Compare the Copay Medical Options

Benefit Highlights	Copay 500		Copay 750	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	$500 Individual $1,500 Family	$1,000 Individual $3,000 Family	$750 Individual $2,250 Family	$1,500 Individual $4,500 Family
Out-of-Pocket Maximum (Annual)	$4,000 Individual $8,000 Family	$10,000 Individual $20,000 Family	$5,000 Individual $10,000 Family	$12,000 Individual $24,000 Family
Lifetime Maximum Benefit	Unlimited for active members $1,000,000 per individual for early retirees		Unlimited for active members $1,000,000 per individual for early retirees	
Plan Coinsurance	75% Plan 25% Member	50% Plan 50% Member	70% Plan 30% Member	50% Plan 50% Member
Copays	Copays do not count toward the deductible and/or out of pocket maximums	N/A	Copays do not count toward the deductible and/or out of pocket maximums	N/A
Wellness/Preventive Services				
Well Childcare (1st 24 months up to 9 visits, 1 exam per year for ages 2–6)	100%, after copay: $25 PCP/$35 specialist	50% after deductible	100%, after copay: $35 PCP/$45 specialist	50% after deductible
Physical Exams (Age 7–34 limit one exam/24 months; Age 35 and up limit one exam/12 months)	100%, after copay: $25 PCP/$35 specialist	50% after deductible	100%, after copay: $35 PCP/$45 specialist	50% after deductible
Pap Smears	Covered at 100% (when part of office visit) Subject to office visit copay	50% after deductible	Covered at 100% (when part of office visit) Subject to office visit copay	50% after deductible
Mammograms	100%	50% after deductible	100%	50% after deductible
Immunizations	100%, after copay: $25 PCP/$35 specialist (when part of office visit)	50% after deductible	100%, after copay: $35 PCP/$45 specialist (when part of office visit)	50% after deductible

Compare the Copay Medical Options (continued)

Benefit Highlights	Copay 500		Copay 750	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician/Provider Office Services				
Office Visits	100%, after copay: $25 PCP/$35 specialist	50% after deductible	100%, after copay: $35 PCP/$45 specialist	50% after deductible
Maternity Office Visits	$25 copay per PCP visit; $35 copay per specialist visit — for initial visit, then 75% after deductible	50% after deductible	$35 copay per PCP visit; $45 copay per specialist visit — for initial visit, then 70% after deductible	50% after deductible
Diagnostic Testing (includes lab work, X-rays)	Included in copay when billed by physician. Otherwise, covered at 75% after deductible	50% after deductible	Included in copay when billed by physician. Otherwise, covered at 70% after deductible	50% after deductible
Emergency Room Physician	$35 copay	Covered 50% after deductible	$45 copay	Covered 50% after deductible
Hospital & Outpatient Facility Services				
Inpatient Facility Charges	75% after deductible	$300/admission, then 50% after deductible	70% after deductible	$400/admission, the 50% after deductible
Outpatient Facility Charges (includes surgery, hemodialysis, IV therapy, chemotherapy, radiation treatment)	75% after deductible	50%, after deductible (additional $400 copay when performed in a hospital)	70% after deductible	50% after deductible (additional $400 copay when performed in a hospital)
Emergency Room Visits (Facility) (no coverage for non-emergency use of emergency room)	75% after $100 copay (copay waived if admitted)	75% after $100 copay (copay waived if admitted)	70% after $250 copay (copay waived if admitted)	70% after $250 copay (copay waived if admitted)
Urgent Care	$35 copay per visit, then covered 75%	$200 copay per visit, then covered 50%	$45 copay per visit, then covered 70%	$500 copay per visit, then covered 50%
Pre-natal Program	Newborn's initial calendar year deductible waived if mother enrolls in program within first 24 weeks of pregnancy and completes program	Newborn's initial calendar year deductible ($500 maximum) waived if mother enrolls in program within first 24 weeks of pregnancy and completes program	Newborn's initial calendar year deductible waived if mother enrolls in program within first 24 weeks of pregnancy and completes program	Newborn's initial calendar year deductible (maximum $750) waived if mother enrolls in program within first 24 weeks of pregnancy and completes program

Compare the Copay Medical Options (continued)

Benefit Highlights	Copay 500		Copay 750	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Physical/Speech Therapy (Up to 60 visits combined per calendar year)				
	75% after deductible.	50% after deductible	70% after deductible	50% after deductible
Mental Healthcare				
Inpatient Pre-authorization required.	Covered 75% after deductible. Prior authorization required.	$300 copay per admission for acute inpatient level of care, then covered 50% of billed charges. Covered at 50% for all other higher levels of care. Prior authorization required.	Covered 75% after deductible. Prior authorization required.	$300 copay per admission for acute inpatient level of care, then covered 50% of billed charges. Covered at 50% for all other higher levels of care. Prior authorization required.
Routine Outpatient and Ongoing Medication Management	100% after $15 copay for up to 25 visits, after 25 visits copay is $25. Pre-authorization required.	Covered 50% of Usual and Customary charges.	100% after $15 copay for up to 25 visits, after 25 visits copay is $25. Pre-authorization required.	Covered 50% of Usual and Customary charges.
Substance Abuse				
Inpatient Pre-authorization required.	Covered 75% after deductible. Prior authorization required.	$300 copay per admission for acute inpatient level of care, then covered 50% of billed charges. Covered at 50% for all other higher levels of care. Prior authorization required.	Covered 75% after deductible. Prior authorization required.	$300 copay per admission for acute inpatient level of care, then covered 50% of billed charges. Covered at 50% for all other higher levels of care. Prior authorization required.
Routine Outpatient and Ongoing Medication Management	100% after $15 copay for up to 25 visits, after 25 visits copay is $25. Pre-authorization required.	Covered 50% of Usual and Customary charges.	100% after $15 copay for up to 25 visits, after 25 visits copay is $25. Pre-authorization required.	Covered 50% of Usual and Customary charges.

Compare the Copay Medical Options (continued)

Benefit Highlights	Copay 500		Copay 750	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Pharmacy — Retail*				
Tier 1 — Generic	$8 copay	N/A	$8 copay	N/A
Tier 2 — Preferred Brand (no generic therapeutic alternative in drug class)	$25 copay	N/A	$25 copay	N/A
Tier 3 — Preferred Brand	35% member ($35 min / $70 max)	N/A	35% member ($35 min / $70 max)	N/A
Tier 4 — Non-Preferred Brand	35% member ($90 min / $170 max)	N/A	35% member ($90 min / $170 max)	N/A
Tier 5 — Non-Preferred Brand (NSAs, PPIs, Sedative Hypnotics Overactive Bladder)	Restricted to Home Delivery Program only. Member pays full price at retail pharmacy.	N/A	Restricted to Home Delivery Program only. Member pays full price at retail pharmacy.	N/A
Other	Specialty — $25 copay (30-day supply at CuraScript) Smoking Cessation Products — lifetime maximum of $600 Infertility — 50% with lifetime maximum of $5,000	N/A	Specialty — $25 copay (30-day supply at CuraScript) Smoking Cessation Products — lifetime maximum of $600 Infertility — 50% with lifetime maximum of $5,000	N/A
Maintenance Drugs	Must be filled through home delivery. If Home Deliery is not used, must pay full price after two courtesy retail fills.	N/A	Must be filled through home delivery. If Home Deliery is not used, must pay full price after two courtesy retail fills.	N/A

*Pharmacy costs do not count toward the deductible and/or out-of-pocket maximums.

Compare the Copay Medical Options (continued)

Benefit Highlights	Copay 500		Copay 750	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Pharmacy — Mail Order*				
Tier 1 — Generic	$20 copay	N/A	$20 copay	N/A
Tier 2 — Preferred Brand (no generic therapeutic alternative in drug class)	$55 copay	N/A	$55 copay	N/A
Tier 3 — Preferred Brand	35% member ($70 min / $140 max)	N/A	35% member ($70 min / $140 max)	N/A
Tier 4 — Non-Preferred Brand	35% member ($170 min / $340 max)	N/A	35% member ($170 min / $340 max)	N/A
Tier 5 — Non-Preferred Brand (NSAs, PPIs, Sedative Hypnotics Overactive Bladder)	80% member Restricted to Home Delivery Program only. Member pays full price at retail.	N/A	80% member Restricted to Home Delivery Program only. Member pays full price at retail.	N/A
Maintenance Drugs	Must be filled through home delivery. If Home Deliery is not used, must pay full price after two courtesy retail fills.	N/A	Must be filled through home delivery. If Home Deliery is not used, must pay full price after two courtesy retail fills.	N/A

*Pharmacy costs do not count toward the deductible and/or out-of-pocket maximums.