

# 2027 Small Group HMO Plan Summary



## Health Maintenance Organization (HMO) Plans

|              |                   | You Pay (In-Network Services) <sup>2</sup> |             |                                                  |                |              |                     |           |                 |                      |                    |          |
|--------------|-------------------|--------------------------------------------|-------------|--------------------------------------------------|----------------|--------------|---------------------|-----------|-----------------|----------------------|--------------------|----------|
| Metal Tier   | SBC Lookup        | Individual Deductible <sup>1</sup>         | Coinsurance | Individual Annual Max Out of Pocket <sup>1</sup> | Emergency Room | MDLive Visit | Retail Clinic Visit | PCP Visit | Specialty Visit | Outpatient Lab/X-ray | Outpatient Surgery | Hospital |
| Platinum 600 | 86584WI0040001-00 | \$600                                      | 20%         | \$2,500                                          | D/C            | \$0          | \$10                | \$35      | \$70            | 20% after deductible |                    |          |
| Gold 1750    | 86584WI0040002-00 | \$1,750                                    | 20%         | \$7,750                                          | D/C            | \$0          | \$10                | \$35      | \$70            | 20% after deductible |                    |          |
| Gold 2500    | 86584WI0040003-00 | \$2,500                                    | 10%         | \$8,000                                          | D/C            | \$0          | \$10                | \$35      | \$70            | 10% after deductible |                    |          |
| Gold 3000    | 86584WI0040005-00 | \$3,000                                    | 20%         | \$6,000                                          | D/C            | \$0          | \$10                | \$35      | \$70            | 20% after deductible |                    |          |
| Gold 4500    | 86584WI0040006-00 | \$4,500                                    | 20%         | \$7,500                                          | D/C            | \$0          | \$10                | \$35      | \$70            | 20% after deductible |                    |          |
| Silver 5200  | 86584WI0040009-00 | \$5,200                                    | 20%         | \$10,500                                         | D/C            | \$0          | \$10                | \$45      | \$90            | 20% after deductible |                    |          |
| Silver 6000  | 86584WI0040010-00 | \$6,000                                    | 10%         | \$12,000                                         | D/C            | \$0          | \$10                | \$45      | \$90            | 10% after deductible |                    |          |
| Silver 7000  | 86584WI0040011-00 | \$7,000                                    | 20%         | \$10,200                                         | D/C            | \$0          | \$10                | \$45      | \$90            | 20% after deductible |                    |          |
| Silver 8500  | 86584WI0040020-00 | \$8,500                                    | 30%         | \$10,600                                         | D/C            | \$0          | \$10                | \$45      | \$90            | 30% after deductible |                    |          |

**Platinum Prescription Drugs:** Preventive: \$0; Tier 1: \$15; Tier 2: \$30; Tier 3: \$60; Tier 4: 30% coinsurance

**Gold Prescription Drugs:** Preventive: \$0; Tier 1: \$15; Tier 2: \$30; Tier 3: \$60; Tier 4: 30% coinsurance

**Silver Prescription Drugs:** Preventive: \$0; Tier 1: \$25; Tier 2: \$50; Tier 3: \$80; Tier 4: \$750 deductible, then 40% coinsurance

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

<sup>1</sup> Family deductibles and out-of-pocket limits are 2x the individual amounts.

<sup>2</sup> Out-of-network services are not covered under HMO plan options, except in emergency situations. See policy for details.

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 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.

# 2027 Small Group HMO HDHP Plan Summary

Health Maintenance Organization (HMO) HSA-Qualified High-Deductible Health Plans



| Metal Tier               | SBC Lookup        | You Pay (In-Network Services) <sup>2</sup> |             |                                                  |                            |              |                     |           |                 |                      |                    |          |
|--------------------------|-------------------|--------------------------------------------|-------------|--------------------------------------------------|----------------------------|--------------|---------------------|-----------|-----------------|----------------------|--------------------|----------|
|                          |                   | Individual Deductible <sup>1</sup>         | Coinsurance | Individual Annual Max Out of Pocket <sup>1</sup> | Emergency Room             | MDLive Visit | Retail Clinic Visit | PCP Visit | Specialty Visit | Outpatient Lab/X-ray | Outpatient Surgery | Hospital |
| Gold 3700 <sup>3</sup>   | 86584WI0040012-00 | \$3,700                                    | 0%          | \$3,700                                          | No charge after deductible |              |                     |           |                 |                      |                    |          |
| Gold 3900 <sup>4</sup>   | 86584WI0040021-00 | \$3,900                                    | 0%          | \$3,900                                          | No charge after deductible |              |                     |           |                 |                      |                    |          |
| Silver 3500 <sup>4</sup> | 86584WI0040013-00 | \$3,500                                    | 30%         | \$8,700                                          | 30% after deductible       |              |                     |           |                 |                      |                    |          |
| Silver 4200 <sup>4</sup> | 86584WI0040015-00 | \$4,200                                    | 20%         | \$8,400                                          | 20% after deductible       |              |                     |           |                 |                      |                    |          |
| Silver 5500              | 86584WI0040022-00 | \$5,500                                    | 20%         | \$7,000                                          | 20% after deductible       |              |                     |           |                 |                      |                    |          |
| Silver 6500              | 86584WI0040016-00 | \$6,500                                    | 0%          | \$6,500                                          | No charge after deductible |              |                     |           |                 |                      |                    |          |
| Bronze 7500              | 86584WI0040017-00 | \$7,500                                    | 30%         | \$8,700                                          | 30% after deductible       |              |                     |           |                 |                      |                    |          |
| Bronze 8700              | 86584WI0040018-00 | \$8,700                                    | 0%          | \$8,700                                          | No charge after deductible |              |                     |           |                 |                      |                    |          |
| Bronze 11750*            | 86584WI0040024-00 | \$11,750                                   | 0%          | \$11,750                                         | 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.

<sup>1</sup> Family deductibles and out-of-pocket limits are 2x the individual amounts.

<sup>2</sup> Out-of-network services are not covered under HMO plan options, except in emergency situations. See policy for details.

<sup>3</sup> 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.

<sup>4</sup> 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.

\* HMO Bronze 11750 plan does not meet the IRS requirements to be considered an HSA-qualified High Deductible Health Plan (HDHP). Review alternative plan options if maintaining HSA eligibility is important for your benefits strategy.

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 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.

# 2027 Small Group POS Plan Summary

Point-of-Service (POS) Plans



|             |                   | You Pay (At Participating Providers) <sup>2</sup> |                |             |                |                                                  |                |                |              |                     |           |                 |                      |                    |          |
|-------------|-------------------|---------------------------------------------------|----------------|-------------|----------------|--------------------------------------------------|----------------|----------------|--------------|---------------------|-----------|-----------------|----------------------|--------------------|----------|
| Metal Tier  | SBC Lookup        | Individual Deductible <sup>1</sup>                |                | Coinsurance |                | Individual Annual Max Out of Pocket <sup>1</sup> |                | Emergency Room | MDLive Visit | Retail Clinic Visit | PCP Visit | Specialty Visit | Outpatient Lab/X-ray | Outpatient Surgery | Hospital |
|             |                   | In Network                                        | Out of Network | In Network  | Out of Network | In Network                                       | Out of Network |                |              |                     |           |                 |                      |                    |          |
| Gold 1750   | 86584WI0030002-00 | \$1,750                                           | \$2,300        | 20%         | 50%            | \$7,750                                          | \$12,300       | D/C            | \$0          | \$10                | \$35      | \$70            | 20% after deductible |                    |          |
| Gold 3300   | 86584WI0030006-00 | \$3,300                                           | \$5,200        | 20%         | 50%            | \$6,000                                          | \$15,200       | D/C            | \$0          | \$10                | \$35      | \$70            | 20% after deductible |                    |          |
| Silver 5200 | 86584WI0030009-00 | \$5,200                                           | \$7,400        | 20%         | 50%            | \$10,500                                         | \$17,400       | D/C            | \$0          | \$10                | \$45      | \$90            | 20% after deductible |                    |          |
| Silver 6000 | 86584WI0030010-00 | \$6,000                                           | \$9,000        | 10%         | 40%            | \$12,000                                         | \$17,000       | D/C            | \$0          | \$10                | \$45      | \$90            | 10% after deductible |                    |          |

**Gold Prescription Drugs:** Preventive: \$0; Tier 1: \$15; Tier 2: \$30; Tier 3: \$60; Tier 4: 30% coinsurance

**Silver Prescription Drugs:** Preventive: \$0; Tier 1: \$25; Tier 2: \$50; Tier 3: \$80; Tier 4: \$750 deductible, then 40% coinsurance

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

<sup>1</sup> Family deductibles and out-of-pocket limits are 2x the individual amounts.

<sup>2</sup> Services performed out of network under the POS plan options are subject to the out-of-network deductible and coinsurance, except some emergency services. See policy for details.

Unless otherwise noted, plans have an In-Network 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 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. Out-of-Network 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.

# 2027 Small Group POS HDHP Plan Summary

Point-of-Service (POS) HSA-Qualified High-Deductible Health Plans



|                          |                   | You Pay (At Participating Providers) <sup>2</sup> |                |             |                |                                                  |                |                |                  |                     |           |                 |                            |                    |          |
|--------------------------|-------------------|---------------------------------------------------|----------------|-------------|----------------|--------------------------------------------------|----------------|----------------|------------------|---------------------|-----------|-----------------|----------------------------|--------------------|----------|
| Metal Tier               | SBC Lookup        | Individual Deductible <sup>1</sup>                |                | Coinsurance |                | Individual Annual Max Out of Pocket <sup>1</sup> |                | Emergency Room | Telehealth Visit | Retail Clinic Visit | PCP Visit | Specialty Visit | Outpatient Lab/X-ray       | Outpatient Surgery | Hospital |
|                          |                   | In Network                                        | Out of Network | In Network  | Out of Network | In Network                                       | Out of Network |                |                  |                     |           |                 |                            |                    |          |
| Gold 3700 <sup>3</sup>   | 86584WI0030012-00 | \$3,700                                           | \$5,600        | 0%          | 30%            | \$3,700                                          | \$11,600       | D/C            | D/C              | D/C                 | D/C       | D/C             | No charge after deductible |                    |          |
| Silver 4200 <sup>4</sup> | 86584WI0030015-00 | \$4,200                                           | \$6,500        | 20%         | 50%            | \$8,400                                          | \$16,500       | D/C            | D/C              | D/C                 | D/C       | D/C             | 20% after deductible       |                    |          |
| Silver 5500              | 86584WI0030022-00 | \$5,500                                           | \$8,600        | 20%         | 50%            | \$7,000                                          | \$18,600       | D/C            | D/C              | D/C                 | D/C       | D/C             | 20% after deductible       |                    |          |
| Silver 6500              | 86584WI0030016-00 | \$6,500                                           | \$10,400       | 0%          | 30%            | \$6,500                                          | \$16,400       | D/C            | D/C              | D/C                 | D/C       | D/C             | No charge after deductible |                    |          |
| Bronze 7500              | 86584WI0030017-00 | \$7,500                                           | \$12,400       | 30%         | 50%            | \$8,700                                          | \$22,400       | D/C            | D/C              | D/C                 | D/C       | D/C             | 30% after deductible       |                    |          |
| Bronze 8700              | 86584WI0030018-00 | \$8,700                                           | \$14,400       | 0%          | 30%            | \$8,700                                          | \$20,400       | D/C            | D/C              | D/C                 | D/C       | D/C             | 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.

<sup>1</sup> Family deductibles and out-of-pocket limits are 2x the individual amounts.

<sup>2</sup> Services performed out of network under the POS plan options are subject to the out-of-network deductible and coinsurance, except some emergency services. See policy for details.

<sup>3</sup> 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.

<sup>4</sup> In-Network 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 In-Network 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 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. Out-of-Network 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.