**SELECT COVERAGE**

|  |  |  |
| --- | --- | --- |
| **Individual Coverage** | **Network** | **Out-of-Network** |
| Calendar Year Medical Deductible | $1800 | $2300 |
| **Family Coverage** | **Network** | **Out-of-Network** |
| Family Calendar Year Medical Deductible | $3,600 | $4600 |

\*$25 copay for Primary Care Office Visit

\*Participants with SELECT coverage must meet a $75 calendar year deductible for pharmacy benefits prior to receiving prescription copayment. \*

**BASE COVERAGE**

|  |  |  |
| --- | --- | --- |
| **Individual Coverage** | **Network** | **Out-of-Network** |
| Calendar Year Medical Deductible | $1800 | |
| **Family Coverage** | **Network** | **Out-of-Network** |
| Family Calendar Year Medical Deductible | $3200 | |

\*Certain **preventive** medications are subject to a $75.00 deductible. Other medications are subject to the calendar year deductible. \*