

# Individual Coverage Benefits and Rates Guide

Effective April 1, 2024, for policies issued before March 23, 2010. The benefit period (BP) is 12 consecutive months from the effective date of coverage.

BENEFIT	PLAN 1		PLAN 2		PLAN 3		PLAN 4	
Deductible <sup>1</sup>	\$250 per member per BP		\$500 per member per BP		\$750 per member per BP		\$1,500 per member per BP	
Coinsurance Maximum <sup>1</sup>	\$1,500 per member per BP		\$2,000 per member per BP		\$2,500 per member per BP		\$5,000 per member per BP	
Primary Care Physician Services	\$10 copayment per visit		\$15 copayment per visit		\$15 copayment per visit		\$25 copayment per visit	
Routine Preventive Office Services	\$10 copayment per visit		\$15 copayment per visit		\$15 copayment per visit		\$25 copayment per visit	
Specialty Care Office Services <sup>2</sup>	80% — Subject to deductible		80% — Subject to deductible		80% — Subject to deductible		70% — Subject to deductible	
Inpatient Services (Including Behavioral Health) <sup>3</sup>	80% — Subject to deductible		80% — Subject to deductible		80% — Subject to deductible		70% — Subject to deductible	
Outpatient Services (Including Behavioral Health) <sup>4</sup>	80% — Subject to deductible		80% — Subject to deductible		80% — Subject to deductible		70% — Subject to deductible	
Urgent Care Services <sup>5</sup>	\$35 per visit, then 100% coverage		\$35 per visit, then 100% coverage		\$35 per visit, then 100% coverage		\$50 per visit, then 100% coverage	
Mental Health (Office Services Only)	\$10 copayment per visit		\$15 copayment per visit		\$15 copayment per visit		\$25 copayment per visit	
Prescription Drugs	\$7/\$15/\$30 copayment, then 100%		\$7/\$30/\$50 copayment, then 100%		\$7/\$30/\$50 copayment, then 100%		\$8/\$30/\$60 copayment, then 100%	
Specialty Pharmaceuticals	100% after \$100 copayment		100% after \$100 copayment		100% after \$100 copayment		100% after \$100 copayment	
Vision Care	Free annual eye exam		Free annual eye exam		Free annual eye exam		Free annual eye exam	
Dental Care	Up to \$20 for one exam and \$30 for one cleaning per BP		Up to \$20 for one exam and \$30 for one cleaning per BP		Up to \$20 for one exam and \$30 for one cleaning per BP		Up to \$20 for one exam and \$30 for one cleaning per BP	
Durable Medical Equipment	80% — Subject to deductible		80% — Subject to deductible		80% — Subject to deductible		80% — Subject to deductible	
Physical Therapy, Speech Therapy and Occupational Therapy	80% — Subject to deductible		80% — Subject to deductible		80% — Subject to deductible		70% — Subject to deductible	
MONTHLY PREMIUMS	PLAN 1		PLAN 2		PLAN 3		PLAN 4	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
Ages 6 Weeks – 4	668.84	668.84	629.68	629.68	571.91	571.91	461.24	461.24
Ages 5 – 18	524.91	524.91	494.56	494.56	449.51	449.51	362.32	362.32
Ages 19 – 24	604.23	659.05	569.99	620.89	518.04	564.11	416.20	454.34
Ages 25 – 29	662.94	806.99	625.76	759.89	568.99	690.43	456.34	556.27
MONTHLY PREMIUMS WITH BANK DRAFT**	PLAN 1		PLAN 2		PLAN 3		PLAN 4	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
Ages 6 Weeks – 4	652.12	652.12	613.90	613.90	557.61	557.61	449.73	449.73
Ages 5 – 18	511.80	511.80	482.17	482.17	438.25	438.25	353.28	353.28
Ages 19 – 24	589.12	642.60	555.70	605.36	505.10	549.99	405.78	442.99
Ages 25 – 29	646.38	786.80	610.12	740.89	554.76	673.16	444.92	542.34

BENEFIT	PLAN 5		PLAN 6 — HDHP*		PLAN 7 — HDHP	
Deductible <sup>1</sup>	\$2,500 per member per BP		\$3,000 per member per BP		\$5,000 per member per BP	
Coinsurance Maximum <sup>1</sup>	\$5,000 per member per BP		N/A		N/A	
Primary Care Physician Services	\$35 copayment per visit		100% — Subject to deductible		100% — Subject to deductible	
Routine Preventive Office Services	\$35 copayment per visit		\$35 copayment per visit		\$35 copayment per visit	
Specialty Care Office Services <sup>2</sup>	70% — Subject to deductible		100% — Subject to deductible		100% — Subject to deductible	
Inpatient Services (Including Behavioral Health) <sup>3</sup>	70% — Subject to deductible		100% — Subject to deductible		100% — Subject to deductible	
Outpatient Services (Including Behavioral Health) <sup>4</sup>	70% — Subject to deductible		100% — Subject to deductible		100% — Subject to deductible	
Urgent Care Services <sup>5</sup>	\$50 per visit, then 100% coverage		100% — Subject to deductible		100% — Subject to deductible	
Mental Health (Office Services Only)	\$35 copayment per visit		100% — Subject to deductible		100% — Subject to deductible	
Prescription Drugs	\$8/\$30/\$60 copayment, then 100%		100% — Subject to deductible		100% — Subject to deductible	
Specialty Pharmaceuticals	100% after \$100 copayment		100% — Subject to deductible		100% — Subject to deductible	
Vision Care	Free annual eye exam		Free annual eye exam		Free annual eye exam	
Dental Care	Up to \$20 for one exam and \$30 for one cleaning per BP		Up to \$20 for one exam and \$30 for one cleaning per BP		Up to \$20 for one exam and \$30 for one cleaning per BP	
Durable Medical Equipment	70% — Subject to deductible		100% — Subject to deductible		100% — Subject to deductible	
Physical Therapy, Speech Therapy and Occupational Therapy	70% — Subject to deductible		100% — Subject to deductible		100% — Subject to deductible	
MONTHLY PREMIUMS	PLAN 5		PLAN 6 — HDHP		PLAN 7 — HDHP	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
Ages 6 Weeks – 4	402.48	402.48	410.33	410.33	315.35	315.35
Ages 5 – 18	316.34	316.34	322.18	322.18	247.72	247.72
Ages 19 – 24	363.31	395.62	370.20	403.48	284.98	310.48
Ages 25 – 29	398.57	484.75	406.43	493.58	312.37	379.96
MONTHLY PREMIUMS WITH BANK DRAFT**	PLAN 5		PLAN 6 — HDHP		PLAN 7 — HDHP	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
Ages 6 Weeks – 4	392.40	392.40	400.10	400.10	307.45	307.45
Ages 5 – 18	308.43	308.43	314.10	314.10	241.56	241.56
Ages 19 – 24	354.22	385.77	360.93	393.39	277.86	302.70
Ages 25 – 29	388.61	472.62	396.27	481.22	304.59	370.46

\*High deductible health plan (HDHP)

\*\*Rates reflect a 2.5 percent discount when the payer takes advantage of the bank draft option.

<sup>1</sup>Includes out-of-network air ambulance services, emergency services and, subject to limited provider advance notice and consent requirements, other (nonemergency) provider services furnished at certain in-network facilities.

<sup>2</sup>Except behavioral health care.

<sup>3</sup>Includes inpatient services provided by an out-of-network provider at certain in-network facilities, out-of-network inpatient emergency services and, unless provider advance notice and consent requirements are met, inpatient post-stabilization services resulting from an emergency.

<sup>4</sup>Includes outpatient services provided by an out-of-network provider at certain in-network facilities, unless provider advance notice and consent requirements are met.

<sup>5</sup>For services provided by a participating urgent care center.

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