2022 Health Plan Offerings

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Your Benefits and Amount YOU PAY after Deductible (except where noted)

Plan	$2,000 Deductible	$3,000 Deductible	$5,500 Deductible	$8,700 Deductible	$4,500 Deductible*	$6,750 Deductible*
Benefit	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Annual Deductible** • Individual • Family	$2,000 $6,000	$3,000 $7,150	$5,500 $11,000	$8,700 $17,400	$4,500 $9,000	$6,750 $13,500
Your Benefit Coinsurance & Out-of-Pocket maximum** • Individual • Family	Deductible and 20% $6,000 $12,000	Deductible and 25% $8,700 $17,400	Deductible and 25% $8,700 $17,400	Covered 100% after deductible $8,700 $17,400	Deductible and 20% $7,050 $14,100	Covered 100% after deductible $6,750 $13,500
Office Visits (Illness and Injury) • Primary Care • Specialist • Retail Health Clinic • Urgent Care • Virtual Visits	$50 $80 $40 $80 Based on provider specialty *(Deductible does not apply)*	$50 $80 $40 $80 Based on provider specialty *(Deductible does not apply)*	25% 25% 25% 25% 25% *(First 3 PCP Visits at 100%)*	Covered 100% after deductible *(First 3 PCP Visits at 100%)*	20% 20% 20% 20% 20%	Covered 100% after deductible
Routine Preventive Care	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Hospital & Professional Services Inpatient, Outpatient, and Emergency Room	20%	25%	25%	Covered 100% after deductible	20%	Covered 100% after deductible
Prescription Drugs **Retail** • Generic • Formulary • Non-formulary **Mail-Order** • Generic • Formulary • Non-formulary **Specialty (per script)**	*31-Day Supply* $10 copay $60 copay $120 copay *90-Day Supply* $25 copay $150 copay $300 copay 30% coinsurance	*31-Day Supply* $10 copay $60 copay $120 copay *90-Day Supply* $25 copay $150 copay $300 copay 30% coinsurance	*31-Day Supply* $10 copay 25% coinsurance 25% coinsurance *90-Day Supply* $25 copay 25% coinsurance 25% coinsurance 25% coinsurance	*31-Day Supply* $10 copay Covered 100% after ded Covered 100% after ded *90-Day Supply* $25 copay Covered 100% after ded Covered 100% after ded Covered 100% after ded	*Preventive Drugs are covered at a copay *Non-Preventive drugs you pay deductible then 20%	*Preventive Drugs are covered at a copay *Non-Preventive drugs you pay deductible then all drugs are covered at 100%

Benefit	Out-Of-Network
Benefit Percentage & Out-of-Pocket Maximum**	*Deductible:* Individual $10,000 and Family $20,000 *Coinsurance Percentage:* 50% *Maximum Out-of-Pocket:* Unlimited

*HSA Compatible Plan
** Embedded means you can satisfy the Family "Deductible" or the Family Maximum Out-of-Pocket by meeting the individual amount for any one (1) covered family member and then any combination of family members may satisfy the remaining amount. Maximum Out-of-Pocket includes Deductibles, Coinsurance percentage and Copays.
This is a benefit summary only and does not outline all the benefits and exclusions under the plan. Please see the full legal plan document for details.