

HDHP

POS B

POS D

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Deductible - Single	\$3,000	\$6,000		\$500	\$1,000		\$600	\$1,000	
Deductible - Family	\$6,000	\$12,000		\$1,000	\$2,000		\$1,200	\$2,000	
Coinsurance	20%	40%		20%	40%		20%	40%	
Annual Out of Pocket Maximum - Single	\$6,000	\$12,000		\$6,450	\$9,500		\$6,800	\$11,500	
Annual Out of Pocket Maximum - Family	\$12,000	\$24,000		\$12,900	\$19,000		\$13,600	\$23,000	
Annual Out of Pocket Maximum - Per Person Cap	\$8,500	\$24,000		N/A	N/A		N/A	N/A	

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Cost Share - Primary Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		\$40 Copayment	40% Coinsurance Subject to Deductible		\$45 Copayment	40% Coinsurance Subject to Deductible	
Cost Share - Specialist	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		\$55 Copayment	40% Coinsurance Subject to Deductible		\$60 Copayment	40% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Plan/Calendar Year			Calendar Year Benefits			Calendar Year Benefits			Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			No			No			No

Who is Covered

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Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Domestic Partner Coverage			Covered			Covered			Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Inpatient Hospital Services	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Substance Use Detoxification	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Skilled Nursing Facility	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Days per year	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Days per year	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Days per year
Physical Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per year	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per year	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per year
Maternity Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Inpatient Hospital Surgery	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Anesthesia	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to \$3,000 Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

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Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Diagnostic X-ray	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		\$55 Copayment	40% Coinsurance Subject to Deductible		\$60 Copayment	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	
Radiation Therapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		\$55 Copayment	40% Coinsurance Subject to Deductible		\$60 Copayment	40% Coinsurance Subject to Deductible	
Chemotherapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		\$55 Copayment	40% Coinsurance Subject to Deductible		\$60 Copayment	40% Coinsurance Subject to Deductible	
Infusion Therapy Outpatient	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		Inclusive in Primary Service	Inclusive in Primary Service		Inclusive in Primary Service	Inclusive in Primary Service	
Dialysis	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		\$55 Copayment	40% Coinsurance Subject to Deductible		\$60 Copayment	40% Coinsurance Subject to Deductible	
Substance Use Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		\$55 Copayment	40% Coinsurance Subject to Deductible		\$60 Copayment	40% Coinsurance Subject to Deductible	

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Home Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to \$50 Deductible		Covered in Full	40% Coinsurance Subject to Deductible	
Home Infusion Therapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to \$50 Deductible		Covered in Full	40% Coinsurance Subject to Deductible	

Hospice Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Hospice Care Inpatient	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

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Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Office Surgery	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - \$55 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - \$60 Copayment	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - \$55 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - \$60 Copayment	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Radiation Therapy	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - \$55 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - \$60 Copayment	40% Coinsurance Subject to Deductible	
Chemotherapy	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - \$55 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - \$60 Copayment	40% Coinsurance Subject to Deductible	
Infusion Therapy Services	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Inclusive in Primary Service	Inclusive in Primary Service		PCP / Specialist - Inclusive in Primary Service	Inclusive in Primary Service	
Dialysis	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - \$55 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - \$60 Copayment	40% Coinsurance Subject to Deductible	
Mental Health Care	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - \$55 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - \$60 Copayment	40% Coinsurance Subject to Deductible	
Maternity Care	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	40% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Telehealth	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		Specialist - \$55 Copayment PCP - \$40 Copayment	40% Coinsurance Subject to Deductible		Specialist - \$60 Copayment PCP - \$45 Copayment	40% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP / Specialist - 0% Coinsurance Subject to Deductible	Not Covered		PCP / Specialist - \$10 Copayment	Not Covered		PCP / Specialist - \$10 Copayment	Not Covered	
Chiropractic Care	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - \$55 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - \$60 Copayment	40% Coinsurance Subject to Deductible	
Allergy Testing	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		Specialist - \$55 Copayment PCP - \$40 Copayment	40% Coinsurance Subject to Deductible		Specialist - \$60 Copayment PCP - \$45 Copayment	40% Coinsurance Subject to Deductible	
Allergy Treatment Including Serum	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		Specialist - \$55 Copayment PCP - \$40 Copayment	40% Coinsurance Subject to Deductible		Specialist - \$60 Copayment PCP - \$45 Copayment	40% Coinsurance Subject to Deductible	
Hearing Evaluations Routine	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	1 Exam per year	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Physical Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year	\$55 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year	\$60 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year
Occupational Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year	\$55 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year	\$60 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year	\$55 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year	\$60 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Physical Rehabilitation	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - \$55 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - \$60 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year
Occupational Rehabilitation	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - \$55 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - \$60 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - \$55 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - \$60 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Adult Physical Examination	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	1 Exam per year	PCP / Specialist - Covered in Full	Not Covered	1 Exam per year	PCP / Specialist - Covered in Full	Not Covered	1 Exam per year
Adult Immunizations	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Well Child Visits and Immunizations	PCP / Specialist - Covered in Full	0% Coinsurance		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Routine GYN Visit	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

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Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Mammography Screening Professional	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Cervical Cytology Preventative	Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Prostate Cancer Screening	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		Specialist - \$55 Copayment PCP - \$40 Copayment	40% Coinsurance Subject to Deductible		Specialist - \$60 Copayment PCP - \$45 Copayment	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Facility

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Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - \$40 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - \$45 Copayment	40% Coinsurance Subject to Deductible	
Treatment of Diabetes - Insulin	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - \$40 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - \$45 Copayment	40% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	40% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	40% Coinsurance Subject to Deductible	
Medical Supplies	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	40% Coinsurance Subject to Deductible	
Acupuncture	Not Covered	Not Covered	Not Covered	PCP / Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits per year	PCP / Specialist - 50% Coinsurance	50% Coinsurance Subject to \$700 Deductible	10 Visits per year
Private Duty Nursing	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

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Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Facility Emergency Room Visit	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to \$3,000 Deductible		\$190 Copayment	\$190 Copayment		\$215 Copayment	\$215 Copayment	

Transportation

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Prehospital Emergency and Transportation - Ground or Water	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to \$3,000 Deductible		Covered in Full	Covered in Full		Covered in Full	Covered in Full	

Urgent Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Urgent Care Center Facility Visit	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		\$60 Copayment	40% Coinsurance Subject to Deductible		\$65 Copayment	40% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Pediatric Eye Exams - Routine	Not Covered	Not Covered	Not Covered	\$55 Copayment	Not Covered	1 Exam per year	\$60 Copayment	Not Covered	1 Exam per year
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	Not Covered	Not Covered	Not Covered	\$55 Copayment	Not Covered	1 Exam every 2 calendar years	\$60 Copayment	Not Covered	1 Exam every 2 calendar years
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

Rx Benefits (Administered by OptumRx)

Rx Plan Cost Sharing

Benefit Name	Limits and Additional Information	In Network	Limits and Additional Information	In Network	Limits and Additional Information
Annual Rx Deductible	Annual Medical and Rx Deductibles are combined. See "Cost Sharing Expenses" section.	Annual Out of Pocket Maximum: \$2,550 (single) \$5,100 (Family)	Does not include medical expenses	Annual Rx Deductible: \$1,250 per person Annual Out of Pocket Maximum: \$2,650 (single) \$5,300 (Family)	Does not include medical expenses
Annual Out of Pocket Maximum	Annual Medical and Rx Out-of-Pocket Maximums are combined. See "Cost Sharing Expenses" section.				

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Benefit Name	In Network	In Network	In Network
Retail (30-day supply)	Generic: \$30 Preferred brand: \$80 Non-preferred brand: \$150	Generic: \$17 Preferred brand: \$40 Non-preferred brand: \$60	Generic: \$30 Preferred brand: \$80 Non-preferred brand: \$150
Wegman's (30-day supply)	Generic: \$25 Preferred brand: \$70 Non-preferred brand: \$130 Specialty (limited to 30-day supply):	Generic: \$15 Preferred brand: \$35 Non-preferred brand: \$50 Specialty (limited to 30-day supply):	Generic: \$25 Preferred brand: \$70 Non-preferred brand: \$130 Specialty (limited to 30-day supply):
Mail Order and Wegman's (90-day supply)	Generic: \$62.50 Preferred brand: \$175 Non-preferred brand: \$325 \$30- \$150	Generic: \$37.50 Preferred brand: \$87.50 Non-preferred brand: \$125 \$17- \$60	Generic: \$62.50 Preferred brand: \$175 Non-preferred brand: \$325 \$30- \$150

Limits and Additional Information

Copayments apply after the Rx deductible has been met.
Some medications are not covered, have limits, require prior authorization, or have clinical management requirements. Refer to the Medical and Prescription Drug Plan Summary on the HR website for more details or visit www.OptumRx.com.

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This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits. * For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.