

2023 HEALTH BENEFIT PLAN COMPARISON



MEDICAL BENEFITS	PLATINUM		GOLD		SILVER	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
DEDUCTIBLE	\$0 / Single \$0 / Family	\$1,000 / Single \$2,000 / Family	\$1,000 / Single \$2,000 / Family	\$2,500 / Single \$5,000 / Family	\$2,500 / Single \$5,000 / Family	\$5,000 / Single \$10,000 / Family
OUT-OF-POCKET MAXIMUM¹	\$2,000 / Single \$4,000 / Family	\$4,000 / Single \$8,000 / Family	\$4,000 / Single \$8,000 / Family	\$8,000 / Single \$16,000 / Family	\$6,000 / Single \$12,000 / Family	\$12,000 / Single \$24,000 / Family
PREVENTATIVE SERVICES	100% Coverage no deductible	100% Coverage no deductible	100% Coverage no deductible	100% Coverage no deductible	100% Coverage no deductible	100% Coverage no deductible
PRIMARY CARE SERVICES	\$0 Copay	\$40 Copay	\$20 Copay	70% Coverage after deductible	\$35 Copay	60% Coverage after deductible
SPECIALTY CARE SERVICES	\$35 Copay	\$75 Copay	\$50 Copay	70% Coverage after deductible	\$75 Copay	60% Coverage after deductible
URGENT CARE CENTER SERVICES	\$50 Copay	\$100 Copay	\$75 Copay	70% Coverage after \$150 Copay	\$100 Copay	60% Coverage after \$250 Copay
EMERGENCY ROOM SERVICES	\$150 Copay	\$150 Copay	90% Coverage after \$250 Copay	90% Coverage after \$250 Copay	80% Coverage after \$2,500/\$5,000 deductible	80% Coverage after \$2,500/\$5,000 deductible
INDEPENDENT LAB SERVICES	\$50 Copay	80% Coverage after deductible	\$75 Copay	70% Coverage after deductible	\$75 Copay	60% Coverage after deductible
INDEPENDENT IMAGING SERVICES	\$75 Copay	80% Coverage after deductible	\$150 Copay	70% Coverage after deductible	\$150 Copay	60% Coverage after deductible
OUTPATIENT SURGERY	100% Coverage of allowed amount	80% Coverage after deductible	90% Coverage after deductible	70% Coverage after deductible	80% Coverage after deductible	60% Coverage after deductible
HOSPITAL INPATIENT SERVICES	100% Coverage of allowed amount	80% Coverage after deductible	90% Coverage after deductible	70% Coverage after deductible	80% Coverage after deductible	60% Coverage after deductible
MATERNITY SERVICES: • Office Visit • Childbirth/Delivery Professional & Facility Services	\$0 Copay 100% Coverage of allowed amount	\$40 Copay 80% Coverage after deductible	\$20 Copay 90% Coverage after deductible	70% Coverage after deductible	\$35 Copay 80% Coverage after deductible	60% Coverage after deductible
EMERGENCY AMBULANCE SERVICES	100% Coverage of allowed amount	100% Coverage of allowed amount	90% Coverage after deductible	90% Coverage after deductible	80% Coverage after deductible	80% Coverage after deductible
REHABILITATION SERVICES	\$35 Copay	80% Coverage after deductible	\$50 Copay	70% Coverage after deductible	\$75 Copay	60% Coverage after deductible
MENTAL HEALTH & SUBSTANCE ABUSE • Professional Services • Facility Services	\$0 Copay 100% Coverage of allowed amount	\$40 Copay 80% Coverage after deductible	\$20 Copay 90% Coverage after deductible	70% Coverage after deductible	\$35 Copay 80% Coverage after deductible	60% Coverage after deductible

PHARMACEUTICAL BENEFITS	PLATINUM		GOLD		SILVER	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
RETAIL² • Generic Drugs • Brand Drugs • Non-Preferred Drugs	\$0 \$50 \$100	Not Covered	\$0 \$50 \$100	Not Covered	\$0 \$50 \$100	Not Covered
MAIL ORDER³ • Generic Drugs • Brand Drugs • Non-Preferred Drugs • Specialty Drugs ⁴ • Preferred Drugs • Non-Preferred Drugs	\$0 \$125 \$250 \$250 70% Coverage no deductible	Not Covered	\$0 \$125 \$250 \$250 70% Coverage no deductible	Not Covered	\$0 \$125 \$250 \$250 70% Coverage no deductible	Not Covered

Nondiscrimination Notice: Trinity Marketing Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. NOTE: This is only a brief summary of benefits. Limitations and coverage maximums apply. See the Schedule of Benefits for each plan and Summary Plan Document for more information.

¹ In- and out-of-network out-of-pocket maximums are combined.
² Retail rates based on 30-day supply.
³ Mail order rates based on a 90-day supply.
⁴ Specialty is only available as a 30-day supply through mail order.



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MEDICAL BENEFITS	BRONZE		SILVER HSA		BRONZE HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
DEDUCTIBLE	\$5,000 / Single \$10,000 / Family	\$7,000 / Single \$12,000 / Family	\$3,000 / Single \$6,000 / Family	\$5,000 / Single \$10,000 / Family	\$5,000 / Single \$10,000 / Family	\$7,000 / Single \$12,000 / Family
OUT-OF-POCKET MAXIMUM¹	\$8,000 / Single \$16,000 / Family	\$16,000 / Single \$32,000 / Family	\$6,000 / Single \$12,000 / Family	\$6,000 / Single \$12,000 / Family	\$7,500 / Single \$15,000 / Family	\$7,500 / Single \$15,000 / Family
PREVENTATIVE SERVICES	100% Coverage no deductible	100% Coverage no deductible	100% Coverage no deductible	100% Coverage no deductible	100% Coverage no deductible	100% Coverage no deductible
PRIMARY CARE SERVICES	\$50 Copay	50% Coverage after deductible	80% Coverage after deductible	60% Coverage after deductible	70% Coverage after deductible	50% Coverage after deductible
SPECIALTY CARE SERVICES	\$100 Copay	50% Coverage after deductible	80% Coverage after deductible	60% Coverage after deductible	70% Coverage after deductible	50% Coverage after deductible
URGENT CARE CENTER SERVICES	\$100 Copay	50% Coverage after deductible	80% Coverage after deductible	60% Coverage after deductible	70% Coverage after deductible	50% Coverage after deductible
EMERGENCY ROOM SERVICES	70% Coverage after \$5,000/\$10,000 deductible	70% Coverage after \$5,000/\$10,000 deductible	80% Coverage after \$3,000/\$6,000 deductible	80% Coverage after \$3,000/\$6,000 deductible	70% Coverage after \$5,000/\$10,000 deductible	70% Coverage after \$5,000/\$10,000 deductible
INDEPENDENT LAB SERVICES	70% Coverage after deductible	50% Coverage after deductible	80% Coverage after deductible	60% Coverage after deductible	70% Coverage after deductible	50% Coverage after deductible
INDEPENDENT IMAGING SERVICES	70% Coverage after deductible	50% Coverage after deductible	80% Coverage after deductible	60% Coverage after deductible	70% Coverage after deductible	50% Coverage after deductible
OUTPATIENT SURGERY	70% Coverage after deductible	50% Coverage after deductible	80% Coverage after deductible	60% Coverage after deductible	70% Coverage after deductible	50% Coverage after deductible
HOSPITAL INPATIENT SERVICES	70% Coverage after deductible	50% Coverage after deductible	80% Coverage after deductible	60% Coverage after deductible	70% Coverage after deductible	50% Coverage after deductible
MATERNITY SERVICES • Office Visits • Childbirth/Delivery Professional & Facility Services	\$50 Copay 70% Coverage after deductible	50% Coverage after deductible	80% Coverage after deductible	60% Coverage after deductible	70% Coverage after deductible	50% Coverage after deductible
EMERGENCY AMBULANCE SERVICES	70% Coverage after deductible	70% Coverage after deductible	80% Coverage after deductible	80% Coverage after deductible	70% Coverage after deductible	70% Coverage after deductible
REHABILITATION SERVICES	70% Coverage after deductible	50% Coverage after deductible	80% Coverage after deductible	60% Coverage after deductible	70% Coverage after deductible	50% Coverage after deductible
MENTAL HEALTH & SUBSTANCE ABUSE • Professional Services • Facility Services	\$50 Copay 70% Coverage after deductible	50% Coverage after deductible	80% Coverage after deductible	60% Coverage after deductible	70% Coverage after deductible	50% Coverage after deductible

PHARMACEUTICAL BENEFITS	BRONZE		SILVER HSA		BRONZE HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
RETAIL² • Generic Drugs • Brand Drugs • Non-Preferred Drugs	\$0 \$50 \$100	Not Covered	80% Coverage after deductible	Not Covered	70% Coverage after deductible	Not Covered
MAIL ORDER³ • Generic Drugs • Brand Drugs • Non-Preferred Drugs • Specialty Drugs ⁴ • Preferred Drugs • Non-Preferred Drugs	\$0 \$125 \$250 \$250 70% Coverage no deductible	Not Covered	80% Coverage after deductible	Not Covered	70% Coverage after deductible	Not Covered

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