



	Copay 1 Simply Blue Plus Gold 4 - PPO	Copay 2 Simply Blue Plus Gold 1 - PPO	Copay 3 Simply Blue Plus Gold 5 - PPO	Copay 4 Simply Blue Plus Platinum 1 - PPO	Copay 5 Embrace Health 318 Plainum - HMO
Network Deductible	None	None	None	None	None
Network Coinsurance	None	None	None	None	None
Network Deductible & Co-insurance Out of Pocket Maximum	\$6,350 Single \$12,700 Family	\$6,350 Single \$12,700 Family	\$6,350 Single \$12,700 Family	\$6,350 Single \$12,700 Family	\$6,350 Single \$12,700 Family
Preventive	Federally mandated qualified preventive services covered in full				
Primary Care / Specialist	\$40	\$25	\$40	\$15	\$25
Urgent Care	\$60	\$40	\$60	\$25	\$25
Emergency Room	\$250	\$350	\$250	\$150	\$100
Outpatient Surgery	\$250	\$350	\$250	\$150	\$100
Inpatient Hospitalization	\$750	\$750	\$500	\$250	\$500
Prescription Coverage Rider - In Network Only	\$10/40%/50%	\$15/\$50/50%	\$5/\$45/\$90	\$5/\$35/\$70	\$4/\$30/\$60
There is a separate Out-Of Network Deductible and Co-Insurance; Out-of network benefits are subject to balance billing by out-of-network providers. Plan benefits are paid subject to a maximum allowable fee schedule for the out-of-network services provided.					
Out-of-Network Deductible	\$500 Single \$1,000 Family	\$500 Single \$1,000 Family	\$500 Single \$1,000 Family	\$500 Single \$1,500 Family	N/A N/A
Out -of-Network ON Coinsurance	20%	20%	20%	20%	N/A
Out-of-Network Deductible & Co-insurance Out of Pocket Maximum	\$6,350 Single \$12,700 Family	\$6,350 Single \$12,700 Family	\$6,350 Single \$12,700 Family	\$6,350 Single \$12,700 Family	N/A N/A
Small Group	Single \$491.09	Single \$501.52	Single \$502.68	Single \$564.65	Single \$576.68
	2-Person \$982.20	2-Person \$1,003.06	2-Person \$1,005.39	2-Person \$1,129.30	2-Person \$1,153.36
	Single w/Child(ren) \$834.85	Single w/Child(ren) \$852.60	Single w/Child(ren) \$854.56	Single w/Child(ren) \$959.89	Single w/Child(ren) \$980.36
	Family \$1,399.62	Family \$1,429.35	Family \$1,432.67	Family \$1,609.25	Family \$1,643.54

Please note - all premium rates include qualified pediatric dental as required by law.



	Hybrid 1 Simply Blue Plus Silver 10 - PPO	Hybrid 2 Simply Blue Plus Silver 6 - PPO	Hybrid 3 Embrace Health 58 Gold - EPO	Hybrid 4 Simply Blue Plus Gold 11 - PPO
Network Deductible	Embedded \$2,000 single \$4,000 family	Embedded \$1,000 single \$2,000 family	Embedded \$250 single \$500 family	Embedded \$500 single \$1,000 family
Network Coinsurance	20%	20%	N/A	20%
Network Deductible & Co-insurance Out of Pocket Maximum	\$5,000 single \$10,000 family	\$5,000 single \$10,000 family	\$6,350 single \$12,,700 family	\$3,000 single \$6,000 family
Preventive	Federally mandated qualified preventive services covered in full			
Primary Care / Specialist	\$30 Subject to Deductible	\$40 Subject to Deductible	\$30 Subject to Deductible	\$25 Subject to Deductible
Urgent Care	\$50 Subject to Deductible	\$60 Subject to Deductible	\$50 Subject to Deductible	\$40 Subject to Deductible
Emergency Room	\$250 Subject to Deductible	\$350 Subject to Deductible	\$100 Subject to Deductible	\$250 Subject to Deductible
Outpatient Surgery	80% Subject to Deductible	80% Subject to Deductible	\$100 Subject to Deductible	80% Subject to Deductible
Inpatient Hospitalization	80% Subject to Deductible	80% Subject to Deductible	\$1,000 Subject to Deductible	80% Subject to Deductible
Prescription Coverage Rider - In Network Only	\$5/\$45/\$90	\$5/\$45/\$90	\$10/\$50/\$80	\$5/\$35/\$70
There is a separate Out-Of Network Deductible and Co-Insurance; Out-of network benefits are subject to balance billing by out-of-network providers. Plan benefits are paid subject to a maximum allowable fee schedule for the out-of-network services provided.				
Out-of-Network Deductible	\$2,000 single \$4,000 family	\$1,000 single \$2,000 family	N/A N/A	\$500 single \$1000 family
Out -of-NetworkON Coinsurance	40%	40%	N/A	40%
Out-of-Network Deductible & Co-insurance Out of Pocket Maximum	\$5,000 single \$10,000 family	\$5,000 single \$10,000 family	N/A N/A	\$3,000 single \$6,000 family
Small Group	Single \$423.24 2-Person \$846.49 Single w/Child(ren) \$719.50 Family \$1,206.25	\$440.40 \$880.80 \$748.67 \$1,255.15	\$484.82 \$969.63 \$824.19 \$1,381.73	\$497.24 \$994.48 \$845.30 \$1,417.13

Please note - all premium rates include qualified pediatric dental as required by law.



	HDHP 1 Simply Blue Plus Bronze 3 - PPO	HDHP 2 HDEPOQ 354 Bronze - EPO	HDHP 3 Simply Blue Plus Silver 1 - PPO	HDHP 4 Simply Blue Plus Gold 9 - PPO
Network Deductible	Aggregate \$4,500 single \$9,000 family	Aggregate \$3,500 single \$7,000 family	Aggregate \$1,500 single \$3,000 family	Aggregate \$2,100 single \$4,200 family
Network Coinsurance	50%	20%	30%	None
Network Deductible & Co-insurance Out of Pocket Maximum	\$6,350 single \$12,700 family	\$6,350 single \$12,700 family	\$4,500 single \$9,000 family	\$2,100 single \$4,200 family
Preventive	Federally mandated qualified preventive services covered in full			
Primary Care / Specialist	Deductible then 50%	Deductible then 20%	70% Subject to Deductible	Deductible then 100%
Urgent Care	Deductible then 50%	Deductible then 20%	70% Subject to Deductible	Deductible then 100%
Emergency Room	Deductible then 50%	Deductible then 20%	70% Subject to Deductible	Deductible then 100%
Outpatient Surgery	Deductible then 50%	Deductible then 20%	70% Subject to Deductible	Deductible then 100%
Inpatient Hospitalization	Deductible then 50%	Deductible then 20%	70% Subject to Deductible	Deductible then 100%
Prescription Coverage Rider - In Network Only	\$10/40%/50% Subject to Deductible	50%/50%/50% Subject to Deductible	\$10/40%/50% Subject to Deductible	Deductible then 100%
There is a separate Out-Of Network Deductible and Co-Insurance; Out-of network benefits are subject to balance billing by out-of-network providers. Plan benefits are paid subject to a maximum allowable fee schedule for the out-of-network services provided.				
Out-of-Network Deductible	\$6,350 single \$12,700 family	N/A N/A	\$4,500 single \$9,000 family	\$2,100 single \$4,200 family
Out -of-NetworkON Coinsurance	50%	N/A	50%	None
Out-of-Network Deductible & Co-insurance Out of Pocket Maximum	\$6,350 single \$12,700 family	N/A N/A	\$4,500 single \$9,000 family	\$2,100 single \$4,200 family
Small Group				
Single	\$315.35	\$343.75	\$400.31	\$456.42
2-Person	\$630.71	\$687.49	\$800.63	\$912.84
Single w/Child(ren)	\$536.10	\$584.37	\$680.53	\$775.91
Family	\$898.76	\$979.68	\$1,140.89	\$1,300.78

Please note - all premium rates include qualified pediatric dental as required by law.