

Your Medical Benefits at a Glance – Plan 1

Type of Coverage	Network Benefit	Non-Network Benefit
<u>Deductible</u> Individual Family	\$0 \$0	\$300 \$600
<u>Out-of-Pocket Maximum</u> (includes <u>Deductible</u>) Individual Family	\$500 \$500	\$800 \$1,100
Physician's Office Services	\$10 Copayment	20% after Deductible
Specialist Office Visit	\$10 Copayment	20% after Deductible
Preventive Care	No annual limits or maximum dollar amounts	No annual limits or maximum dollar amounts
Emergency Room Services	\$35 Copayment	\$35 Copayment
Inpatient Hospital Stay	10%	20% after Deductible
Urgent Care Center Services	\$35 Copayment	20% after Deductible

Your Medical Benefits at a Glance – Plan 2

Type of Coverage	Network Benefit	Non-Network Benefit
<u>Deductible</u> Individual Family	\$300 \$600	\$600 \$1,200
<u>Out-of-Pocket Maximum</u> (includes <u>Deductible</u>) Individual Family	\$1,000 \$2,000	\$2,000 \$4,000
Physician's Office Services	\$15 Copayment	30% after Deductible
Specialist Office Visit	\$30 Copayment	30% after Deductible
Preventive Care	No annual limits or maximum dollar amounts	No annual limits or maximum dollar amounts
Emergency Room Services	10% after Deductible	Same as Network Benefit
Inpatient Hospital Stay	10% after Deductible	30% after Deductible
Urgent Care Center Services	10% after Deductible	30% after Deductible

Your Medical Benefits at a Glance – Plan 3

Type of Coverage	Network Benefit	Non-Network Benefit
<u>Deductible</u> Individual Family	\$600 \$1,200	\$1,200 \$2,400
Out-of-Pocket Maximum (includes <u>Deductible</u>) Individual Family	\$2,000 \$4,000	\$4,000 \$8,000
Physician's Office Services	\$20 Copayment	30% after Deductible
Specialist Office Visit	\$40 Copayment	30% after Deductible
Preventive Care	No annual limits or maximum dollar amounts	No annual limits or maximum dollar amounts
Emergency Room Services	10% after Deductible	Same as Network Benefit
Inpatient Hospital Stay	10% after Deductible	30% after Deductible
Urgent Care Center Services	10% after Deductible	30% after Deductible

Your Medical Benefits at a Glance – Plan 4

Type of Coverage	Network Benefit	Non-Network Benefit
<u>Deductible</u> Individual Family	\$1,200 \$2,400	\$2,400 \$4,800
<u>Out-of-Pocket Maximum</u> (includes Deductible) Individual Family	\$2,500 \$5,000	\$5,000 \$10,000
Physician's Office Services	\$20 Copayment	30% after Deductible
Specialist Office Visit	\$40 Copayment	30% after Deductible
Preventive Care	No annual limits or maximum dollar amounts	No annual limits or maximum dollar amounts
Emergency Room Services	\$100 Copayment	Same as Network Benefit
Inpatient Hospital Stay	10% after Deductible	30% after Deductible
Urgent Care Center Services	\$40 Copayment	30% after Deductible

Pharmacy for Medical Plan 1

	Retail	Mail order
Tier 1	\$10 Co-pay 31-Day Supply	\$20 Co-pay 90-Day Supply
Tier 2	\$10 Co-pay 31-Day Supply	\$20 Co-pay 90-Day Supply
Tier 3	\$10 Co-pay 31-Day Supply	\$20 Co-pay 90-Day Supply

Pharmacy for Medical Plan 2

	Retail	Mail order
Tier 1	\$10 Co-pay 31-Day Supply	\$20 Co-pay 90-Day Supply
Tier 2	\$20 Co-pay 31-Day Supply	\$40 Co-pay 90-Day Supply
Tier 3	\$30 Co-pay 31-Day Supply	\$60 Co-pay 90-Day Supply

Pharmacy for Medical Plans 3 and 4

	Retail	Mail order
Tier 1	\$10 Co-pay 31-Day Supply	\$20 Co-pay 90-Day Supply
Tier 2	\$30 Co-pay 31-Day Supply	\$60 Co-pay 90-Day Supply
Tier 3	\$55 Co-pay 31-Day Supply	\$110 Co-pay 90-Day Supply