



DEDUCTIBLE (Individual Family)	\$0 \$0
OUT OF POCKET MAXIMUM (Individual Family)	\$8,550 \$17,100
PREVENTIVE & WELLNESS SERVICES	\$0 Copay (Plan pays 100% of covered preventive and wellness services)
TELEMEDICINE SERVICES	\$0 Copay
UNLIMITED PRIMARY CARE OFFICE VISITS	\$10 Copay
URGENT CARE	\$25 Copay
PHARMACY BENEFITS (Subject to Formulary)	Generic - \$0 Copay (Limited to Preventive Generic drugs. Plan pays 100% of covered preventive drugs. In addition, a discount pharmacy program is provided that allows other drugs to be obtained at payments ranging from \$0 to \$50).

PLEASE NOTE:

- Out of Network services, and services provided at a hospital, will not be covered, unless otherwise specified.
- Refer to the Schedule of Benefits for a more in-depth list of Benefits Coverage, Limitations and Exclusions. If this document differs from the Schedule of Benefits, the Schedule of Benefits will govern.