



2021 Medical/Rx Plan Offerings

Effective January 1, 2021

| 2021 MEDICAL/Rx BENEFITS | | PLATINUM PPO | GOLD PPO | SILVER PPO | GOLD HDHP | BRONZE HDHP |
|--------------------------|---|-----------------------------|-------------------------------|-------------------------------|--|---|
| IN-NETWORK | Required Employer Contributions to HSA | N/A | N/A | N/A | \$1,000 Individual/ \$2,000 Family | Employer Discretion |
| | Medical Plan Annual Deductibles: Individual/Two-Person/Family | \$450/\$900/ \$1,350 | \$1,050/\$2,100/ \$2,950 | \$1,850/\$3,700/ \$5,350 | \$3,050/\$6,100 Combined Medical & Rx Deductible | \$6,200/\$12,400 Combined Medical & Rx Deductible |
| | Prescription Drug Plan Annual Deductibles: Individual/Two-Person/Family | \$0/\$0/\$0 | \$200/\$400/\$500 | \$250/\$500/ \$700 | | |
| | Co-Insurance: (after deductible) Plan pays/Individual pays | 90%/10% | 80%/20% | 70%/30% | 80%/20% | 60%/40% |
| | Maximum out-of-pocket (in-network services only, including deductible, co-pays, and co-insurance, combined Medical/Rx): Individual/Two-Person/Family | \$2,800/\$5,600/ \$5,600 | \$5,100/\$10,200/ \$10,200 | \$6,750/\$13,500/ \$13,500 | \$6,750/\$13,500 | \$6,750/\$13,500 |
| | Wellness and Preventive Care Visits (Not subject to deductible) See Preventive Care Schedule for list of covered services. | \$0 | \$0 | \$0 | \$0 | \$0 |
| | 98point6: On-demand primary care via private, secure in-app messaging | \$0 | \$0 | \$0 | \$0 | \$0 |
| | Primary Care Visit, Co-Pay (co-pay not credited toward annual deductible) | \$20 | \$20 | \$25 | 20% | 40% |
| | Retail Clinic | \$25 | \$35 | \$40 | 20% | 40% |
| | Specialist Visit (co-pay not credited toward annual deductible) | \$50 | \$60 | \$60 | 20% | 40% |
| | Urgent Care (co-pay not credited toward annual deductible) | \$40 | \$45 | \$50 | 20% | 40% |
| | Emergency room services (per visit) (deductible does not apply for PPO plans) | \$175 | \$250 | \$250 | 20% | 40% |
| | Outpatient Surgery/Outpatient Services (CT Scan, MRI, Diagnostic) (after deductible) | 10% | 20% | 30% | 20% | 40% |
| | Hospital inpatient (including maternity) | 10% after \$250 Co-Pay | 20% after \$250 Co-Pay | 30% after \$250 Co-Pay | 20% after \$250 Co-Pay | 40% after \$250 Co-Pay |
| | Inpatient Mental Health/Substance Abuse | 10% after \$250 Co-Pay | 20% after \$250 Co-Pay | 30% after \$250 Co-Pay | 20% after \$250 Co-Pay | 40% after \$250 Co-Pay |
| | Outpatient Mental Health/Substance Abuse (office and professional services) | \$50 Co-Pay | \$60 Co-Pay | \$60 Co-Pay | 20% | 40% |
| | Habilitative Services (with limitations) | 10% | 20% | 30% | 20% | 40% |
| | Rehabilitative and Therapy Services (for Medical Necessity) Maximum 30 Visits | 10% | 20% | 30% | 20% | 40% |
| | Chiropractic Services | 50% | 50% | 50% | 50% | 30% |

| 2021 PRESCRIPTION DRUG BENEFITS (All coinsurance and co-pays are effective after deductible is met) | | | | | | |
|--|-----------------------------|---|---|---|---|---|
| | | PLATINUM PPO | GOLD PPO | SILVER PPO | GOLD HDHP | BRONZE HDHP |
| Short-Term Med | Generic Drug, Co-Pay | \$10 for Generic | \$10 for Generic | \$10 for Generic | 20% (Plan pays 80%) | 40% (Plan pays 60%) |
| | Formulary Brand, Co-Pay | \$40 for 30-Day Supply | \$45 for 30-Day Supply | \$50 for 30-Day Supply | | |
| | Non-Formulary Brand, Co-Pay | \$80 for 30-Day Supply | \$90 for 30-Day Supply | \$100 for 30-Day Supply | | |
| Long-Term Maintenance | Generic Drug, Co-Pay | \$20 for 90-Day Supply | \$25 for 90-Day Supply | \$25 for 90-Day Supply | 20% (Plan pays 80%) | 40% (Plan pays 60%) |
| | Formulary Brand, Co-Pay | \$80 for 90-Day Supply | \$95 for 90-Day Supply | \$100 for 90-Day Supply | | |
| | Non-Formulary Brand, Co-Pay | \$160 for 90-Day Supply | \$190 for 90-Day Supply | \$200 for 90-Day Supply | | |
| SPECIALTY Acredo | Generic Drug, Co-Pay | Participant pays 20% up to a max \$500 per 30-Day Supply | Participant pays 20% up to a max \$500 per 30-Day Supply | Participant pays 20% up to a max \$500 per 30-Day Supply | Participant pays 20% up to a max \$500 per 30-Day Supply | Participant pays 40% up to a max \$500 per 30-Day Supply |
| | Formulary Brand, Co-Pay | | | | | |
| | Non-Formulary Brand, Co-Pay | | | | | |

| 2021 OUT-OF-NETWORK MEDICAL BENEFITS | | PLATINUM PPO | GOLD PPO | SILVER PPO | GOLD HDHP | BRONZE HDHP |
|--------------------------------------|--|-------------------------|---------------------------|---------------------------|--|------------------------------------|
| OUT-OF-NETWORK | Medical Plan Annual Deductibles: Individual/Two-Person/Family | \$1,350/\$2,700/\$4,050 | \$2,000/\$4,000/\$6,000 | \$3,800/\$7,600/\$11,400 | \$3,050/\$6,100 Combined Medical & Rx Deductible | N/A |
| | Co-Insurance: (after deductible) Plan pays/Individual pays | 60%/40% | 60%/40% | 60%/40% | 60%/40% | Not Covered |
| | Maximum out-of-pocket (out-of-network services only, including deductible, co-pays, and co-insurance, combined Medical/Rx): Individual/Two-Person/Family | \$4,200/\$8,400/\$8,400 | \$6,300/\$12,600/\$12,600 | \$7,900/\$15,800/\$15,800 | \$6,750/\$13,500 | Not Covered |
| | Wellness and preventive care visits | 40% | 40% | 40% | 40% | Not Covered |
| | 98point6: On-demand primary care via private, secure in-app messaging | \$0 | \$0 | \$0 | \$0 for the remainder of year 2021 | \$0 for the remainder of year 2021 |
| | Primary Care Visit, Co-Pay (co-pay not credited toward annual deductible) | 40% | 40% | 40% | 40% | Not Covered |
| | Specialist Visit, Co-Pay (co-pay not credited toward annual deductible) | 40% | 40% | 40% | 40% | Not Covered |
| | Urgent Care, co-pay (co-pay not credited toward annual deductible) | 40% | 40% | 40% | 40% | Not Covered |
| | Emergency Room Services (per visit) (deductible does not apply for PPO plans) | \$175 | \$250 | \$250 | 40% | 40% |
| | Retail Clinic | 40% | 40% | 40% | 40% | Not Covered |
| | Outpatient Surgery/Outpatient Services (CT Scan, MRI, Diagnostic) (after deductible) | 40% | 40% | 40% | 40% | Not Covered |
| | Hospital Inpatient (including maternity) | 40% after \$250 Co-Pay | 40% after \$250 Co-Pay | 40% after \$250 Co-Pay | 40% after \$250 Co-Pay | Not Covered |
| | Inpatient Mental Health/Substance Abuse | 40% after \$250 Co-Pay | 40% after \$250 Co-Pay | 40% after \$250 Co-Pay | 40% after \$250 Co-Pay | Not Covered |
| | Outpatient Mental Health/Substance Abuse (office and professional services) | 40% | 40% | 40% | 40% | Not Covered |
| | Therapy and Rehabilitation Services (for Medical Necessity) Limit: 30 visits | 40% | 40% | 40% | 40% | Not Covered |
| | Chiropractic Services | 50% | 50% | 50% | 50% | Not Covered |