

Medical Plan Year Deductible	\$500 Individual; \$1,500 Family
Out-of-Pocket Maximum <i>(includes medical & drug deductibles, copayments & coinsurance)</i>	\$6,000 Individual; \$12,000 Family
Annual Maximum	Unlimited
Primary Care Provider (PCP) Office Visit <ul style="list-style-type: none"> Includes routine lab/X-ray services, injectables, and supplies Other services provided in a physician's office are subject to additional deductible and copayments/coinsurance 	\$20 copayment
PCP Office Visit—Dependents, through age 19	\$0 copayment
Specialist Office Visit <ul style="list-style-type: none"> Includes routine lab/X-ray services Other services provided in a physician's office are subject to additional deductible and copayments/coinsurance 	\$60 copayment
Preventive Care Well-woman exam, immunizations, physicals, mammograms, colorectal cancer screening	No copayment
Surgical Procedures Performed in the Physician's Office	25% copayment ¹
Minor Emergency/Urgency Care Visit	\$75 copayment
Emergency Room	\$500 copayment ¹
Ambulance Air/Ground	25% copayment ¹
Inpatient Services Facility charges, physician services, surgical procedures, pre-admission testing, operating/recovery room, newborn delivery and nursery, ICU/coronary care units, laboratory tests/X-rays, rehabilitation facility, behavioral health (mental health/chemical dependency)	25% copayment ¹
Outpatient Services Facility charges, physician services, surgical procedures, observation unit	25% copayment ¹
MRI, CT Scan, PET Scan (Facility/Physician)	\$250 copayment ¹
Diagnostic Tests Sleep study; Stess test; EKG; Ultrasound; Cardiac imaging; Genetic testing; Non-preventive Colonoscopy (Facility/Physician)	25% copayment ¹
Home Health Care <i>Limited to 60 visits per plan year</i>	25% copayment ¹
Hospice Care	25% copayment ¹
Skilled Nursing Facility <i>Limited to 30 days per plan year</i>	25% copayment ¹
Accidental Dental Care	25% copayment ¹
Prosthetics	25% copayment ¹
Orthotics	25% copayment ¹
Spinal Manipulation <i>Limited to 10 visits per year</i>	25% copayment ¹
Durable Medical Equipment	25% copayment ¹
All Other Covered Services	25% copayment ¹

Prescription Drug Plan Year Deductible	\$100 Individual; \$300 Family
Annual Maximum	Unlimited
Participating Retail Pharmacy Select Generic/ACA (Tier 1) deductible waived Preferred Generic (Tier 2) deductible waived Preferred Brand/Non-Preferred Generic (Tier 3) Non-Preferred Brand/Non-Preferred Generic (Tier 4) Specialty/Injectables (Tier 5)	Standard Drugs/30-day supply \$0 per prescription \$15 per prescription \$40 per prescription ² \$100 per prescription ² 20% per prescription ²
Participating Mail Order Pharmacy Select Generic/ACA (Tier 1) deductible waived Preferred Generic (Tier 2) deductible waived Preferred Brand/Non-Preferred Generic (Tier 3) Non-Preferred Brand/Non-Preferred Generic (Tier 4) Specialty/Injectables (Tier 5)	Maintenance Drugs/90-day supply \$0 per prescription \$45 per prescription \$120 per prescription ² \$300 per prescription ² 20% per prescription ²



¹Subject to medical deductible ²Subject to prescription drug deductible