

ARISE HEALTH PLAN

Small Group HMO Plan Summary



HEALTH MAINTENANCE ORGANIZATION (HMO) PLANS

Metal Tier	Individual Deductible*	Coinsurance	Individual Annual Max Out of Pocket*	You Pay**							
				Teladoc Visit	Retail Clinic Visit	PCP Visit	Specialty Visit	Emergency Room	Outpatient Lab/X-ray	Outpatient Surgery	Hospitalization
Platinum	\$500	20%	\$1,650	No charge	\$10	\$35	\$55	\$375	20% after deductible		
Gold	\$1,000	20%	\$5,000	No charge	\$10	\$35	\$55	\$375	20% after deductible		
Gold	\$1,500	10%	\$6,000	No charge	\$10	\$35	\$55	\$375	10% after deductible		
Gold	\$2,000	20%	\$7,900	No charge	\$10	\$35	\$55	\$375	20% after deductible		
Gold	\$2,500	20%	\$7,900	No charge	\$10	\$35	\$55	\$375	20% after deductible		
Silver	\$3,000	20%	\$7,900	No charge	\$10	\$45	\$90	\$500	20% after deductible		
Silver	\$3,500	10%	\$7,900	No charge	\$10	\$45	\$90	\$500	10% after deductible		
Silver	\$4,500	0%	\$7,900	No charge	\$10	\$45	\$90	\$500	No charge after deductible		
Silver	\$4,500	20%	\$7,900	No charge	\$10	\$45	\$90	\$500	20% after deductible		
Silver	\$5,500	20%	\$7,900	No charge	\$10	\$45	\$90	\$500	20% after deductible		
Silver	\$6,500	20%	\$7,900	No charge	\$10	\$45	\$90	\$500	20% after deductible		

Platinum and Gold Prescription Drugs: Preventive and Preferred Generics: \$0; Non-Preferred Generics: \$15; Preferred Brand: \$40; Non-Preferred Brand: \$70; Specialty Drugs: 30% coinsurance

Silver Prescription Drugs: Preventive and Preferred Generics: \$0; Non-Preferred Generics: \$25; Preferred Brand: \$60; Non-Preferred Brand: \$100; Specialty Drugs: \$500 deductible, then 40% coinsurance

HEALTH MAINTENANCE ORGANIZATION (HMO) HIGH-DEDUCTIBLE HEALTH PLANS

Metal Tier	Individual Deductible*	Coinsurance	Individual Annual Max Out of Pocket*	You Pay**							
				Teladoc Visit	Retail Clinic Visit	PCP Visit	Specialty Visit	Emergency Room	Outpatient Lab/X-ray	Outpatient Surgery	Hospitalization
Gold+	\$2,000	0%	\$2,000	No charge after deductible							
Gold	\$2,800	0%	\$2,800	No charge after deductible							
Silver++	\$1,550	30%	\$6,750	30% after deductible							
Silver++	\$2,500	30%	\$6,750	30% after deductible							
Silver	\$2,700	20%	\$6,750	20% after deductible							
Silver	\$3,500	20%	\$6,750	20% after deductible							
Silver	\$3,850	0%	\$3,850	No charge after deductible							
Bronze	\$5,500	30%	\$6,750	30% after deductible							
Bronze	\$6,750	0%	\$6,750	No charge after deductible							

Prescription Drugs: Preventive: \$0; All others: deductible and coinsurance

Preventive drugs include specific supplements, contraceptives, immunizations, and other preventive drugs ranked A or B by the U.S. Preventive Services Task Force. Preventive care services include routine exams, screenings, immunizations, and other services ranked A or B by the U.S. Preventive Services Task Force.

***Family deductibles and out-of-pocket limits are 2x the individual amounts.**

**Services performed out of network under the POS plan options are subject to the out-of-network deductible and coinsurance, except some emergency services. Out-of-network services are not covered under HMO plan options, except in emergency situations. See policy for details.

+ Non-Embedded Deductible and Out-of-Pocket Limit: This plan features a non-embedded deductible and out-of-pocket limit. If an employee has family coverage, the family deductible must be satisfied before this plan will pay benefits. One person can satisfy the family deductible. If an employee has family coverage, the family out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits. One person can satisfy the family out-of-pocket limit. Deductibles and out-of-pocket maximums apply annually.

++ Non-Embedded Deductible and Embedded Out-of-Pocket Limit: This plan features a non-embedded deductible. If an employee has family coverage, the family deductible must be satisfied before this plan will pay benefits. One person can satisfy the family deductible. This plan features an embedded out-of-pocket limit. The individual out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits. Deductibles and out-of-pocket maximums apply annually.

Unless otherwise noted, plans have an Embedded Deductible and Embedded Out-of-Pocket Limit: These plans feature an embedded deductible where an individual deductible must be satisfied before this plan will pay benefits. These plans feature an embedded out-of-pocket limit where the out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits. Deductibles and out-of-pocket maximums apply annually.

ARISE HEALTH PLAN

Small Group POS Plan Summary



POINT-OF-SERVICE (POS) PLANS														
You Pay														
Metal Tier	Individual Deductible*		Coinsurance		Individual Annual Max Out of Pocket*		At Participating Providers**							
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	Teladoc Visit	Retail Clinic Visit	PCP Visit	Specialty Visit	Emergency Room	Outpatient Lab/X-ray	Outpatient Surgery	Hospitalization
Platinum	\$500	\$1,000	20%	50%	\$1,650	\$11,000	No charge	\$10	\$35	\$55	\$375	20% after deductible		
Gold	\$1,000	\$2,000	20%	50%	\$5,000	\$12,000	No charge	\$10	\$35	\$55	\$375	20% after deductible		
Gold	\$1,500	\$3,000	10%	40%	\$6,000	\$11,000	No charge	\$10	\$35	\$55	\$375	10% after deductible		
Gold	\$2,000	\$4,000	20%	50%	\$7,900	\$14,000	No charge	\$10	\$35	\$55	\$375	20% after deductible		
Gold	\$2,500	\$5,000	20%	50%	\$7,900	\$15,000	No charge	\$10	\$35	\$55	\$375	20% after deductible		
Silver	\$3,000	\$6,000	20%	50%	\$7,900	\$16,000	No charge	\$10	\$45	\$90	\$500	20% after deductible		
Silver	\$3,500	\$7,000	10%	40%	\$7,900	\$15,000	No charge	\$10	\$45	\$90	\$500	10% after deductible		
Silver	\$4,500	\$9,000	0%	30%	\$7,900	\$15,000	No charge	\$10	\$45	\$90	\$500	No charge after deductible		
Silver	\$4,500	\$9,000	20%	50%	\$7,900	\$19,000	No charge	\$10	\$45	\$90	\$500	20% after deductible		
Silver	\$5,500	\$11,000	20%	50%	\$7,900	\$21,000	No charge	\$10	\$45	\$90	\$500	20% after deductible		
Silver	\$6,500	\$13,000	20%	50%	\$7,900	\$23,000	No charge	\$10	\$45	\$90	\$500	20% after deductible		

Platinum and Gold Prescription Drugs: Preventive and Preferred Generics: \$0; Non-Preferred Generics: \$15; Preferred Brand: \$40; Non-Preferred Brand: \$70; Specialty Drugs: 30% coinsurance

Silver Prescription Drugs: Preventive and Preferred Generics: \$0; Non-Preferred Generics: \$25; Preferred Brand: \$60; Non-Preferred Brand: \$100; Specialty Drugs: \$500 deductible, then 40% coinsurance

POINT-OF-SERVICE (POS) HIGH-DEDUCTIBLE HEALTH PLANS														
You Pay														
Metal Tier	Individual Deductible*		Coinsurance		Individual Annual Max Out of Pocket*		At Participating Providers**							
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	Teladoc Visit	Retail Clinic Visit	PCP Visit	Specialty Visit	Emergency Room	Outpatient Lab/X-ray	Outpatient Surgery	Hospitalization
Gold+	\$2,000	\$4,000	0%	30%	\$2,000	\$10,000	No charge after deductible							
Gold	\$2,800	\$5,600	0%	30%	\$2,800	\$11,600	No charge after deductible							
Silver++	\$1,550	\$3,100	30%	50%	\$6,750	\$13,100	30% after deductible							
Silver++	\$2,500	\$5,000	30%	50%	\$6,750	\$15,000	30% after deductible							
Silver	\$2,700	\$5,400	20%	50%	\$6,750	\$15,400	20% after deductible							
Silver	\$3,500	\$7,000	20%	50%	\$6,750	\$17,000	20% after deductible							
Silver	\$3,850	\$7,700	0%	30%	\$3,850	\$13,700	No charge after deductible							
Bronze	\$5,500	\$11,000	30%	50%	\$6,750	\$21,000	30% after deductible							
Bronze	\$6,750	\$13,500	0%	30%	\$6,750	\$19,500	No charge after deductible							

Prescription Drugs: Preventive: \$0; All others: deductible and coinsurance

Preventive drugs include specific supplements, contraceptives, immunizations, and other preventive drugs ranked A or B by the U.S. Preventive Services Task Force. Preventive care services include routine exams, screenings, immunizations, and other services ranked A or B by the U.S. Preventive Services Task Force.

***Family deductibles and out-of-pocket limits are 2x the individual amounts.**

**Services performed out of network under the POS plan options are subject to the out-of-network deductible and coinsurance, except some emergency services. Out-of-network services are not covered under HMO plan options, except in emergency situations. See policy for details.

+ Non-Embedded Deductible and Out-of-Pocket Limit: This plan features a non-embedded deductible and out-of-pocket limit. If an employee has family coverage, the family deductible must be satisfied before this plan will pay benefits. One person can satisfy the family deductible. If an employee has family coverage, the family out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits. One person can satisfy the family out-of-pocket limit. Deductibles and out-of-pocket maximums apply annually.

++ Non-Embedded Deductible and Embedded Out-of-Pocket Limit: This plan features a non-embedded deductible. If an employee has family coverage, the family deductible must be satisfied before this plan will pay benefits. One person can satisfy the family deductible. This plan features an embedded out-of-pocket limit. The individual out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits. Deductibles and out-of-pocket maximums apply annually.

Unless otherwise noted, plans have an Embedded Deductible and Embedded Out-of-Pocket Limit: These plans feature an embedded deductible where an individual deductible must be satisfied before this plan will pay benefits. These plans feature an embedded out-of-pocket limit where the out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits. Deductibles and out-of-pocket maximums apply annually.