On the chart below, you’ll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible (per calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual (employee only)</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Parent/Child(ren) (employee + child(ren))</td>
<td>$375</td>
<td>$1,000</td>
</tr>
<tr>
<td>Family (employee + spouse + child(ren))</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Coinsurance Maximums (Excludes deductible)</strong> Employee pays 10% of plan allowance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Parent/Child(ren)</td>
<td>$1,500</td>
<td>$4,000</td>
</tr>
<tr>
<td>Family</td>
<td>$2,000</td>
<td>$4,000</td>
</tr>
<tr>
<td><strong>Out-of-Pocket (Deductible + Coinsurance) Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,250</td>
<td></td>
</tr>
<tr>
<td>Parent/Child(ren)</td>
<td>$1,875</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>$2,500</td>
<td></td>
</tr>
<tr>
<td><strong>Plan Pays – payment based on the plan allowance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Two or More Persons</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Maximum Out-of-Pocket Amount (TMOOP)</strong></td>
<td>See note at the end of the grid</td>
<td>See note above regarding out-of-pocket maximum and note at the end of the grid</td>
</tr>
<tr>
<td>Individual</td>
<td>$7,150</td>
<td></td>
</tr>
<tr>
<td>Two or More Persons</td>
<td>$14,300</td>
<td></td>
</tr>
<tr>
<td><strong>Office/Clinic/Urgent Care Visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Provider Office Visits &amp; Virtual Visits</td>
<td>100% after $10 copayment</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Specialist Office Visits &amp; Virtual Visits</td>
<td>100% after $20 copayment</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Urgent Care Center Visits</td>
<td>100% after $20 copayment</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Walk-In Clinic Visits</td>
<td>100% after $20 copayment</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Telemedicine Services</td>
<td>100% after $10 copayment</td>
<td>Not Applicable</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible does NOT apply to IN-NETWORK Preventive Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Adult</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical exams</td>
<td>100% (deductible does not apply)</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Adult immunizations</td>
<td>100% (deductible does not apply)</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>100% (deductible does not apply)</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Routine gynecological exams, including a Pap Test</td>
<td>100% (deductible does not apply)</td>
<td>70% (deductible does not apply)</td>
</tr>
<tr>
<td>Mammograms, annual routine and medically necessary</td>
<td>100% (deductible does not apply)</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Diagnostic services and procedures</td>
<td>100% (deductible does not apply)</td>
<td>70% after deductible</td>
</tr>
<tr>
<td><strong>Routine Pediatric</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical exams</td>
<td>100% (deductible does not apply)</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Pediatric immunizations</td>
<td>100% (deductible does not apply)</td>
<td>70% (deductible does not apply)</td>
</tr>
<tr>
<td>Diagnostic services and procedures</td>
<td>100% (deductible does not apply)</td>
<td>70% after deductible</td>
</tr>
<tr>
<td><strong>Hospital and Medical/Surgical Expenses (including maternity)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity (non-preventive facility &amp; professional services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical/Surgical (except office visits)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>100% after $100 copayment (waived if admitted)</td>
<td>Emergency: 90% after deductible Non-emergency: 70% after deductible</td>
</tr>
<tr>
<td>Ambulance</td>
<td>Emergency and Non-emergency: 90% after deductible</td>
<td>Emergency: 90% after deductible Non-emergency: 70% after deductible</td>
</tr>
<tr>
<td><strong>Therapy and Rehabilitation Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>100% after $20 copayment</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Spinal Manipulations</td>
<td>100% after $20 copayment</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Speech &amp; Occupational Therapy</td>
<td>100% after $20 copayment</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Benefit</td>
<td>Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td>---------------</td>
</tr>
<tr>
<td><strong>Other Therapy Services</strong> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)</td>
<td>Limit: 24 visits per therapy per calendar year</td>
<td>90% after deductible</td>
</tr>
<tr>
<td><strong>Mental Health/Substance Abuse</strong></td>
<td></td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Inpatient</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Inpatient Detoxification/Rehabilitation</td>
<td>100% after $10 copayment</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Extracts and Injections</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Applied Behavior Analysis for Autism Spectrum Disorders</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Assisted Fertilization Procedures</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Dental Services Related to Accidental Injury</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td></td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Advanced Imaging (MRI, CAT, PET scan, etc.)</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment, Orthotics and Prosthetics</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Gastric Bypass/Bariatric Surgery</td>
<td>90% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Gender Reassignment Surgery/Transgender Services – Hearing Care Services</td>
<td></td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Limit: 120 visits calendar year</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Infertility Counseling, Testing and Treatment (5)</td>
<td></td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>Limit: 70 eight-hour shifts</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Skilled Nursing Facility Care</td>
<td>Limit: 100 days per calendar year</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Transplant Services</td>
<td></td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Wigs</td>
<td>Cancer diagnosis only</td>
<td>90% after deductible</td>
</tr>
<tr>
<td><strong>Precertification Requirements</strong></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drug Deductible</strong></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Total Prescription Drug Out-of-Pocket Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,000</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>$6,000</td>
<td></td>
</tr>
<tr>
<td><strong>Retail</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Drugs</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Preferred Brand Drugs</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Brand Drugs</td>
<td>70% coinsurance</td>
<td></td>
</tr>
<tr>
<td>*Retail includes University Health Services Pharmacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mail Order</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Drugs</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Preferred Brand Drugs</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Brand Drugs</td>
<td>70% coinsurance</td>
<td></td>
</tr>
<tr>
<td>* Mail Order includes University Health Services Pharmacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialty</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred Brand Drugs</td>
<td>50% coinsurance, $50 maximum</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Brand Drugs</td>
<td>70% coinsurance, $100 maximum</td>
<td></td>
</tr>
</tbody>
</table>

**Preventive Prescription Drugs – CVS Caremark**

**"LOWER GENERIC COINSURANCE"**

<table>
<thead>
<tr>
<th>Category</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>10%</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>20%</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>40%</td>
</tr>
</tbody>
</table>

*Note: Total Maximum Out-of-Pocket Maximum (TMOOP) is mandated by the federal government effective with plan years beginning on or after January 1, 2014. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense. With plan years beginning on or after January 1, 2021, TMOOP cannot be more than $8,150 for an individual and $16,300 for plans with two or more persons. Your plan satisfies this requirement as TMOOP is set at $7,150 for an individual and $14,300 for plans with two or more persons.*