Fixed Funding Solutions plan options for groups with 51-99 employees	FlexPOS HSA* $5,000 20% CNT	FlexPOS HSA* $6,000/$12,000 10% CNT	FlexPOS HSA* $4,000I/$8,000F CNT	FlexPOS $5,000/$10,000 20% COINS CNT	FlexPOS HSA* $3,300 25% CNT
PLAN/MEDICAL DEDUCTIBLE					
Deductible (individual/family)	$5,000/$10,000	$6,000/$12,000	$4,000/$8,000	$5,000/$10,000	$3,300/$6,600
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
IN-NETWORK MEDICAL BENEFITS					
Preventive care/screenings/immunizations	$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
Specialist services	$50 copay after deductible	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	25% coinsurance after deductible
Mental health and substance use office visits	$30 copay after deductible	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	25% coinsurance after deductible
Telemedicine visit through Teladoc® Primary care members must be age 18 and older	Primary care, mental health, and general medical services: 0% coinsurance after deductible Dermatologists: $50 copay after deductible	Primary care, mental health, and general medical services: 0% coinsurance after deductible Dermatologists: 10% coinsurance after deductible	Primary care, mental health, and general medical services: 0% coinsurance after deductible Dermatologists: 20% coinsurance after deductible	Primary care, mental health, and general medical services: No charge Dermatologists: 20% after deductible	Primary care, mental health, and general medical services: 0% coinsurance after deductible Dermatologists: 25% 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)
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
Worldwide emergency coverage**	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	25% 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
Hospital outpatient facilities	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	25% 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
Lab services	$10 copay after deductible	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	25% 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
Advanced imaging (CT scans ad 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
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
Coinsurance	50%	50%	50%	50%	50%
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
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
Tier 1 – Generic drugs	$10 copay after deductible	$10 copay after deductible	$10 copayment after deductible	$10 copayment	$10 copay 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
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
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

*Health savings account
**Subject to limitations.

Fixed Funding Solutions plan options for groups with 51-99 employees (continued)	**FLEXPOS HSA* $5,000/$10,000 CNT**	**FlexPOS $30POV $2,500 50% CNT**	**FlexPOS $30POV $2,500 20% CNT**	**FLEXPOS HSA* $2,500I/$5,000F CNT**
PLAN/MEDICAL DEDUCTIBLE				
Deductible (individual/family)	$5,000/$10,000	$2,500/$5,000	$2,500/$5,000	$2,500/$5,000
Maximum out-of-pocket limit (individual/family)	$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
Primary care provider (PCP) services	0% coinsurance after deductible	$30 copayment/visit; deductible does not apply	$30 copayment; deductible does not apply	0% coinsurance after deductible
Specialist services	0% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Mental health and substance use office visits	No charge	No charge	No charge	0% coinsurance after deductible
Telemedicine visit through Teladoc® Primary care members must be age 18 and older	Primary care, mental health, and general medical services: 0% coinsurance after deductible Dermatologists: 0% coinsurance after deductible	Primary care, mental health, and general medical services: No charge Dermatologists: 50% coinsurance after deductible	Primary care, mental health, and general medical services: No charge Dermatologists: 20% coinsurance after deductible	Primary care, mental health, and general medical services: 0% coinsurance after deductible Dermatologists: 0% coinsurance after deductible
Routine vision	No charge	50% coinsurance; deductible does not apply	20% coinsurance; deductible does not apply	No charge
Walk-in/urgent care center	0% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Worldwide emergency coverage**	0% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Inpatient hospital coverage	0% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Hospital outpatient facilities	0% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Outpatient surgery freestanding locations	0% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Lab services	0% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
X-rays	0% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Advanced imaging (CT scans and MRI)	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	$6,000/$12,000	$6,000/$12,000	$5,000/$10,000
Coinsurance	30%	50%	50%	30%
Maximum out-of-pocket limit (individual/family)	$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	N/A	N/A	Plan has integrated deductible with medical
Tier 1 – Generic drugs	$10 copayment after deductible	$10 copayment	$10 copayment	$10 copayment after deductible
Tier 2 – Preferred brand drugs	$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	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	20% coinsurance; $500 maximum per prescription	20% coinsurance; $500 maximum per prescription after deductible

*Health savings account
**Subject to limitations.

Fixed Funding Solutions plan options for groups with 51-99 employees (continued)	**FlexPOS HSA Copay* $1,650/$3,300 CNT**	**FlexPOS HSA* $2,000/$4,000 10% CNT**	**FlexPOS $35/$50 $4,000 20% CNT**	**FlexPOS $30/$50 $3,500 20% CNT**
PLAN/MEDICAL DEDUCTIBLE				
Deductible (individual/family)	$1,650 / $3,300	$2,000/$4,000	$4,000/$8,000	$3,500/$7,000
Maximum out-of-pocket limit (individual/family)	$5,000/$10,000	$3,000/$6,000	$7,900/$15,800	$7,900/$15,800
IN-NETWORK MEDICAL BENEFITS				
Preventive care/screenings/immunizations	$0	$0	$0	$0
Primary care provider (PCP) services	$30 copayment per visit after deductible	10% coinsurance after deductible	$35 copay (deductible waived)	$30 copay (deductible waived)
Specialist services	$45 copayment per visit after deductible	10% coinsurance after deductible	$50 copay (deductible waived)	$50 copay (deductible waived)
Mental health and substance use office visits	$30 copayment per visit after deductible	10% coinsurance after deductible	$35 copay (deductible waived)	$30 copay (deductible waived)
Telemedicine visit through Teladoc® Primary care members must be age 18 and older	Primary care, mental health, and general medical services: 0% coinsurance after deductible Dermatologists: $45 copay after deductible	Primary care, mental health, and general medical services: 0% coinsurance after deductible Dermatologists: 10% coinsurance after deductible	Primary care, mental health, and general medical services: No charge Dermatologists: $50 copay (deductible waived)	Primary care, mental health, and general medical services: No charge Dermatologists: $50 copay (deductible waived)
Routine vision	$45 copayment per visit; deductible does not apply	10% coinsurance, deductible does not apply	$50 copay (deductible waived)	$50 copay (deductible waived)
Walk-in/urgent care center	$100 copayment per visit after deductible	10% coinsurance after deductible	$75 copay (deductible waived)	$75 copay (deductible waived)
Worldwide emergency coverage**	$350 copayment per visit after deductible	10% coinsurance after deductible	20% coinsurance after deductible	$350 copay (deductible waived)
Inpatient hospital coverage	$350 copayment per day; up to $1,400 per admission after deductible	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Hospital outpatient facilities	$350 copayment per visit after deductible	10% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient surgery freestanding locations	$200 copayment per visit after deductible	10% coinsurance after deductible	20% coinsurance (deductible waived)	$500 copay (deductible waived)
Lab services	$10 copayment per visit after deductible	10% coinsurance after deductible	$10 copay (deductible waived)	$10 copay (deductible waived)
X-rays	$40 copayment per visit after deductible	10% coinsurance after deductible	$40 copay (deductible waived)	$40 copay (deductible waived)
Advanced imaging (CT scans and MRI)	Freestanding facility: $100 copayment per service after deductible Hospital setting: $100 copayment per 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)
OUT-OF-NETWORK MEDICAL BENEFITS				
Deductible (individual/family)	$3,000/$6,000	$4,000/$8,000	$8,000/$16,000	$7,000/$14,000
Coinsurance	30%	50%	50%	50%
Maximum out-of-pocket limit (individual/family)	$8,000/$16,000	$8,000/$16,000	$15,800/$31,600	$15,800/$31,600
PRESCRIPTION DRUG BENEFITS				
Prescription drug deductible (individual/family)	Plan has integrated deductible with medical	Plan has integrated deductible with medical	N/A	N/A
Tier 1 – Generic drugs	$10 copayment after deductible	$10 copayment after deductible	$10 copay	$10 copay
Tier 2 – Preferred brand drugs	$50 copayment after deductible	$50 copayment after deductible	$50 copay	$50 copay
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
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

*Health savings account
**Subject to limitations.

Fixed Funding Solutions plan options for groups with 51-99 employees (continued)	**FlexPOS $30/$45 $5,000 DED CNT**	**FlexPOS $30/$50 $2,000 CNT**	**FlexPOS $30/$45 $1,500 DED CNT**	**FLEXPOS $30/$45 $500 $500 DAY CNT**
PLAN/MEDICAL DEDUCTIBLE				
Deductible (individual/family)	$5,000/$10,000	$2,000/$4,000	$1,500/$3,000	$0/$0
Maximum out-of-pocket limit (individual/family)	$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
Primary care provider (PCP) services	$30 copayment per visit; deductible does not apply	$30 copay (deductible waived)	$30 copayment per visit; deductible does not apply	$30 copayment/visit
Specialist services	$45 copayment per visit; deductible does not apply	$50 copay (deductible waived)	$45 copayment per visit; deductible does not apply	$45 copayment
Mental health and substance use office visits	$30 copayment per visit; deductible does not apply	$30 copay (deductible waived)	$30 copayment per visit; deductible does not apply	$30 copayment/visit
Telemedicine visit through Teladoc® Primary care members must be age 18 and older	Primary care, mental health, and general medical services: No charge Dermatologists: $45 copay (deductible waived)	Primary care, mental health, and general medical services: No charge Dermatologists: $50 copay (deductible waived)	Primary care, mental health, and general medical services: No charge Dermatologists: $45 copay (deductible waived)	Primary care, mental health, and general medical services: No charge Dermatologists: $45 copay
Routine vision	$45 copayment per visit; deductible does not apply	$50 copay (deductible waived)	$45 copayment per visit; deductible does not apply	$45 copayment
Walk-in/urgent care center	$100 copayment per visit; deductible does not apply	$75 copay (deductible waived)	$100 copayment per visit; deductible does not apply	$75 copayment
Worldwide emergency coverage**	$350 copayment per visit; deductible does not apply	$350 copay (deductible waived)	$350 copayment per visit; deductible does not apply	$150 copayment per per visit (copayment waived if admitted)
Inpatient hospital coverage	0% coinsurance after deductible	$500 copay/day; $2,500 maximum per admission after deductible	0% coinsurance after deductible	$500 copayment per day up to $2,000 per admission
Hospital outpatient facilities	0% coinsurance after deductible	$500 copay after deductible	0% coinsurance after deductible	$500 copayment/per visit
Outpatient surgery freestanding locations	0% coinsurance after deductible	$500 copay after deductible	0% coinsurance after deductible	$500 copayment/per visit
Lab services	No charge	$10 copay (deductible waived)	$10 copayment per visit; deductible does not apply	$0
X-rays	$40 copayment per visit; deductible does not apply	$40 copay (deductible waived)	$40 copayment per visit; deductible does not apply	$10 copayment/per visit
Advanced imaging (CT scans and MRI)	Freestanding facility: $100 copayment per service; deductible does not apply Hospital setting: $100 copayment per service; deductibe does not apply	Freestanding facility: $100 copay (deductible waived) Hospital setting: $100 copay after deductible	Freestanding facility: $100 copayment per service; deductible does not apply Hospital setting: $100 copayment per service; deductibe does not apply	Freestanding facility: $75 copayment per service Hospital setting: $75 copayment per service
OUT-OF-NETWORK MEDICAL BENEFITS				
Deductible (individual/family)	$8,000/$16,000	$4,000/$8,000	$5,000/$10,000	$4,000/$8,000
Coinsurance	50%	50%	30%	50%
Maximum out-of-pocket limit (individual/family)	$12,000/$24,000	$11,000/$22,000	$10,000/$20,000	$10,000/$20,000
PRESCRIPTION DRUG BENEFITS				
Prescription drug deductible (individual/family)	N/A	N/A	N/A	N/A
Tier 1 – Generic drugs	$10 copayment	$10 copay	$10 copayment	$10 copayment
Tier 2 – Preferred brand drugs	$50 copayment	$50 copay	$50 copayment	$50 copayment
Tier 3 – Non-preferred brand drugs	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	20% coinsurance; $500 maximum per prescription	20% coinsurance; $500 maximum per prescription	20% coinsurance; $500 maximum per prescription

**Subject to limitations.