Fixed Funding Solutions plan options: for Groups with 51-99 employees	FlexPOS HSA $5,000 20%	FlexPOS HSA $6,000 10%	FlexPOS HSA $4,000	FlexPOS $5000 20%	FlexPOS HSA $3,000 25%	FlexPOS HSA $5000	FlexPOS $30 $2,500 50%	FlexPOS $30 $2,500 20%	FlexPOS HSA $2500
PLAN/MEDICAL DEDUCTIBLE									
Deductible (Individual/Family)	$5,000/$10,000	$6,000/$12,000	$4,000/$8,000	$5,000/$10,000	$3,000/$6,000	$5,000/$10,000	$2,500/$5,000	$2,500/$5,000	$2,500/$5,000
Maximum out-of-pocket limit (Individual/Family)	$6,750/$13,500	$6,225/$12,450	$7,000/$14,000	$9,000/$18,000	$6,750/$13,500	$7,000/$14,000	$6,350/$12,700	$5,000/$10,000	$6,000/$12,000
IN-NETWORK MEDICAL BENEFITS									
Preventive care/Screenings/ Immunizations	$0	$0	$0	$0	$0	$0	$0	$0	$0
Primary care provider (PCP) services	$30 copay after deductible	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	25% coinsurance after deductible	0% coinsurance after deductible	$30 copayment/visit deductible does not apply	$30 copayment, deductible does not apply	0% coinsurance after deductible
Specialist services	$50 copay after deductible	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	25% coinsurance after deductible	0% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Mental health and substance abuse office visits	$50 copay after deductible	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	25% coinsurance after deductible	0% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Telemedicine visit through Teladoc ® Primary Care- members must be 18 and older	Primary Care, Mental Health and General medicine Service: 0% coinsurance after deductible Dermatologists: $50 copay after deductible	Primary Care, Mental Health and General medicine Service: 0% coinsurance after deductible Dermatologists: 10% coinsurance after deductible	Primary Care, Mental Health and General medicine Service: 0% coinsurance after deductible Dermatologists: 20% coinsurance after deductible	Primary Care, Mental Health and General medicine Service: No charge Dermatologists: 20% after deductible	Primary Care, Mental Health and General medicine Service: 0% coinsurance after deductible Dermatologists: 25% coinsurance after deductible	Primary Care, Mental Health and General medicine Service: 0% coinsurance after deductible Dermatologists: 0% coinsurance after deductible	Primary Care, Mental Health and General medicine Service: No charge Dermatologists: 50% coinsurance after deductible	Primary Care, Mental Health and General medicine Service: No charge Dermatologists: 20% coinsurance after deductible	Primary Care, Mental Health and General medicine Service: 0% coinsurance after deductible Dermatologists: 0% coinsurance after deductible
Routine vision	$50 copay (deductible waived)	10% coinsurance, deductible does not apply	20% coinsurance, deductible does not apply	20% coinsurance after deductible	25% coinsurance (deductible waived)	No charge	50% coinsurance; deductible does not apply	20% coinsurance, deductible does not apply	No charge
Walk-in/Urgent care center	$75 copay after deductible	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	25% coinsurance after deductible	0% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Worldwide emergency coverage**	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	25% coinsurance after deductible	0% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Inpatient hospital coverage	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	25% coinsurance after deductible	0% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Hospital outpatient facilities	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	25% coinsurance after deductible	0% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Outpatient surgery freestanding locations	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	25% coinsurance after deductible	0% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Lab services	$10 copay after deductible	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	25% coinsurance after deductible	0% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
X-rays	$40 copay after deductible	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	25% coinsurance after deductible	0% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Advanced imaging (CT Scans & MRI)	Freestanding facility: $100 copay after deductible Hospital setting: 20% coinsurance after deductible	Freestanding facility: 10% coinsurance after deductible Hospital setting: 10% coinsurance after deductible	Freestanding facility: 20% coinsurance after deductible Hospital setting: 20% coinsurance after deductible	Freestanding facility: 20% coinsurance after deductible Hospital setting: 20% coinsurance after deductible	Freestanding facility: 25% coinsurance after deductible Hospital setting: 25% coinsurance after deductible	Freestanding facility: 0% coinsurance after deductible Hospital setting: 0% coinsurance after deductible	Freestanding facility: 50% coinsurance after deductible Hospital setting: 50% coinsurance after deductible	Freestanding facility: 20% coinsurance after deductible Hospital setting: 20% coinsurance after deductible	Freestanding facility: 0% coinsurance after deductible Hospital setting: 0% coinsurance after deductible
OUT-OF-NETWORK MEDICAL BENEFITS									
Deductible (Individual/Family)	$10,000/$20,000	$10,000/$20,000	$8,000/$16,000	$6,350/$12,700	$6,000/$12,000	$10,000/$20,000	$6,000/$12,000	$6,000/$12,000	$5,000/$10,000
Coinsurance	50%	50%	50%	50%	50%	30%	50%	50%	30%
Maximum out-of-pocket limit (Individual/Family)	$13,500/$27,000	$15,000/$30,000	$15,000/$30,000	$15,000/$30,000	$13,500/$27,000	$15,000/$30,000	$12,000/$24,000	$12,000/$24,000	$10,000/$20,000
PRESCRIPTION DRUG BENEFITS									
Prescription drug deductible (Individual/Family)	Plan has integrated deductible with medical	Plan has integrated deductible with medical	Plan has integrated deductible with medical	N/A	Plan has integrated deductible with medical	Plan has integrated deductible with medical	N/A	N/A	Plan has integrated deductible with medical
Tier 1 – Generic drugs	$10 copay after deductible	$10 copay after deductible	$10 copayment after deductible	$10 copayment	$10 copay after deductible	$10 copayment after deductible	$10 copayment	$10 copayment	$10 copayment after deductible
Tier 2 – Preferred brand drugs	$50 copay after deductible	$50 copay after deductible	$50 copayment after deductible	$50 copayment	$50 copay after deductible	$50 copayment after deductible	$50 copayment	$50 copayment	$50 copayment after deductible
Tier 3 – Non-preferred brand drugs	20% coinsurance; $250 maximum per prescription after deductible	20% coinsurance; $250 maximum per prescription after deductible	20% coinsurance; $250 maximum per prescription after deductible	20% coinsurance; $250 maximum per prescription	20% coinsurance; $250 maximum per prescription after deductible	20% coinsurance; $250 maximum per prescription after deductible	20% coinsurance; $250 maximum per prescription	20% coinsurance; $250 maximum per prescription	20% coinsurance; $250 maximum per prescription after deductible
Tier 4 – Specialty drugs	20% coinsurance; $500 maximum per prescription after deductible	20% coinsurance; $500 maximum per prescription after deductible	20% coinsurance; $500 maximum per prescription after deductible	20% coinsurance; $500 maximum per prescription	20% coinsurance; $500 maximum per prescription after deductible	20% coinsurance; $500 maximum per prescription after deductible	20% coinsurance; $500 maximum per prescription	20% coinsurance; $500 maximum per prescription	20% coinsurance; $500 maximum per prescription after deductible

Fixed Funding Solutions plan options: for Groups with 51-99 employees	FlexPOS HSA $1500	FlexPOS HSA $2,000 10%	FlexPOS $35/$50 $4,000 20%	FlexPOS $30/$50 $3,500 20%	FlexPOS $30/$45 $5000	FlexPOS $30/$50 $2,000	FlexPOS $30/$45 $1500	FlexPOS $30/$45
PLAN/MEDICAL DEDUCTIBLE								
Deductible (Individual/Family)	$1,500/$3,000	$2,000/$4,000	$4,000/$8,000	$3,500/$7,000	$5,000/$10,000	$2,000/$4,000	$1,500/$3,000	$0/$0
Maximum out-of-pocket limit (Individual/Family)	$5,000/$10,000	$3,000/$6,000	$7,900/$15,800	$7,900/$15,800	$7,000/$14,000	$5,500/$11,000	$6,850/$13,700	$5,000/$10,000
IN-NETWORK MEDICAL BENEFITS								
Preventive care/Screenings/ Immunizations	$0	$0	$0	$0	$0	$0	$0	$0
Primary care provider (PCP) services	$30 copayment/visit after deductible	10% coinsurance after deductible	$35 copay (deductible waived)	$30 copay (deductible waived)	$30 copayment/visit deductible does not apply	$30 copay (deductible waived)	$30 copayment/visit deductible does not apply	$30 copayment/visit
Specialist services	$45 copayment/visit after deductible	10% coinsurance after deductible	$50 copay (deductible waived)	$50 copay (deductible waived)	$45 copayment/visit deductible does not apply	$50 copay (deductible waived)	$45 copayment/visit deductible does not apply	$45 copayment
Mental health and substance abuse office visits	$45 copayment/visit after deductible	10% coinsurance after deductible	$50 copay (deductible waived)	$50 copay (deductible waived)	$45 copayment/visit deductible does not apply	$50 copay (deductible waived)	$45 copayment/visit deductible does not apply	$45 copayment
Telemedicine visit through Teladoc ® Primary Care- members must be 18 and older	Primary Care, Mental Health and General medicine Service: 0% coinsurance after deductible Dermatologists: $45 copay after deductible	Primary Care, Mental Health and General medicine Service: 0% coinsurance after deductible Dermatologists: 10% coinsurance after deductible	Primary Care, Mental Health and General medicine Service: No charge Dermatologists: $50 copay (deductible waived)	Primary Care, Mental Health and General medicine Service: No charge Dermatologists: $50 copay (deductible waived)	Primary Care, Mental Health and General medicine Service: No charge Dermatologists: $45 copay (deductible waived)	Primary Care, Mental Health and General medicine Service: No charge Dermatologists: $50 copay (deductible waived)	Primary Care, Mental Health and General medicine Service: No charge Dermatologists: $45 copay (deductible waived)	Primary Care, Mental Health and General medicine Service: No charge Dermatologists: $45 copay
Routine vision	$45 copayment/visit deductible does not apply	10% coinsurance, deductible does not apply	$50 copay (deductible waived)	$50 copay (deductible waived)	$45 copayment/visit deductible does not apply	$50 copay (deductible waived)	$45 copayment/visit deductible does not apply	$45 copayment
Walk-in/Urgent care center	$100 copayment/visit after deductible	10% coinsurance after deductible	$75 copay (deductible waived)	$75 copay (deductible waived)	$100 copayment/visit deductible does not apply	$75 copay (deductible waived)	$100 copayment/visit deductible does not apply	$75 copayment
Worldwide emergency coverage**	$350 copayment/visit after deductible	10% coinsurance after deductible	20% coinsurance after deductible	$350 copay (deductible waived)	$350 copayment/visit deductible does not apply	$350 copay (deductible waived)	$350 copayment/visit deductible does not apply	$150 copayment/per visit (copayment waived if admitted)
Inpatient hospital coverage	$350 copayment per day up to $1400 per admission after deductible	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible	$500 copay/day; $2,500 maximum per admission after deductible	0% coinsurance after deductible	$500 copayment/day up to $2,000 per admission
Hospital outpatient facilities	$350 copayment/visit after deductible	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible	$500 copay after deductible	0% coinsurance after deductible	$500 copayment/per visit
Outpatient surgery freestanding locations	$200 copayment/visit after deductible	10% coinsurance after deductible	20% coinsurance (deductible waived)	$500 copay (deductible waived)	0% coinsurance after deductible	$500 copay after deductible	0% coinsurance after deductible	$500 copayment/per visit
Lab services	$10 copayment/visit after deductible	10% coinsurance after deductible	$10 copay (deductible waived)	$10 copay (deductible waived)	No charge	$10 copay (deductible waived)	$10 copayment/visit deductible does not apply	$0
X-rays	$40 copayment/visit after deductible	10% coinsurance after deductible	$40 copay (deductible waived)	$40 copay (deductible waived)	$40 copayment/visit deductible does not apply	$40 copay (deductible waived)	$40 copayment/visit deductible does not apply	$10 copayment/per visit
Advanced imaging (CT Scans & MRI)	Freestanding facility: $100 copayment/service after deductible Hospital setting: $100 copayment/service after deductible	Freestanding facility: 10% coinsurance after deductible Hospital setting: 10% coinsurance after deductible	Freestanding facility: 20% coinsurance (deductible waived) Hospital setting: 20% coinsurance after deductible	Freestanding facility: $100 copay (deductible waived) Hospital setting: $500 copay (deductible waived)	Freestanding facility: $100 copayment/service deductible does not apply Hospital setting: $100 copayment/service deductibe does not apply	Freestanding facility: $100 copay (deductible waived) Hospital setting: $100 copay after deductible	Freestanding facility: $100 copayment/service deductible does not apply Hospital setting: $100 copayment/service deductibe does not apply	Freestanding facility: $75 copayment/service Hospital setting: $75 copayment/service
OUT-OF-NETWORK MEDICAL BENEFITS								
Deductible (Individual/Family)	$3,000/$6,000	$4,000/$8,000	$8,000/$16,000	$7,000/$14,000	$8,000/$16,000	$4,000/$8,000	$5,000/$10,000	$4,000/$8,000
Coinsurance	30%	50%	50%	50%	50%	50%	30%	50%
Maximum out-of-pocket limit (Individual/Family)	$8,000/$16,000	$8,000/$16,000	$15,800/$31,600	$15,800/$31,600	$12,000/$24,000	$11,000/$22,000	$10,000/$20,000	$10,000/$20,000
PRESCRIPTION DRUG BENEFITS								
Prescription drug deductible (Individual/Family)	Plan has integrated deductible with medical	Plan has integrated deductible with medical	N/A	N/A	N/A	N/A	N/A	N/A
Tier 1 – Generic drugs	$10 copayment after deductible	$10 copayment after deductible	$10 copay	$10 copay	$10 copayment	$10 copay	$10 copayment	$10 copayment
Tier 2 – Preferred brand drugs	$50 copayment after deductible	$50 copayment after deductible	$50 copay	$50 copay	$50 copayment	$50 copay	$50 copayment	$50 copayment
Tier 3 – Non-preferred brand drugs	20% coinsurance; $250 maximum per prescription after deductible	20% coinsurance; $250 maximum per prescription after deductible	20% coinsurance; $250 maximum per prescription	20% coinsurance; $250 maximum per prescription	20% coinsurance; $250 maximum per prescription	20% coinsurance; $250 maximum per prescription	20% coinsurance; $250 maximum per prescription	20% coinsurance; $250 maximum per prescription
Tier 4 – Specialty drugs	20% coinsurance; $500 maximum per prescription after deductible	20% coinsurance; $500 maximum per prescription after deductible	20% coinsurance; $500 maximum per prescription	20% coinsurance; $500 maximum per prescription	20% coinsurance; $500 maximum per prescription	20% coinsurance; $500 maximum per prescription	20% coinsurance; $500 maximum per prescription	20% coinsurance; $500 maximum per prescription