

# Fixed Funding Solutions Plan Options

Plans available for 11/1/23 or 12/1/23 effective dates.

	Contract-Year FlexPOS \$40/\$80 \$5,000 20%	Contract-Year FlexPOS \$35/\$50 \$4,000 35%	Contract-Year FlexPOS \$30/\$50 \$3,500 20%	Contract-Year FlexPOS \$40/\$80 \$2,750 20%	Contract-Year FlexPOS \$30/\$50 \$2,000	Contract-Year FlexPOS \$30/\$45 \$500
<b>PLAN/MEDICAL DEDUCTIBLE</b>						
Deductible (Individual/Family)	\$5,000/\$10,000	\$4,000/\$8,000	\$3,500/\$7,000	\$2,750/\$5,500	\$2,000/\$4,000	N/A
Maximum out-of-pocket limit (Individual/Family)	\$7,300/\$14,600	\$7,900/\$15,800	\$7,900/\$15,800	\$6,000/\$12,000	\$5,500/\$11,000	\$5,000/\$10,000
<b>IN-NETWORK MEDICAL BENEFITS</b>						
Preventive care/Screenings/Immunizations	\$0	\$0	\$0	\$0	\$0	\$0
Primary care services	\$40 copay (deductible waived)	\$35 copay (deductible waived)	\$30 copay (deductible waived)	\$40 copay (deductible waived)	\$30 copay (deductible waived)	\$30 copay
Telemedicine visits through Teladoc® <sup>1</sup>	Primary Care, Mental Health, and General Medical Services: \$0 (deductible waived) Dermatologist: \$80 copay (deductible waived)	Primary Care, Mental Health, and General Medical Services: \$0 (deductible waived) Dermatologist: \$50 copay (deductible waived)	Primary Care, Mental Health, and General Medical Services: \$0 (deductible waived) Dermatologist: \$50 copay (deductible waived)	Primary Care, Mental Health, and General Medical Services: \$0 (deductible waived) Dermatologist: \$80 copay (deductible waived)	Primary Care, Mental Health, and General Medical Services: \$0 (deductible waived) Dermatologist: \$50 copay (deductible waived)	Primary Care, Mental Health, and General Medical Services: \$0 Dermatologist: \$45 copay
Specialist services	\$80 copay (deductible waived)	\$50 copay (deductible waived)	\$50 copay (deductible waived)	\$80 copay (deductible waived)	\$50 copay (deductible waived)	\$45 copay
Vision	\$80 copay (deductible waived)	\$50 copay (deductible waived)	\$50 copay (deductible waived)	\$80 copay (deductible waived)	\$50 copay (deductible waived)	\$45 copay
Walk-in/Urgent care center	\$75 copay (deductible waived)	\$75 copay (deductible waived)	\$75 copay (deductible waived)	\$75 copay (deductible waived)	\$75 copay (deductible waived)	\$75 copay
Worldwide emergency coverage <sup>2</sup>	\$400 copay (deductible waived)	35% coinsurance after deductible	\$350 copay (deductible waived)	\$350 copay (deductible waived)	\$350 copay (deductible waived)	\$150 copay
Outpatient surgery freestanding	\$500 copay (deductible waived)	35% coinsurance (deductible waived)	\$500 copay (deductible waived)	\$400 copay (deductible waived)	\$500 copay after deductible	\$500 copay
Hospital outpatient facilities	20% coinsurance after deductible	35% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	\$500 copay after deductible	\$500 copay
Inpatient hospital coverage	20% coinsurance after deductible	35% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	\$500 copay/day; \$2,500 maximum per admission after deductible	\$500 copay/day; \$2,000 maximum per admission
Lab services	20% coinsurance after deductible	\$10 copay (deductible waived)	\$10 copay (deductible waived)	20% coinsurance after deductible	\$10 copay (deductible waived)	No charge
X-rays	Freestanding facility: \$50 copay (deductible waived) Hospital setting: 20% coinsurance after deductible	\$40 copay (deductible waived)	\$40 copay (deductible waived)	Freestanding facility: \$50 copay (deductible waived) Hospital setting: 20% coinsurance after deductible	\$40 copay (deductible waived)	\$10 copay
Advanced imaging (CT Scans and MRI)	Freestanding facility: \$100 copay (deductible waived) Hospital setting: 20% coinsurance after deductible	Freestanding facility: 35% coinsurance (deductible waived) Hospital setting: 35% coinsurance after deductible	Freestanding facility: \$100 copay up to \$500 (deductible waived) Hospital setting: \$500 copay (deductible waived)	Freestanding facility: \$100 copay (deductible waived) Hospital setting: 20% coinsurance after deductible	Freestanding facility: \$100 copay up to \$500 (deductible waived) Hospital setting: \$100 copay after deductible	Freestanding facility: \$75 copay Hospital setting: \$75 copay
<b>OUT-OF-NETWORK MEDICAL BENEFITS</b>						
Deductible (Individual/Family)	\$10,000/\$20,000	\$8,000/\$16,000	\$7,000/\$14,000	\$7,000/\$14,000	\$4,000/\$8,000	\$4,000/\$8,000
Coinsurance	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Maximum out-of-pocket limit (Individual/Family)	\$15,000/\$30,000	\$15,800/\$31,600	\$15,800/\$31,600	\$15,800/\$31,600	\$11,000/\$22,000	\$10,000/\$20,000
<b>PRESCRIPTION DRUG BENEFITS</b>						
Prescription drug deductible (Individual/Family)	N/A	N/A	N/A	N/A	N/A	N/A
Tier 1 - Preferred generic drugs	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay
Tier 2 - Non-preferred generic drugs	50% coinsurance \$250 maximum per prescription	50% coinsurance \$250 maximum per prescription	50% coinsurance \$250 maximum per prescription	50% coinsurance; \$250 maximum per prescription	50% coinsurance \$250 maximum per prescription	50% coinsurance \$250 maximum per prescription
Tier 3 - Preferred brand drugs	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay
Tier 4 - Non-preferred brand drugs	50% coinsurance \$500 maximum per prescription	50% coinsurance \$500 maximum per prescription	50% coinsurance \$500 maximum per prescription	50% coinsurance; \$500 maximum per prescription	50% coinsurance \$500 maximum per prescription	50% coinsurance \$500 maximum per prescription
Tier 5 - Preferred specialty drugs	50% coinsurance \$500 maximum per prescription	50% coinsurance \$500 maximum per prescription	50% coinsurance \$500 maximum per prescription	50% coinsurance; \$500 maximum per prescription	50% coinsurance \$500 maximum per prescription	50% coinsurance \$500 maximum per prescription
Tier 6 - Non-preferred specialty drugs	50% coinsurance \$750 maximum per prescription	50% coinsurance \$750 maximum per prescription	50% coinsurance \$750 maximum per prescription	50% coinsurance; \$750 maximum per prescription	50% coinsurance \$750 maximum per prescription	50% coinsurance \$750 maximum per prescription

(continued on next page)

All plans are contract-year.

<sup>1</sup>Telemedicine is not appropriate for all covered services, and restrictions apply. For Primary Care services, members must be 18 or older. <sup>2</sup>Subject to limitations.

# Fixed Funding Solutions Plan Options

## Notes

	Contract-Year		
	FlexPOS HSA \$6,800 40%	FlexPOS HSA \$5,000 50%	FlexPOS HSA \$3,000 25%
<b>PLAN/MEDICAL DEDUCTIBLE</b>			
Deductible (Individual/Family)	\$6,800/\$13,600	\$5,000/\$10,000	\$3,000/\$6,000
Maximum out-of-pocket limit (Individual/Family)	\$7,050/\$14,100	\$6,750/\$13,500	\$6,750/\$13,500
<b>IN-NETWORK MEDICAL BENEFITS</b>			
Preventive care/Screenings/Immunizations	\$0	\$0	\$0
Primary care services	40% coinsurance after deductible	\$30 copay after deductible	25% coinsurance after deductible
Telemedicine visits through Teladoc <sup>® 1</sup>	Primary Care, Mental Health, and General Medical Services: 0% coinsurance after deductible Dermatologist: 40% coinsurance after deductible	Primary Care, Mental Health, and General Medical Services: 0% coinsurance after deductible Dermatologist: \$50 copay after deductible	Primary Care, Mental Health, and General Medical Services: 0% coinsurance after deductible Dermatologist: 25% coinsurance after deductible
Specialist services	40% coinsurance after deductible	\$50 copay after deductible	25% coinsurance after deductible
Vision	20% coinsurance (deductible waived)	\$50 copay (deductible waived)	25% coinsurance (deductible waived)
Walk-in/Urgent care center	40% coinsurance after deductible	\$75 copay after deductible	25% coinsurance after deductible
Worldwide emergency coverage <sup>2</sup>	40% coinsurance after deductible	50% coinsurance after deductible	25% coinsurance after deductible
Outpatient surgery freestanding	40% coinsurance after deductible	50% coinsurance after deductible	25% coinsurance after deductible
Hospital outpatient facilities	40% coinsurance after deductible	50% coinsurance after deductible	25% coinsurance after deductible
Inpatient hospital coverage	40% coinsurance after deductible	50% coinsurance after deductible	25% coinsurance after deductible
Lab services	40% coinsurance after deductible	\$10 copay after deductible	25% coinsurance after deductible
X-rays	40% coinsurance after deductible	\$40 copay after deductible	25% coinsurance after deductible
Advanced imaging (CT Scans and MRI)	Freestanding facility: 40% coinsurance after deductible Hospital setting: 40% coinsurance after deductible	Freestanding facility: \$100 copay after deductible Hospital setting: 50% coinsurance after deductible	Freestanding facility: 25% coinsurance after deductible Hospital setting: 25% coinsurance after deductible
<b>OUT-OF-NETWORK MEDICAL BENEFITS</b>			
Deductible (Individual/Family)	\$10,000/\$20,000	\$10,000/\$20,000	\$6,000/\$12,000
Coinsurance	50%	50%	50%
Maximum out-of-pocket limit (Individual/Family)	\$15,000/\$30,000	\$13,500/\$27,000	\$13,500/\$27,000
<b>PRESCRIPTION DRUG BENEFITS</b>			
Prescription drug deductible (Individual/Family)	Plan has integrated deductible with medical	Plan has integrated deductible with medical	Plan has integrated deductible with medical
Tier 1 - Preferred generic drugs	\$10 copay after deductible	\$10 copay after deductible	\$10 copay after deductible
Tier 2 - Non-preferred generic drugs	50% coinsurance; \$250 maximum per prescription after deductible	50% coinsurance; \$250 maximum per prescription after deductible	50% coinsurance; \$250 maximum per prescription after deductible
Tier 3 - Preferred brand drugs	\$50 copay after deductible	\$50 copay after deductible	\$50 copay after deductible
Tier 4 - Non-preferred brand drugs	50% coinsurance; \$500 maximum per prescription after deductible	50% coinsurance; \$500 maximum per prescription after deductible	50% coinsurance; \$500 maximum per prescription after deductible
Tier 5 - Preferred specialty drugs	50% coinsurance; \$500 maximum per prescription after deductible	50% coinsurance; \$500 maximum per prescription after deductible	50% coinsurance; \$500 maximum per prescription after deductible
Tier 6 - Non-preferred specialty drugs	50% coinsurance; \$750 maximum per prescription after deductible	50% coinsurance; \$750 maximum per prescription after deductible	50% coinsurance; \$750 maximum per prescription after deductible

All plans are contract-year.

<sup>1</sup>Telemedicine is not appropriate for all covered services, and restrictions apply. For Primary Care services, members must be 18 or older. <sup>2</sup>Subject to limitations.

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---