

2027 Medical Plan Comparison

	Premier PPO		Choice PPO		Consumer Select PPO with HSA		Consumer Value PPO with HSA	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Annual Deductible (What You Pay)								
Employee only	\$200	\$2,000	\$500	\$2,000	\$1,750	\$1,750	\$3,000	\$3,000
Family	\$600	\$6,000	\$1,500	\$6,000	\$3,500	\$3,500	\$6,000	\$6,000
Health Savings Account Contribution from Otsuka								
Employee only	N/A	N/A	N/A	N/A	\$1,200	\$1,200	\$500	\$500
Family	N/A	N/A	N/A	N/A	\$2,400	\$2,400	\$1,000	\$1,000
Annual Out-of-Pocket Maximum** (The most you will pay in 2027)								
Employee only	\$1,500	\$5,000	\$1,500	\$5,000	\$2,700	\$5,400	\$4,000	\$8,000
Family	\$4,500	\$15,000	\$4,500	\$15,000	\$5,400	\$10,800	\$8,000	\$16,000
Hospital and Other Facility Expenses (What You Pay)								
Inpatient***	10% after deductible	30% (10% MH/SA) after deductible	10% after deductible	30% (10% MH/SA) after deductible	10% after deductible	30% after deductible	20% after deductible	40% after deductible
Outpatient***	10% after deductible	30% (10% MH/SA) after deductible	10% after deductible	30% (10% MH/SA) after deductible	10% after deductible	30% after deductible	20% after deductible	40% after deductible
Emergency room	\$300 copay	\$300 copay	10% after deductible	10% after deductible	10% after deductible	10% after deductible	20% after deductible	20% after deductible

Family Coverage Out-of-Pocket Maximum (OOPM): Each family member has an individual OOPM within the family OOPM. Once a member reaches their individual OOPM, the plan covers 100% of their eligible expenses—even if the family OOPM hasn't been met.

*The cost of services received from out-of-network providers may be subject to balance billing.

**Copays and out-of-pocket costs paid toward meeting the annual deductible will be applied to your annual out-of-pocket maximum.

***Mental health (MH) and substance abuse (SA) services performed out-of-network are covered at higher reimbursement levels.

2027 Medical Plan Comparison (continued)

	Premier PPO		Choice PPO		Consumer Select PPO with HSA		Consumer Value PPO with HSA	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Professional Expenses (What You Pay)								
Telehealth visits	\$0	N/A	\$0	N/A	\$0	N/A	\$0	N/A
Maternity office visits and delivery	\$30 copay	30% after deductible	10% after deductible	30% after deductible	10% after deductible	30% after deductible	20% after deductible	40% after deductible
Office visits (PCP)	\$15 copay	30% after deductible	\$20 copay	30% after deductible	10% after deductible	30% after deductible	20% after deductible	40% after deductible
Office visits (specialist)	\$30 copay (\$15 copay MH/SA)	30% (10% MH/SA) after deductible	\$40 copay (\$20 copay MH/SA)	30% (10% MH/SA) after deductible	10% after deductible	30% (10% MH/SA) after deductible	20% after deductible	40% (20% MH/SA) after deductible
Physical, speech, and occupational therapy	\$30 copay	30% after deductible	\$40 copay	30% after deductible	10% after deductible	30% after deductible	20% after deductible	40% after deductible
Surgery (inpatient and outpatient)	10% after deductible	30% after deductible	10% after deductible	30% after deductible	10% after deductible	30% after deductible	20% after deductible	40% after deductible
Other Eligible Expenses (What You Pay)								
Lab, X-rays, and diagnostic tests (outside the doctor's office)	10% after deductible	30% after deductible	10% after deductible	30% after deductible	10% after deductible	30% after deductible	20% after deductible	40% after deductible

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**Copays and out-of-pocket costs paid toward meeting the annual deductible will be applied to your annual out-of-pocket maximum.