospice services		\$0		\$0			\$0		40%	X	20% X
Child eye care	Eye exam		\$0		\$0			\$0		\$50		\$50
	1 pair of glasses per year (or contact lenses in lieu of glasses)		\$0		\$0			\$0		\$0		\$0

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Child Dental Diagnostic and Preventive	Oral Exam		\$0	\$0	\$0	\$0	\$0
	Preventive – cleaning		\$0	\$0	\$0	\$0	\$0
	Preventive- x-ray		\$0	\$0	\$0	\$0	\$0
	Sealants per tooth		\$0	\$0	\$0	\$0	\$0
	Topical fluoride application		\$0	\$0	\$0	\$0	\$0
	Space Maintainers – Fixed		\$0	\$0	\$0	\$0	\$0
Child Dental Basic Services	Amalgam Fill – 1 surface		\$25	\$25	\$25	\$41	\$41
Child Dental Major Services	Root canal – molar		\$300	\$300	\$300	\$512	\$512
	Gingivectomy per Quad		\$150	\$150	\$150	\$279	\$279
	Extraction – single tooth exposed root		\$65	\$65	\$65	\$69	\$69
	Extraction – complete bony		\$160	\$160	\$160	\$241	\$241
	Porcelain with Metal Crown		\$300	\$300	\$300	\$523	\$523
Child Orthodontics	Medically necessary orthodontics		\$1,000	\$1,000	\$1,000	\$3,422	\$3,422

\*PCP visits dilated retinal exam (1x per year), diabetic foot exam (1x per year), and nutritional counseling visits (unlimited) with a primary diagnosis of Type 2 diabetes are provided with no cost-sharing.

\*\*For a person with a primary diagnosis of Type 2 diabetes, the following lab services are provided with no cost-sharing:

- Lipid panel test (1x per year)
- Hemoglobin A1C (2x per year)
- Microalbumin urine test or nephrology visit (1x per year)
- Basic metabolic panel (1x per year)
- Liver function test (1x per year)

\*\*\* A select list of diabetes supplies and medications within the diabetic agents drug class, as defined by the carrier, are provided with no cost-sharing. A carrier is not required to change the drugs that are on the carrier’s formulary.

\*\*\*\*Copay may not apply in a staff model HMO setting

\*\*\*\*\* Treatment of mental health conditions for children 18 and under will be provided with \$5 cost-sharing as reflected in the Pediatric Mental Health Cost Sharing Treatment Recommendation.