

Health Insurance Information

Network Health	\$1500/\$3000 HMO Base Plan	
	In-Network	Out-of-Network
Deductible		
Single	\$1,500	n/a
Family	\$3,000	n/a
Co-Insurance	0%	n/a
Out-of-Pocket Max. (Medical Deductible & Coinsurance)		
Single	\$1,500	n/a
Family	\$3,000	n/a
Out-of-Pocket Max. (Medical Deductible, Coinsurance & Copays)		
Single	\$6,850	n/a
Family	\$13,700	n/a
Office Visits		
Primary Care Physician	\$10 copay	Not Covered
Specialty Care Physician	\$25 copay	Not Covered
Virtual Visits	\$0 Copay	n/a
Routine / Preventive Care*	Select Services Covered in Full	Not Covered
Urgent Care	\$100 copay	Not Covered
Emergency Room	\$100 copay	\$100 copay
Hospital Services	Deductible	Not Covered
Retail Prescription Coverage		
Preventive		\$10 copay
Generic		\$25 copay
Preferred Brand Name		\$50 copay
Non-Preferred Brand Name		\$50 copay

*Routine / Preventive Care includes periodic physical exams. The frequency and type of exams are based on the Member's age, sex and medical history including routine immunizations. All benefits are subject to the limitations, and exclusions set forth in the Certificate of Coverage.

HMO Plan

	Monthly Full Rate	Employer Rate	Employee Rate
Employee	\$698.59	\$610.57	\$88.02
Family	\$1,556.59	\$1,360.46	\$196.13

Health Insurance Information (continued)

Network Health	\$2000/\$4000 HMO Plan HDHP H.S.A. Plan	
	In-Network	Out-of-Network
Deductible		
Single	\$2,000	n/a
Family	\$4,000	n/a
Co-Insurance	0%	n/a
Out-of-Pocket Max. (Medical Deductible & Coinsurance)		
Single	\$2,000	n/a
Family	\$4,000	n/a
Office Visits		
Primary Care Physician	Deductible	Not Covered
Specialty Care Physician	Deductible	Not Covered
Virtual Visits	\$41 Fee	n/a
Routine / Preventive Care*	Select Services Covered in Full	Not Covered
Urgent Care	Deductible	Not Covered
Emergency Room	Deductible	Deductible
Hospital Services	Deductible	Not Covered
Retail Prescription Coverage		
Preventive		Deductible
Generic		Deductible
Preferred Brand Name		Deductible
Non-Preferred Brand Name		Deductible

*Routine / Preventive Care includes periodic physical exams. The frequency and type of exams are based on the Member's age, sex and medical history including routine immunizations. All benefits are subject to the limitations, and exclusions set forth in the Certificate of Coverage.

HMO HDHP Plan

	Monthly Full Rate	Employer Rate	Employee Rate
Employee	\$655.30	\$572.73	\$82.57
Family	\$1,460.01	\$1,276.05	\$183.96

Health Insurance Information (continued)

Network Health	\$1500/\$3000 POS Buy Up Plan	
	In-Network	Out-of-Network
Deductible		
Single	\$1,500	\$3,000
Family	\$3,000	\$6,000
Out-of-Network HRA		<i>Employee pays first \$2,500 HRA pays second \$500 for Single (2 x's family)</i>
Co-Insurance	0%	20%
Out-of-Pocket Max. (Medical Deductible & Coinsurance)		
Single	\$1,500	\$4,000
Family	\$3,000	\$8,000
ACA Out-of-Pocket Max. (Medical Deductible, Coinsurance, Medical Copays, & Rx Copays)		
Single	\$6,850	n/a
Family	\$13,700	n/a
Office Visits		
Primary Care Physician	\$10 copay	Deductible & Coinsurance
Specialty Care Physician	\$25 copay	Deductible & Coinsurance
Virtual Visits	\$0	n/a
Routine / Preventive Care*	Select Services Covered in Full	Deductible & Coinsurance
Urgent Care	\$100 copay	Deductible & Coinsurance
Emergency Room	\$100 copay	\$100 copay
Hospital Services	Deductible	Deductible & Coinsurance
Retail Prescription Coverage		
Preventive		\$10
Generic		\$25
Preferred Brand Name		\$50
Non-Preferred Brand Name		\$50

*Routine / Preventive Care includes periodic physical exams. The frequency and type of exams are based on the Member's age, sex and medical history including routine immunizations. All benefits are subject to the limitations, and exclusions set forth in the Certificate of Coverage.

POS Plan

	Monthly Full Rate	Employer Rate	Employee Rate
Employee	\$757.42	\$617.42	\$140.00
Family	\$1,687.67	\$1,412.67	\$275.00