**Benefit Item** | **Preferred** | **Non-Preferred**
--- | --- | ---
This Plan is Available on a Subgroup-wide Basis Only
Employee Only Deductible | $5,000 | $10,000
Family Deductible | $10,000 | $20,000
Family Deductible Basis | Aggregate Only | Aggregate Only
Coinsurance | 0% | 0%
Individual Coinsurance Out-of-Pocket Maximum | $0 | $0
Family Coinsurance Out-of-Pocket Maximum | $0 | $0
Lifetime Maximum | $5,000,000
Office Visit Copay
Inpatient Hospital | Ded | Ded
Outpatient Hospital | Ded | Ded
Emergency Services | Ded | Ded

**Prescription Drugs**
- Generic Copay | Ded
- Formulary Brand Copay | Ded
- Non-Formulary Brand Copay | Ded
- In Network Specialty Copay (30 Day Supply) | Ded
- Out of Network Specialty Copay (30 Day Supply) | Ded
- Formulary Diabetic Supplies | Ded
- Non-Formulary Diabetic Supplies | Ded
- Ostomy Supplies | Ded
- Maximum Copay - Single | n/a
- Maximum Copay - Family | n/a
- Mail Order Maximum | 180 Days Supply
- Mail Order Copay | Ded

Preauthorization Programs Included
- Cox-2 (Including Mobic), Proton Pump Inhibitors, and Leukotriene Modifiers

**Routine Care**
- Adults | $500 per Calendar Year
- Children | Not Subject to Deductible
- Well Baby Care

**Mental Health and Substance Abuse**
- Inpatient Coinsurance | Ded | Ded
- Outpatient Coinsurance | Ded | Ded