MEDICAL PLAN

OPTION 1: HMO COPAY PLAN- BASE PLAN

You have several medical plan options to choose from. Your first option is an HMO Copay Plan. An HMO gives you access to certain doctors and hospitals within its network. You do not have out-of-network coverage. Below is a high-level overview of your benefit options.

| | | Out-of-Network | |
|----------------------------------|--|----------------|--|
| Deductible | | | |
| Single | \$2,000 | Not Covered | |
| Family | \$4,000 | Not Covered | |
| DISTRICT FUNDED HRA | | | |
| Single | \$1,000 | | |
| Family | \$2,000 | | |
| Deductible and Coinsurance Limit | | | |
| Single | \$2,000 | Not Covered | |
| Family | \$4,000 | Not Covered | |
| Out-of-Pocket Maximum | | | |
| Single | \$6,850 | Not Covered | |
| Family | \$13,700 | Not Covered | |
| Coinsurance | 100% | Not Covered | |
| Dependent Eligibility | To Age 26 (end of month) | | |
| PHYSICIAN SERVICES | | | |
| Select Preventative Services | Covered in Full | Not Covered | |
| Primary Care Office Visit | \$20 Copay | Not Covered | |
| Specialty Care Office Visit | \$20 Copay | Not Covered | |
| Partnered Health Location Visit | \$5 Copay | N/A | |
| HOSPITAL SERVICES | | | |
| Inpatient / Outpatient | Deductible | Not Covered | |
| URGENT CARE & ER SERVICES | | | |
| Urgent Care | \$20 Copay and/or Deductible | | |
| Emergency Care | \$200 Copay and/or Deductible (Copay waived if admitted) | | |
| RETAIL PRESCRIPTION DRUGS | | | |
| Tier 1 | \$20 Copay | Not Covered | |
| Tier 2 | \$40 Copay | Not Covered | |
| Tier 3 | \$60 Copay | Not Covered | |
| Tier 4 | Not Covered | Not Covered | |

\$0 Preventive Rx List and Prevea Partnered Health Included

OPTION 2: POS COPAY PLAN - BUY-UP PLAN

Your second option is a Point of Service (POS) option. This option also gives you access to certain doctors and hospitals within its network, as well as coverage for doctors and hospitals outside of the network. Out-of-network services will be processed at the out-of-network coverage level noted below. Below is a high-level overview of your benefit options.

| Prevea360 | In-Network | Out-of-Network |
|----------------------------------|--|--------------------------|
| Deductible | | |
| Single | \$2,000 | \$4,000 |
| Family | \$4,000 | \$8,000 |
| Deductible and Coinsurance Limit | | |
| Single | \$2,000 | \$5,000 |
| Family | \$4,000 | \$10,000 |
| DISTRICT FUNDED HRA | | |
| Single | \$1,000 | |
| Family | \$2,000 | |
| Out-of-Pocket Maximum | | |
| Single | \$6,850 | \$5,000 |
| Family | \$13,700 | \$10,000 |
| Coinsurance | 100% | 80% |
| Dependent Eligibility | To Age 26 (end of month) | |
| PHYSICIAN SERVICES | | |
| Select Preventive Services | Covered in Full | Deductible & Coinsurance |
| Primary Care Office Visit | \$20 Copay | Deductible & Coinsurance |
| Specialty Care Office Visit | \$20 Copay | Deductible & Coinsurance |
| Partnered Health Location Visit | \$5 Copay | N/A |
| HOSPITAL SERVICES | | |
| Inpatient / Outpatient | Deductible | Deductible & Coinsurance |
| URGENT CARE & ER SERVICES | | |
| Urgent Care | \$20 Copay and/or Deductible | |
| Emergency Care | \$200 Copay and/or Deductible (Copay waived if admitted) | |
| RETAIL PRESCRIPTION DRUGS | | |
| Tier 1 | \$20 Copay | 50% Coinsurance |
| Tier 2 | \$40 Copay | 50% Coinsurance |
| Tier 3 | \$60 Copay | Not Covered |
| Tier 4 | Not Covered | Not Covered |

\$0 Preventive Rx List and Prevea Partnered Health Included

OPTION 3: POS HDHP PLAN - BUY-UP PLAN

Your third option is a High Deductible Health Plan that offers lower premiums than a copay plan, but you will pay more before the plan starts to cover some of your costs. This option gives you access to certain doctors and hospitals within its network, as well as coverage for doctors and hospitals outside of the network. This plan has access to a Health Savings Account (HSA) that can be used to save pretax dollars to pay for qualified health care expenses.

| Prevea360 | In-Network | Out-of-Network | |
|----------------------------------|--|--------------------------|--|
| Deductible | | | |
| Single | \$2,000 | \$4,000 | |
| Family | \$4,000 | \$8,000 | |
| Deductible and Coinsurance Limit | | | |
| Single | \$2,000 | \$6,000 | |
| Family | \$4,000 | \$12,000 | |
| DISTRICT HSA CONTRIBUTION | | | |
| Single | \$500 | | |
| Limited Family | \$750 | | |
| Family | \$1,000 | | |
| Out-of-Pocket Maximum | | | |
| Single | \$2,000 | \$6,000 | |
| Family | \$4,000 | \$12,000 | |
| Coinsurance | 100% | 80% | |
| Dependent Eligibility | To Age 26 (end of month) | | |
| PHYSICIAN SERVICES | | | |
| Select Preventive Services | Covered in Full | Deductible & Coinsurance | |
| Primary Care Office Visit | Deductible | Deductible & Coinsurance | |
| Specialty Care Office Visit | Deductible | Deductible & Coinsurance | |
| Partnered Health Location Visit | Deductible (services at discounted rate) | N/A | |
| HOSPITAL SERVICES | | | |
| Inpatient / Outpatient | Deductible | Deductible & Coinsurance | |
| URGENT CARE & ER SERVICES | | | |
| Urgent Care | Deductible & Coinsurance | | |
| Emergency Care | Deductible & Coinsurance | | |
| RETAIL PRESCRIPTION DRUGS | | | |
| Tier 1 | Deductible | Deductible & Coinsurance | |
| Tier 2 | Deductible | Deductible & Coinsurance | |
| Tier 3 | Deductible | Not Covered | |
| Tier 4 | Deductible | Deductible & Coinsurance | |

\$0 Preventive Rx List and Prevea Partnered Health Included

OPTION 4: HMO HDHP PLAN - BUY-DOWN PLAN

Your fourth option is a High Deductible Health Plan that offers lower premiums than a copay plan, but you will pay more before the plan starts to cover some of your costs. This plan is an HMO and gives you access to certain doctors and hospitals within its network. You do not have out-of-network coverage. This plan has access to a Health Savings Account (HSA) that can be used to save pretax dollars to pay for qualified health care expenses.

| Deductible Single \$2,000 Not Covered Family \$4,000 Not Covered DISTRICT HSA CONTRIBUTION Single \$500 Limited Family \$750 Family \$1,000 |
|---|
| Family \$4,000 Not Covered DISTRICT HSA CONTRIBUTION Single \$500 Limited Family \$750 |
| DISTRICT HSA CONTRIBUTION Single \$500 Limited Family \$750 |
| Single \$500 Limited Family \$750 |
| Limited Family \$750 |
| |
| Camily (1,000 |
| |
| Deductible and Coinsurance Limit |
| Single \$2,000 Not Covered |
| Family \$4,000 Not Covered |
| Out-of-Pocket Maximum |
| Single \$2,000 Not Covered |
| Family \$4,000 Not Covered |
| Coinsurance 100% Not Covered |
| Dependent Eligibility To Age 26 (end of month) |
| PHYSICIAN SERVICES |
| Select Preventive Services Covered in Full Not Covered |
| Primary Care Office Visit Deductible Not Covered |
| Specialty Care Office Visit Deductible Not Covered |
| Partnered Health Location Visit Deductible (services at discounted rate) N/A |
| HOSPITAL SERVICES |
| Inpatient / Outpatient Deductible Not Covered |
| URGENT CARE & ER SERVICES |
| Urgent Care Deductible |
| Emergency Care Deductible |
| RETAIL PRESCRIPTION DRUGS |
| Tier 1 Deductible Not Covered |
| Tier 2 Deductible Not Covered |
| Tier 3 Deductible Not Covered |
| Tier 4 Deductible Not Covered |

\$0 Preventive Rx List and Prevea Partnered Health Included

OPTION 5: HMO HDHP PLAN - BUY-DOWN PLAN

Your fifth option is a High Deductible Health Plan that offers lower premiums than a copay plan, but will pay more before the plan starts to cover some of your costs. This plan is an HMO and gives you access to certain doctors and hospitals within its network. You do not have out-of-network coverage. This plan has access to a Health Savings Account (HSA) that can be used to save pretax dollars to pay for qualified health care expenses.

| Single \$3,000 Not Covered Family \$6,000 Not Covered DISTRICT HSA CONTRIBUTION Single \$500 Limited Family \$750 Family \$750 Family \$1,000 Peductible and Coinsurance Limit Single \$3,000 Not Covered Pamily \$6,000 Not Covered Family To Age 26 (end of month) PHYSICIAN SERVICES Select Preventive Services Covered in Full Not Covered Primary Care Office Visit Deductible Not Covered Partnered Health Location Visit Deductible Not Covered Partnered Health Location Visit Deductible Services at discounted rate) N/A HOSPITAL SERVICES Inpatient / Outpatient Deductible Not Covered URGENT CARE & ER SERVICES Urgent Care Deductible Not Covered Deductible RETAIL PRESCRIPTION DRUGS Titer 1 Deductible Not Covered Titer 2 Deductible Not Covered Titer 3 Deductible Not Covered Titer 3 Deductible Not Covered Titer 3 Deductible Not Covered Not Covered Titer 3 Deductible Not Covered Not Covered Titer 3 Deductible Not Covered Not Covered Not Covered Titer 3 Deductible Not Covered Not Covered Titer 3 Deductible Not Covered Not Covered Titer 3 Deductible Not Covered Not Covered Not Covered Titer 3 Deductible Not Covered Not Covered Titer 3 Deductible Not Covered Not Covered Titer 3 Deductible Not Covered Not Covered Not Covered Titer 3 Deductible Not Covered Not Covered Not Covered Titer 3 Deductible Not Covered Not Covered Titer 3 Deductible Not Covered Not C | Prevea360 | In-Network | Out-of-Network |
|--|---|--|----------------|
| Family \$6,000 Not Covered DISTRICT HSA CONTRIBUTION Single \$500 Limited Family \$750 Family \$1,000 Deductible and Coinsurance Limit Single \$3,000 Not Covered Family \$6,000 Not Covered Family \$6,000 Not Covered Out-of-Pocket Maximum Single \$3,000 Not Covered Family \$6,000 Not Covered Coinsurance 100% Not Covered Coinsurance 100% Not Covered Dependent Eligibility To Age 26 (end of month) PHYSICIAN SERVICES Select Preventive Services Covered in Full Not Covered Specialty Care Office Visit Deductible Not Covered Specialty Care Office Visit Deductible Not Covered HOSPITAL SERVICES Inpatient / Outpatient Deductible Not Covered UNGENT CARE & ER SERVICES Urgent Care Deductible Emergency Care Deductible RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered | Deductible | | |
| DISTRICT HSA CONTRIBUTION Single \$500 Limited Family \$750 Family \$1,000 Deductible and Coinsurance Limit Single \$3,000 Not Covered Family \$6,000 Not Covered Out-of-Pocket Maximum Single \$3,000 Not Covered Family \$6,000 Not Covered Coinsurance 100% Not Covered Coinsurance 100% Not Covered Dependent Eligibility To Age 26 (end of month) PHYSICIAN SERVICES Select Preventive Services Covered in Full Not Covered Primary Care Office Visit Deductible Not Covered Partnered Health Location Visit Deductible (services at discounted rate) N/A HOSPITAL SERVICES Inpatient / Outpatient Deductible Not Covered URGENT CARE & ER SERVICES Urgent Care Deductible Emergency Care Deductible Emergency Care Deductible RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered | Single | \$3,000 | Not Covered |
| Single \$500 Limited Family \$750 Family \$1,000 Deductible and Coinsurance Limit Single \$3,000 Not Covered Family \$6,000 Not Covered Family \$6,000 Not Covered Out-of-Pocket Maximum Single \$3,000 Not Covered Family \$6,000 Not Covered Coinsurance 100% Not Covered Dependent Eligibility To Age 26 (end of month) PHYSICIAN SERVICES Select Preventive Services Covered in Full Not Covered Specialty Care Office Visit Deductible Not Covered Specialty Care Office Visit Deductible Not Covered HOSPITAL SERVICES Inpatient / Outpatient Deductible Not Covered URGENT CARE & ER SERVICES Urgent Care Deductible Emergency Care Deductible Emergency Care Deductible RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered | Family | \$6,000 | Not Covered |
| Limited Family \$750 Family \$1,000 Deductible and Coinsurance Limit Single \$3,000 Not Covered Family \$6,000 Not Covered Out-of-Pocket Maximum Single \$3,000 Not Covered Family \$6,000 Not Covered Coinsurance \$100% Not Covered Coinsurance \$100% Not Covered Dependent Eligibility To Age 26 (end of month) PHYSICIAN SERVICES Select Preventive Services Covered in Full Not Covered Primary Care Office Visit Deductible Not Covered Specialty Care Office Visit Deductible Not Covered Partnered Health Location Visit Deductible (services at discounted rate) N/A HOSPITAL SERVICES Inpatient / Outpatient Deductible Not Covered URGENT CARE & ER SERVICES Urgent Care Deductible Emergency Care Deductible RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered Tier 3 Deductible Not Covered | DISTRICT HSA CONTRIBUTION | | |
| Family \$1,000 Deductible and Coinsurance Limit Single \$3,000 Not Covered Family \$6,000 Not Covered Out-of-Pocket Maximum Single \$3,000 Not Covered Coinsurance \$3,000 Not Covered Family \$6,000 Not Covered Family \$6,000 Not Covered Coinsurance 100% Not Covered Dependent Eligibility To Age 26 (end of month) PHYSICIAN SERVICES Select Preventive Services Covered in Full Not Covered Primary Care Office Visit Deductible Not Covered Specialty Care Office Visit Deductible Not Covered Partnered Health Location Visit Deductible Not Covered Partnered Health Location Visit Deductible Not Covered PHOSPITAL SERVICES URGENT CARE & ER SERVICES URGENT CARE & ER SERVICES URGENT CARE & Deductible Emergency Care Deductible RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered Tier 3 Deductible Not Covered | Single | \$500 | |
| Deductible and Coinsurance Limit Single \$3,000 Not Covered Family \$6,000 Not Covered Out-of-Pocket Maximum Single \$3,000 Not Covered Coinsurance \$3,000 Not Covered Coinsurance 100% Not Covered Dependent Eligibility To Age 26 (end of month) PHYSICIAN SERVICES Select Preventive Services Covered in Full Not Covered Primary Care Office Visit Deductible Not Covered Partnered Health Location Visit Deductible Not Covered PHOSPITAL SERVICES Inpatient / Outpatient Deductible Not Covered URGENT CARE & ER SERVICES URGENT CARE & ER SERVICES URGENT CARE & ER SERVICES Tier 1 Deductible Not Covered RETAIL PRESCRIPTION DRUGS Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered | Limited Family | \$750 | |
| Single \$3,000 Not Covered Family \$6,000 Not Covered Family \$6,000 Not Covered Family \$6,000 Not Covered Family \$3,000 Not Covered Family \$6,000 Not Covered Family \$6,000 Not Covered Family \$6,000 Not Covered Family To Age 26 (end of month) Not Covered Family To Age 26 (end of month) PHYSICIAN SERVICES Select Preventive Services Covered in Full Not Covered Primary Care Office Visit Deductible Not Covered Specialty Care Office Visit Deductible Not Covered Partnered Health Location Visit Deductible Not Covered Partnered Health Location Visit Deductible (services at discounted rate) N/A HOSPITAL SERVICES Inpatient / Outpatient Deductible Not Covered URGENT CARE & ER SERVICES Urgent Care Deductible Emergency Care Deductible ERETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered | Family | \$1,000 | |
| Family \$6,000 Not Covered Out-of-Pocket Maximum Single \$3,000 Not Covered Family \$6,000 Not Covered Coinsurance 100% Not Covered Dependent Eligibility To Age 26 (end of month) PHYSICIAN SERVICES Select Preventive Services Covered in Full Not Covered Primary Care Office Visit Deductible Not Covered Specialty Care Office Visit Deductible Not Covered Partnered Health Location Visit Deductible (services at discounted rate) N/A HOSPITAL SERVICES Inpatient / Outpatient Deductible Not Covered URGENT CARE & ER SERVICES Urgent Care Deductible Emergency Care Deductible RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered | Deductible and Coinsurance Limit | | |
| Out-of-Pocket Maximum Single \$3,000 Not Covered Family \$6,000 Not Covered Coinsurance 100% Not Covered Dependent Eligibility To Age 26 (end of month) PHYSICIAN SERVICES Select Preventive Services Covered in Full Not Covered Primary Care Office Visit Deductible Not Covered Specialty Care Office Visit Deductible Not Covered Partnered Health Location Visit Deductible (services at discounted rate) N/A HOSPITAL SERVICES Inpatient / Outpatient Deductible Not Covered URGENT CARE & ER SERVICES Urgent Care Deductible Emergency Care Deductible RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered | Single | \$3,000 | Not Covered |
| Single \$3,000 Not Covered Family \$6,000 Not Covered Semily \$6,000 Not Covered Semily Select Preventive Services Covered in Full Not Covered Primary Care Office Visit Deductible Not Covered Specialty Care Office Visit Deductible Not Covered Partnered Health Location Visit Deductible (services at discounted rate) N/A HOSPITAL SERVICES Inpatient / Outpatient Deductible Not Covered URGENT CARE & ER SERVICES Urgent Care Deductible RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered Tier 3 | Family | \$6,000 | Not Covered |
| Family \$6,000 Not Covered Coinsurance 100% Not Covered Dependent Eligibility To Age 26 (end of month) PHYSICIAN SERVICES Select Preventive Services Covered in Full Not Covered Primary Care Office Visit Deductible Not Covered Specialty Care Office Visit Deductible Not Covered Partnered Health Location Visit Deductible (services at discounted rate) N/A HOSPITAL SERVICES Inpatient / Outpatient Deductible Not Covered URGENT CARE & ER SERVICES Urgent Care Deductible Emergency Care Deductible RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered Tier 3 Deductible Not Covered | Out-of-Pocket Maximum | | |
| Coinsurance 100% Not Covered Dependent Eligibility To Age 26 (end of month) PHYSICIAN SERVICES Select Preventive Services Covered in Full Not Covered Primary Care Office Visit Deductible Not Covered Specialty Care Office Visit Deductible Not Covered Partnered Health Location Visit Deductible (services at discounted rate) N/A HOSPITAL SERVICES Inpatient / Outpatient Deductible Not Covered URGENT CARE & ER SERVICES Urgent Care Deductible Emergency Care Deductible RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered Tier 3 Deductible Not Covered | Single | • • | |
| Dependent Eligibility To Age 26 (end of month) PHYSICIAN SERVICES Select Preventive Services Covered in Full Not Covered Primary Care Office Visit Deductible Not Covered Specialty Care Office Visit Deductible Partnered Health Location Visit Deductible (services at discounted rate) N/A HOSPITAL SERVICES Inpatient / Outpatient Deductible URGENT CARE & ER SERVICES Urgent Care Deductible Emergency Care Deductible RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered Not Covered Not Covered Not Covered | Family | \$6,000 | Not Covered |
| PHYSICIAN SERVICES Select Preventive Services Covered in Full Not Covered Primary Care Office Visit Deductible Not Covered Specialty Care Office Visit Deductible Not Covered Partnered Health Location Visit Deductible (services at discounted rate) N/A HOSPITAL SERVICES Inpatient / Outpatient Deductible Not Covered URGENT CARE & ER SERVICES Urgent Care Deductible Emergency Care Deductible RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered Tier 3 Not Covered | Coinsurance | 100% | Not Covered |
| Select Preventive Services Primary Care Office Visit Deductible Specialty Care Office Visit Deductible Partnered Health Location Visit Deductible (services at discounted rate) Not Covered N/A HOSPITAL SERVICES Inpatient / Outpatient Deductible URGENT CARE & ER SERVICES Urgent Care Deductible Emergency Care Deductible RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered | Dependent Eligibility | To Age 26 (end of month) | |
| Primary Care Office Visit Specialty Care Office Visit Partnered Health Location Visit Deductible (services at discounted rate) Not Covered N/A HOSPITAL SERVICES Inpatient / Outpatient Deductible URGENT CARE & ER SERVICES Urgent Care Emergency Care Deductible RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Deductible Not Covered | PHYSICIAN SERVICES | | |
| Specialty Care Office Visit Deductible Not Covered Partnered Health Location Visit Deductible (services at discounted rate) N/A HOSPITAL SERVICES Inpatient / Outpatient Deductible Not Covered URGENT CARE & ER SERVICES Urgent Care Deductible Emergency Care Deductible RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered Not Covered | Select Preventive Services | Covered in Full | Not Covered |
| Partnered Health Location Visit Deductible (services at discounted rate) N/A HOSPITAL SERVICES Inpatient / Outpatient Deductible Not Covered URGENT CARE & ER SERVICES Urgent Care Deductible Emergency Care Deductible RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered | Primary Care Office Visit | Deductible | Not Covered |
| HOSPITAL SERVICES Inpatient / Outpatient Deductible Not Covered URGENT CARE & ER SERVICES Urgent Care Deductible Emergency Care Deductible RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered | Specialty Care Office Visit | Deductible | Not Covered |
| Inpatient / Outpatient Deductible Not Covered URGENT CARE & ER SERVICES Urgent Care Deductible Emergency Care Deductible RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered | Partnered Health Location Visit | Deductible (services at discounted rate) | N/A |
| URGENT CARE & ER SERVICES Urgent Care Deductible Emergency Care Deductible RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered | HOSPITAL SERVICES | | |
| Urgent Care Deductible Emergency Care Deductible RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered | Inpatient / Outpatient | Deductible | Not Covered |
| Emergency Care RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered | URGENT CARE & ER SERVICES | | |
| RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered | Urgent Care | Deductible | |
| RETAIL PRESCRIPTION DRUGS Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered | Emergency Care | Deductible | |
| Tier 1 Deductible Not Covered Tier 2 Deductible Not Covered Tier 3 Deductible Not Covered | RETAIL PRESCRIPTION DRUGS | | |
| Tier 3 Deductible Not Covered | Tier 1 | Deductible | Not Covered |
| | Tier 2 | Deductible | Not Covered |
| Tier 4 Deductible Not Covered | Tier 3 | Deductible | Not Covered |
| | Tier 4 | Deductible | Not Covered |

\$0 Preventive Rx List and Prevea Partnered Health Included