

HEALTH INSURANCE SERVICES COMPARISON CHART

(FOR JULY 2026-JUNE 2027)

Service	Non-Standard Low Gold (Premium): Complete HMO 1000 35%		Standard Low Silver HSA: Complete HMO HSA 2500 30/60 Enhanced FlexRx	
	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)
Primary Care Visit to Treat an Injury or Illness	\$25.00	Not Applicable	\$30.00 Copay after deductible	Not Applicable
Specialist Visit	\$45.00	Not Applicable	\$60.00 Copay after deductible	Not Applicable
Other Practitioner Office Visit (Nurse, Physician Assistant)	\$45.00	Not Applicable	\$30.00 Copay after deductible	Not Applicable
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Not Applicable	35.00% Coinsurance after deductible	\$500.00 Copay after deductible	Not Applicable
Outpatient Surgery Physician / Surgical Services	Not Applicable	35.00% Coinsurance after deductible	No Charge after deductible	Not Applicable
Hospice Services	No Charge	Not Applicable	No Charge after deductible	Not Applicable
Infertility Treatment	\$45.00	Not Applicable	\$60.00 Copay after deductible	Not Applicable
Routine Eye Exam (Adult)	\$45.00	Not Applicable	\$60.00 Copay after deductible	Not Applicable
Urgent Care Centers or Facilities	\$45.00	Not Applicable	\$60.00 Copay after deductible	Not Applicable
Home Health Care Services	No Charge	Not Applicable	No Charge after deductible	Not Applicable
Emergency Room Services	Not Applicable	35.00% Coinsurance after deductible	\$300.00 Copay after deductible	Not Applicable
Emergency Transportation/Ambulance	No Charge after deductible	Not Applicable	No Charge after deductible	Not Applicable
Inpatient Hospital Services (e.g., Hospital Stay)	Not Applicable	35.00% Coinsurance after deductible	\$750.00 Copay per Stay after deductible	Not Applicable
Inpatient Physician and Surgical Services	Not Applicable	35.00% Coinsurance after deductible	No Charge after deductible	Not Applicable
Bariatric Surgery	Not Applicable	35.00% Coinsurance after deductible	\$750.00 Copay after deductible	Not Applicable

HEALTH INSURANCE SERVICES COMPARISON CHART

(FOR JULY 2026-JUNE 2027)

Service	Non-Standard Low Gold (Premium): Complete HMO 1000 35%		Standard Low Silver HSA: Complete HMO HSA 2500 30/60 Enhanced FlexRx	
	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)
Skilled Nursing Facility	Not Applicable	35.00% Coinsurance after deductible	\$750.00 Copay per Stay after deductible	Not Applicable
Prenatal and Postnatal Care	No Charge	Not Applicable	No Charge after deductible	Not Applicable
Delivery and All Inpatient Services for Maternity Care	Not Applicable	35.00% Coinsurance after deductible	\$750.00 Copay after deductible	Not Applicable
Mental / Behavioral Health Outpatient Services	\$25.00	Not Applicable	\$30.00 Copay after deductible	Not Applicable
Mental / Behavioral Health Inpatient Services	Not Applicable	35.00% Coinsurance after deductible	\$750.00 Copay per Stay after deductible	Not Applicable
Substance Abuse Disorder Outpatient Services	\$25.00	Not Applicable	\$30.00 Copay after deductible	Not Applicable
Substance Abuse Disorder Inpatient Services	Not Applicable	35.00% Coinsurance after deductible	\$750.00 Copay per Stay after deductible	Not Applicable
Generic Drugs	\$20.00	Not Applicable	\$30.00 Copay after deductible	Not Applicable
Preferred Brand Drugs	\$50.00	Not Applicable	\$60.00 Copay after deductible	Not Applicable
Non-Preferred Brand Drugs	Not Applicable	35.00% Coinsurance after deductible	\$105.00 Copay after deductible	Not Applicable
Specialty Drugs	Not Applicable	35.00% Coinsurance after deductible	\$105.00 Copay after deductible	Not Applicable
Outpatient Rehabilitation Services	\$45.00	Not Applicable	\$60.00 Copay after deductible	Not Applicable
Habilitation Services	\$45.00	Not Applicable	\$60.00 Copay after deductible	Not Applicable
Chiropractic Care	\$25.00	Not Applicable	\$30.00 Copay after deductible	Not Applicable
Durable Medical Equipment	Not Applicable	35.00% Coinsurance after deductible	Not Applicable	20.00% Coinsurance after deductible
Hearing Aids	No Charge	Not Applicable	No Charge after deductible	Not Applicable

HEALTH INSURANCE SERVICES COMPARISON CHART

(FOR JULY 2026-JUNE 2027)

Service	Non-Standard Low Gold (Premium): Complete HMO 1000 35%		Standard Low Silver HSA: Complete HMO HSA 2500 30/60 Enhanced FlexRx	
	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)
Imaging (CT/PET Scans, MRIs)	Not Applicable	35.00% Coinsurance after deductible	\$500.00 Copay after deductible	Not Applicable
Preventive Care/Screening/Immunization	No Charge	Not Applicable	No Charge	Not Applicable
Routine Foot Care	\$45.00	Not Applicable	\$60.00 Copay after deductible	Not Applicable
Weight Loss Programs	No Charge	Not Applicable	No Charge	Not Applicable
Routine Eye Exam for Children	No Charge	Not Applicable	No Charge after deductible	Not Applicable
Eye Glasses for Children	No Charge	Not Applicable	No Charge after deductible	Not Applicable
Dental Check-Up for Children	No Charge	Not Applicable	No Charge after deductible	Not Applicable
Rehabilitative Speech Therapy	\$45.00	Not Applicable	\$60.00 Copay after deductible	Not Applicable
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$45.00	Not Applicable	\$60.00 Copay after deductible	Not Applicable
Well Baby Visits and Care	No Charge	Not Applicable	No Charge	Not Applicable
Laboratory Outpatient and Professional Services	\$50.00 Copay after deductible	Not Applicable	\$60.00 Copay after deductible	Not Applicable
X-rays and Diagnostic Imaging	\$75.00 Copay after deductible	Not Applicable	\$75.00 Copay after deductible	Not Applicable
Basic Dental Care - Child	Not Applicable	25.00% Coinsurance after deductible	Not Applicable	25.00% Coinsurance after deductible
Orthodontia - Child	Not Applicable	50.00% Coinsurance after deductible	Not Applicable	50.00% Coinsurance after deductible
Major Dental Care - Child	Not Applicable	50.00% Coinsurance after deductible	Not Applicable	50.00% Coinsurance after deductible
Abortion for Which Public Funding is Prohibited	No Charge	Not Applicable	No Charge after deductible	Not Applicable

HEALTH INSURANCE SERVICES COMPARISON CHART

(FOR JULY 2026-JUNE 2027)

Service	Non-Standard Low Gold (Premium): Complete HMO 1000 35%		Standard Low Silver HSA: Complete HMO HSA 2500 30/60 Enhanced FlexRx	
	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)
Transplant	Not Applicable	35.00% Coinsurance after deductible	\$750.00 Copay after deductible	Not Applicable
Accidental Dental	Not Applicable	35.00% Coinsurance after deductible	\$300.00 Copay after deductible	Not Applicable
Dialysis	No Charge	Not Applicable	No Charge after deductible	Not Applicable
Allergy Testing	\$75.00 Copay after deductible	Not Applicable	\$75.00 Copay after deductible	Not Applicable
Chemotherapy	\$75.00	Not Applicable	No Charge after deductible	Not Applicable
Radiation	\$75.00	Not Applicable	No Charge after deductible	Not Applicable
Diabetes Education	\$45.00	Not Applicable	\$60.00 Copay after deductible	Not Applicable
Prosthetic Devices	Not Applicable	35.00% Coinsurance after deductible	Not Applicable	20.00% Coinsurance after deductible
Infusion Therapy	No Charge	Not Applicable	No Charge after deductible	Not Applicable
Treatment for Temporomandibular Joint Disorders	\$45.00	Not Applicable	\$60.00 Copay after deductible	Not Applicable
Nutritional Counseling	\$45.00	Not Applicable	\$60.00 Copay after deductible	Not Applicable
Reconstructive Surgery	Not Applicable	35.00% Coinsurance after deductible	\$750.00 Copay after deductible	Not Applicable

HEALTH INSURANCE SERVICES COMPARISON CHART

(FOR JULY 2026-JUNE 2027)

Service	Standard High Silver: Complete HMO 2000 25/60	
	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)
Primary Care Visit to Treat an Injury or Illness	\$25.00	Not Applicable
Specialist Visit	\$60.00	Not Applicable
Other Practitioner Office Visit (Nurse, Physician Assistant)	\$25.00	Not Applicable
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$500.00 Copay after deductible	Not Applicable
Outpatient Surgery Physician / Surgical Services	No Charge after deductible	Not Applicable
Hospice Services	No Charge	Not Applicable
Infertility Treatment	\$60.00	Not Applicable
Routine Eye Exam (Adult)	\$60.00	Not Applicable
Urgent Care Centers or Facilities	\$60.00	Not Applicable
Home Health Care Services	No Charge	Not Applicable
Emergency Room Services	\$350.00 Copay after deductible	Not Applicable
Emergency Transportation/Ambulance	No Charge after deductible	Not Applicable
Inpatient Hospital Services (e.g., Hospital Stay)	\$1000.00 Copay per Stay after deductible	Not Applicable
Inpatient Physician and Surgical Services	No Charge after deductible	Not Applicable
Bariatric Surgery	\$1000.00 Copay after deductible	Not Applicable

HEALTH INSURANCE SERVICES COMPARISON CHART

(FOR JULY 2026-JUNE 2027)

Service	Standard High Silver: Complete HMO 2000 25/60	
	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)
Skilled Nursing Facility	\$1000.00 Copay per Stay after deductible	Not Applicable
Prenatal and Postnatal Care	No Charge	Not Applicable
Delivery and All Inpatient Services for Maternity Care	\$1000.00 Copay after deductible	Not Applicable
Mental / Behavioral Health Outpatient Services	\$25.00	Not Applicable
Mental / Behavioral Health Inpatient Services	\$1000.00 Copay per Stay after deductible	Not Applicable
Substance Abuse Disorder Outpatient Services	\$25.00	Not Applicable
Substance Abuse Disorder Inpatient Services	\$1000.00 Copay per Stay after deductible	Not Applicable
Generic Drugs	\$30.00	Not Applicable
Preferred Brand Drugs	\$55.00	Not Applicable
Non-Preferred Brand Drugs	\$75.00 Copay after deductible	Not Applicable
Specialty Drugs	\$75.00 Copay after deductible	Not Applicable
Outpatient Rehabilitation Services	\$60.00	Not Applicable
Habilitation Services	\$60.00	Not Applicable
Chiropractic Care	\$25.00	Not Applicable
Durable Medical Equipment	Not Applicable	20.00% Coinsurance after deductible
Hearing Aids	No Charge	Not Applicable

HEALTH INSURANCE SERVICES COMPARISON CHART

(FOR JULY 2026-JUNE 2027)

Service	Standard High Silver: Complete HMO 2000 25/60	
	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)
Imaging (CT/PET Scans, MRIs)	\$350.00 Copay after deductible	Not Applicable
Preventive Care/Screening/Immunization	No Charge	Not Applicable
Routine Foot Care	\$60.00	Not Applicable
Weight Loss Programs	No Charge	Not Applicable
Routine Eye Exam for Children	No Charge	Not Applicable
Eye Glasses for Children	No Charge	Not Applicable
Dental Check-Up for Children	No Charge	Not Applicable
Rehabilitative Speech Therapy	\$60.00	Not Applicable
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$60.00	Not Applicable
Well Baby Visits and Care	No Charge	Not Applicable
Laboratory Outpatient and Professional Services	\$30.00 Copay after deductible	Not Applicable
X-rays and Diagnostic Imaging	\$60.00 Copay after deductible	Not Applicable
Basic Dental Care - Child	Not Applicable	25.00% Coinsurance after deductible
Orthodontia - Child	Not Applicable	50.00% Coinsurance after deductible
Major Dental Care - Child	Not Applicable	50.00% Coinsurance after deductible
Abortion for Which Public Funding is Prohibited	No Charge	Not Applicable

HEALTH INSURANCE SERVICES COMPARISON CHART

(FOR JULY 2026-JUNE 2027)

Service	Standard High Silver: Complete HMO 2000 25/60	
	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)
Transplant	\$1000.00 Copay after deductible	Not Applicable
Accidental Dental	\$350.00 Copay after deductible	Not Applicable
Dialysis	No Charge	Not Applicable
Allergy Testing	\$60.00 Copay after deductible	Not Applicable
Chemotherapy	\$75.00	Not Applicable
Radiation	\$75.00	Not Applicable
Diabetes Education	\$60.00	Not Applicable
Prosthetic Devices	Not Applicable	20.00% Coinsurance after deductible
Infusion Therapy	No Charge	Not Applicable
Treatment for Temporomandibular Joint Disorders	\$60.00	Not Applicable
Nutritional Counseling	\$60.00	Not Applicable
Reconstructive Surgery	\$1000.00 Copay after deductible	Not Applicable

HEALTH INSURANCE SERVICES COMPARISON CHART

(FOR JULY 2026-JUNE 2027)

Service	Standard High Gold: Complete HMO 1000 20/40		Standard Platinum: Complete HMO 20/40	
	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)
Primary Care Visit to Treat an Injury or Illness	\$20.00	Not Applicable	\$20.00	Not Applicable
Specialist Visit	\$40.00	Not Applicable	\$40.00	Not Applicable
Other Practitioner Office Visit (Nurse, Physician Assistant)	\$20.00	Not Applicable	\$20.00	Not Applicable
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$150.00 Copay after deductible	Not Applicable	250	Not Applicable
Outpatient Surgery Physician / Surgical Services	No Charge after deductible	Not Applicable	No Charge	Not Applicable
Hospice Services	No Charge	Not Applicable	No Charge	Not Applicable
Infertility Treatment	\$40.00	Not Applicable	\$40.00	Not Applicable
Routine Eye Exam (Adult)	\$40.00	Not Applicable	\$40.00	Not Applicable
Urgent Care Centers or Facilities	\$40.00	Not Applicable	\$40.00	Not Applicable
Home Health Care Services	No Charge	Not Applicable	No Charge	Not Applicable
Emergency Room Services	250	Not Applicable	150	Not Applicable
Emergency Transportation/Ambulance	No Charge	Not Applicable	No Charge	Not Applicable
Inpatient Hospital Services (e.g., Hospital Stay)	\$300.00 Copay per Stay after deductible	Not Applicable	\$500.00 Copay per Stay	Not Applicable
Inpatient Physician and Surgical Services	No Charge after deductible	Not Applicable	No Charge	Not Applicable
Bariatric Surgery	\$300.00 Copay after deductible	Not Applicable	500	Not Applicable

HEALTH INSURANCE SERVICES COMPARISON CHART

(FOR JULY 2026-JUNE 2027)

Service	Standard High Gold: Complete HMO 1000 20/40		Standard Platinum: Complete HMO 20/40	
	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)
Skilled Nursing Facility	\$300.00 Copay per Stay after deductible	Not Applicable	\$500.00 Copay per Stay	Not Applicable
Prenatal and Postnatal Care	No Charge	Not Applicable	No Charge	Not Applicable
Delivery and All Inpatient Services for Maternity Care	\$300.00 Copay after deductible	Not Applicable	500	Not Applicable
Mental / Behavioral Health Outpatient Services	\$20.00	Not Applicable	\$20.00	Not Applicable
Mental / Behavioral Health Inpatient Services	\$300.00 Copay per Stay after deductible	Not Applicable	\$500.00 Copay per Stay	Not Applicable
Substance Abuse Disorder Outpatient Services	\$20.00	Not Applicable	\$20.00	Not Applicable
Substance Abuse Disorder Inpatient Services	\$300.00 Copay per Stay after deductible	Not Applicable	\$500.00 Copay per Stay	Not Applicable
Generic Drugs	\$25.00	Not Applicable	\$10.00	Not Applicable
Preferred Brand Drugs	\$45.00	Not Applicable	\$25.00	Not Applicable
Non-Preferred Brand Drugs	\$75.00 Copay after deductible	Not Applicable	50	Not Applicable
Specialty Drugs	\$75.00 Copay after deductible	Not Applicable	50	Not Applicable
Outpatient Rehabilitation Services	\$40.00	Not Applicable	\$40.00	Not Applicable
Habilitation Services	\$40.00	Not Applicable	\$40.00	Not Applicable
Chiropractic Care	\$20.00	Not Applicable	\$20.00	Not Applicable
Durable Medical Equipment	Not Applicable	20.00% Coinsurance after deductible	Not Applicable	0.2
Hearing Aids	No Charge	Not Applicable	No Charge	Not Applicable

HEALTH INSURANCE SERVICES COMPARISON CHART

(FOR JULY 2026-JUNE 2027)

Service	Standard High Gold: Complete HMO 1000 20/40		Standard Platinum: Complete HMO 20/40	
	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)
Imaging (CT/PET Scans, MRIs)	\$150.00 Copay after deductible	Not Applicable	150	Not Applicable
Preventive Care/Screening/Immunization	No Charge	Not Applicable	No Charge	Not Applicable
Routine Foot Care	\$40.00	Not Applicable	\$40.00	Not Applicable
Weight Loss Programs	No Charge	Not Applicable	No Charge	Not Applicable
Routine Eye Exam for Children	No Charge	Not Applicable	No Charge	Not Applicable
Eye Glasses for Children	No Charge	Not Applicable	No Charge	Not Applicable
Dental Check-Up for Children	No Charge	Not Applicable	No Charge	Not Applicable
Rehabilitative Speech Therapy	\$40.00	Not Applicable	\$40.00	Not Applicable
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$40.00	Not Applicable	\$40.00	Not Applicable
Well Baby Visits and Care	No Charge	Not Applicable	No Charge	Not Applicable
Laboratory Outpatient and Professional Services	\$25.00 Copay after deductible	Not Applicable	No Charge	Not Applicable
X-rays and Diagnostic Imaging	\$35.00 Copay after deductible	Not Applicable	No Charge	Not Applicable
Basic Dental Care - Child	Not Applicable	25.00% Coinsurance after deductible	Not Applicable	0.25
Orthodontia - Child	Not Applicable	50.00% Coinsurance after deductible	Not Applicable	0.5
Major Dental Care - Child	Not Applicable	50.00% Coinsurance after deductible	Not Applicable	0.5
Abortion for Which Public Funding is Prohibited	No Charge	Not Applicable	No Charge	Not Applicable

HEALTH INSURANCE SERVICES COMPARISON CHART

(FOR JULY 2026-JUNE 2027)

Service	Standard High Gold: Complete HMO 1000 20/40		Standard Platinum: Complete HMO 20/40	
	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)
Transplant	\$300.00 Copay after deductible	Not Applicable	500	Not Applicable
Accidental Dental	250	Not Applicable	150	Not Applicable
Dialysis	No Charge	Not Applicable	No Charge	Not Applicable
Allergy Testing	\$35.00 Copay after deductible	Not Applicable	No Charge	Not Applicable
Chemotherapy	\$75.00	Not Applicable	\$75.00	Not Applicable
Radiation	\$75.00	Not Applicable	\$75.00	Not Applicable
Diabetes Education	\$40.00	Not Applicable	\$40.00	Not Applicable
Prosthetic Devices	Not Applicable	20.00% Coinsurance after deductible	Not Applicable	0.2
Infusion Therapy	No Charge	Not Applicable	No Charge	Not Applicable
Treatment for Temporomandibular Joint Disorders	\$40.00	Not Applicable	\$40.00	Not Applicable
Nutritional Counseling	\$40.00	Not Applicable	\$40.00	Not Applicable
Reconstructive Surgery	\$300.00 Copay after deductible	Not Applicable	500	Not Applicable

HEALTH INSURANCE SERVICES COMPARISON CHART

(FOR JULY 2026-JUNE 2027)

Service	Standard High Silver: Complete PPO Plus 2000 25/60	
	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)
Primary Care Visit to Treat an Injury or Illness	\$20.00	Not Applicable
Specialist Visit	\$40.00	Not Applicable
Other Practitioner Office Visit (Nurse, Physician Assistant)	\$20.00	Not Applicable
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$150.00 Copay after deductible	Not Applicable
Outpatient Surgery Physician / Surgical Services	No Charge after deductible	Not Applicable
Hospice Services	No Charge	Not Applicable
Infertility Treatment	\$40.00	Not Applicable
Routine Eye Exam (Adult)	\$40.00	Not Applicable
Urgent Care Centers or Facilities	\$40.00	Not Applicable
Home Health Care Services	No Charge	Not Applicable
Emergency Room Services	250	Not Applicable
Emergency Transportation/Ambulance	No Charge	Not Applicable
Inpatient Hospital Services (e.g., Hospital Stay)	\$300.00 Copay per Stay after deductible	Not Applicable
Inpatient Physician and Surgical Services	No Charge after deductible	Not Applicable
Bariatric Surgery	\$300.00 Copay after deductible	Not Applicable

HEALTH INSURANCE SERVICES COMPARISON CHART

(FOR JULY 2026-JUNE 2027)

Service	Standard High Silver: Complete PPO Plus 2000 25/60	
	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)
Skilled Nursing Facility	\$300.00 Copay per Stay after deductible	Not Applicable
Prenatal and Postnatal Care	No Charge	Not Applicable
Delivery and All Inpatient Services for Maternity Care	\$300.00 Copay after deductible	Not Applicable
Mental / Behavioral Health Outpatient Services	\$20.00	Not Applicable
Mental / Behavioral Health Inpatient Services	\$300.00 Copay per Stay after deductible	Not Applicable
Substance Abuse Disorder Outpatient Services	\$20.00	Not Applicable
Substance Abuse Disorder Inpatient Services	\$300.00 Copay per Stay after deductible	Not Applicable
Generic Drugs	\$25.00	Not Applicable
Preferred Brand Drugs	\$45.00	Not Applicable
Non-Preferred Brand Drugs	\$75.00 Copay after deductible	Not Applicable
Specialty Drugs	\$75.00 Copay after deductible	Not Applicable
Outpatient Rehabilitation Services	\$40.00	Not Applicable
Habilitation Services	\$40.00	Not Applicable
Chiropractic Care	\$20.00	Not Applicable
Durable Medical Equipment	Not Applicable	20.00% Coinsurance after deductible
Hearing Aids	No Charge	Not Applicable

HEALTH INSURANCE SERVICES COMPARISON CHART

(FOR JULY 2026-JUNE 2027)

Service	Standard High Silver: Complete PPO Plus 2000 25/60	
	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)
Imaging (CT/PET Scans, MRIs)	\$150.00 Copay after deductible	Not Applicable
Preventive Care/Screening/Immunization	No Charge	Not Applicable
Routine Foot Care	\$40.00	Not Applicable
Weight Loss Programs	No Charge	Not Applicable
Routine Eye Exam for Children	No Charge	Not Applicable
Eye Glasses for Children	No Charge	Not Applicable
Dental Check-Up for Children	No Charge	Not Applicable
Rehabilitative Speech Therapy	\$40.00	Not Applicable
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$40.00	Not Applicable
Well Baby Visits and Care	No Charge	Not Applicable
Laboratory Outpatient and Professional Services	\$25.00 Copay after deductible	Not Applicable
X-rays and Diagnostic Imaging	\$35.00 Copay after deductible	Not Applicable
Basic Dental Care - Child	Not Applicable	25.00% Coinsurance after deductible
Orthodontia - Child	Not Applicable	50.00% Coinsurance after deductible
Major Dental Care - Child	Not Applicable	50.00% Coinsurance after deductible
Abortion for Which Public Funding is Prohibited	No Charge	Not Applicable

HEALTH INSURANCE SERVICES COMPARISON CHART

(FOR JULY 2026-JUNE 2027)

Service	Standard High Silver: Complete PPO Plus 2000 25/60	
	YOUR COST AT PARTICIPATING PROVIDER CO-PAY	COINSURANCE (IN NETWORK)
Transplant	\$300.00 Copay after deductible	Not Applicable
Accidental Dental	250	Not Applicable
Dialysis	No Charge	Not Applicable
Allergy Testing	\$35.00 Copay after deductible	Not Applicable
Chemotherapy	\$75.00	Not Applicable
Radiation	\$75.00	Not Applicable
Diabetes Education	\$40.00	Not Applicable
Prosthetic Devices	Not Applicable	20.00% Coinsurance after deductible
Infusion Therapy	No Charge	Not Applicable
Treatment for Temporomandibular Joint Disorders	\$40.00	Not Applicable
Nutritional Counseling	\$40.00	Not Applicable
Reconstructive Surgery	\$300.00 Copay after deductible	Not Applicable