

	Gold 2000 PD [†]	
	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	\$2,000 / \$4,000	\$10,000 / \$20,000
Out-of-Pocket Maximum Individual / Family	\$6,000 / \$12,000	\$25,000 / \$50,000
Preventive Services	Covered in full	50% after deductible
Preventive Drug Coverage	Covered in full	90% after deductible
Office Visits: Primary, Urgent Care, and Specialist	Primary / Urgent Care: \$20 no deductible Specialist: \$40 no deductible	50% after deductible
Telehealth	\$20 no deductible	50% after deductible
Inpatient Hospital	20% after deductible	50% after deductible
Lab / X-ray	20% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Emergency Services	20% after deductible	20% after deductible
Chiropractic / Acupuncture Visits per benefit period: Chiro: 12 / Acu: 12	\$20 no deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: \$15 no deductible Tier 2: \$70 no deductible Tier 3: 20% no deductible Tier 4: 20% no deductible	90% after deductible
Pediatric Eye Exam	Covered in full	Covered in full up to \$40
Pediatric Vision Hardware	Covered in full up to \$150, then subject to in-network deductible and 20%	
Pediatric Dental Included	Yes	

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	Silver 3500 PD [^]	Silver 5000 PD [†]	
	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	\$3,500 / \$7,000	\$5,000 / \$10,000	\$10,000 / \$20,000
Out-of-Pocket Maximum Individual / Family	\$9,300 / \$18,600	\$7,750 / \$15,500	\$25,000 / \$50,000
Preventive Services	Covered in full		50% after deductible
Preventive Drug Coverage	Covered in full		90% after deductible
Office Visits: Primary, Urgent Care, and Specialist	Primary / Urgent Care: \$40 no deductible Specialist: \$80 after deductible	Primary / Urgent Care: \$15 no deductible Specialist: \$30 no deductible	50% after deductible
Telehealth	\$40 no deductible	\$15 no deductible	50% after deductible
Inpatient Hospital	35% after deductible	30% after deductible	50% after deductible
Lab / X-ray	35% after deductible	30% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	35% after deductible	30% after deductible	50% after deductible
Outpatient Surgery	35% after deductible	30% after deductible	50% after deductible
Emergency Services	35% after deductible	30% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 12 / Acu: 12	\$40 no deductible	\$15 no deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: \$20 no deductible Tier 2: \$80 no deductible Tier 3: 35% no deductible Tier 4: 35% no deductible	30% after deductible	90% after deductible
Pediatric Eye Exam	Covered in full		Covered in full up to \$40
Pediatric Vision Hardware	Covered in full up to \$150, then subject to in-network deductible and 35%	Covered in full up to \$150, then subject to in-network deductible and 30%	Same as in-network
Pediatric Dental Included	Yes		

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	Bronze 7000 PD [†]	Bronze HSA 7500 PD [†]	
	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	\$7,000 / \$14,000	\$7,500 / \$15,000	\$10,000 / \$20,000
Out-of-Pocket Maximum Individual / Family	\$8,700 / \$17,400	\$7,500 / \$15,000	\$25,000 / \$50,000
Preventive Services	Covered in full		50% after deductible
Preventive Drug Coverage	Covered in full		90% after deductible
Office Visits: Primary, Urgent Care, and Specialist	Primary / Urgent Care: \$35 no deductible Specialist: \$50 after deductible	0% after deductible	50% after deductible
Telehealth	\$35 no deductible	0% after deductible	50% after deductible
Inpatient Hospital	40% after deductible	0% after deductible	50% after deductible
Lab / X-ray	40% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	40% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	40% after deductible	0% after deductible	50% after deductible
Emergency Services	40% after deductible	0% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 12 / Acu: 12	\$35 no deductible	0% after deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	40% after deductible	0% after deductible	90% after deductible
Pediatric Eye Exam	Covered in full		Covered in full up to \$40
Pediatric Vision Hardware	Covered in full up to \$150, then subject to in-network deductible and 40%	Covered in full up to \$150, then subject to in-network deductible and 0%	Same as in-network
Pediatric Dental Included	Yes		

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	Cascade Gold**†	Cascade Silver**†	Cascade Bronze**†	
	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	\$600 / \$1,200	\$2,500 / \$5,000	\$6,000 / \$12,000	\$10,000 / \$20,000
Out-of-Pocket Maximum Individual / Family	\$6,100 / \$12,200	\$9,200 / \$18,400	\$9,200 / \$18,400	\$25,000 / \$50,000
Preventive Services	Covered in full			50% after deductible
Preventive Drug Coverage	Covered in full			90% after deductible
Office Visits: Primary, Urgent Care, and Specialist	Primary: \$15 no deductible Urgent: \$35 no deductible Specialist: \$40 no deductible	Primary/telehealth combined visits 1-2: \$1, visits 3+: \$30 no deductible Urgent/Specialist: \$65 no deductible	Primary/telehealth combined visits 1-2: \$1, visits 3+: \$50 no deductible Urgent: \$100 no deductible Specialist: \$100 after deductible	50% after deductible
Telehealth	\$15 no deductible			50% after deductible
Inpatient Hospital	\$525 no deductible (per day limit of 5 copays per stay)	\$800 after deductible (per day limit of 5 copays per stay)	40% after deductible	50% after deductible
Lab / X-ray	\$30 no deductible	\$65 no deductible	40% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	\$25 no deductible	\$40 no deductible	40% after deductible	50% after deductible
Outpatient Surgery	\$350 after deductible	\$600 after deductible	40% after deductible	50% after deductible
Emergency Services	\$450 after deductible	\$800 after deductible	40% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 12 / Acu: 12	\$15 no deductible	\$30 no deductible	\$50 no deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: \$10 no deductible Tier 2: \$60 no deductible Tier 3 & 4: \$100 no deductible	Tier 1: \$25 no deductible Tier 2: \$75 no deductible Tier 3 & 4: \$250 after deductible	Tier 1: \$32 no deductible Tier 2, 3, & 4: 40% after deductible	90% after deductible
Pediatric Eye Exam	Covered in full			Covered in full up to \$40
Pediatric Vision Hardware	Covered in full			Covered in full up to \$40
Pediatric Dental Included	No			

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