2025 MEDICAL AND PRESCRIPTION DRUG COVERAGE

MEDICAL COVERAGE

IN-NETWORK MEDICAL BENEFITS	NETWORK ONLY PLAN	CHOICE LOWER DEDUCTIBLE PLAN	CHOICE HIGHER DEDUCTIBLE PLAN
Network	In-network coverage only	In-and out-of-network coverage	In-and out-of-network coverage
HSA Eligible	No	Yes	Yes
DEDUCTIBLE			
Individual	$1,000	$2,000	$6,000
Family	$2,000	$4,000	$12,000
OUT-OF-POCKET MAXIMUM			
Individual	$2,500	$4,500	$6,000
Family	$5,000	$9,000	$12,000
MEDICAL			
Preventive Care	Plan pays 100%	Plan pays 100%	Plan pays 100%
Primary Care Physician Office Visit	Plan pays 100% after $25 Copay	Plan pays 80% after the deductible	Plan pays 70% after the deductible
Specialist Office Visit	Plan pays 100% after $40 Copay	Plan pays 80% after the deductible	Plan pays 70% after the deductible
Telemedicine	Plan pays 100% after $25 or $40 Copay	Plan pays 80% after the deductible	Plan pays 70% after the deductible
Emergency Room & Urgent Care	Plan pays 80% after the deductible	Plan pays 80% after the deductible	Plan pays 70% after the deductible
Inpatient and Outpatient Hospitalization	Plan pays 80% after the deductible	Plan pays 80% after the deductible	Plan pays 70% after the deductible
Outpatient Behavioral Health	Plan pays 100% after $25 Copay	Plan pays 80% after the deductible	Plan pays 70% after the deductible
Occupational & Physical Therapy 60 combined visits per year	Plan pays 100% after $40 Copay	Plan pays 80% after the deductible	Plan pays 70% after the deductible
Speech Therapy 25 visits per year	Plan pays 100% after $40 Copay	Plan pays 80% after the deductible	Plan pays 70% after the deductible
Chiropractic Care 20 visits per year	Plan pays 100% after $40 Copay	Plan pays 80% after the deductible	Plan pays 70% after the deductible
Bariatric Surgery Covered at Blue Distinction Centers only	Plan pays 80% after the deductible	Plan pays 80% after the deductible	Plan pays 70% after the deductible
Infertility Services $20,000 medical lifetime maximum	Plan pays 80% after the deductible	Plan pays 80% after the deductible	Plan pays 70% after the deductible
Hearing Aids $1,000 lifetime maximum	Plan pays 80% after the deductible	Plan pays 80% after the deductible	Plan pays 70% after the deductible
Gender Reassignment Surgery	Plan pays 80% after the deductible	Plan pays 80% after the deductible	Plan pays 70% after the deductible
Autism Spectrum Disorder Applied Behavioral Analysis (ABA)	Plan pays 80% after the deductible	Plan pays 80% after the deductible	Plan pays 70% after the deductible

2025 PRESCRIPTION DRUG COVERAGE

PRESCRIPTION DRUG COVERAGE

	NETWORK ONLY PLAN	CHOICE LOWER DEDUCTIBLE PLAN	CHOICE HIGHER DEDUCTIBLE PLAN
PRESCRIPTION DRUG			
Medical Deductible Applies	No	Yes	Yes
Fertility Lifetime Maximum	$15,000	$15,000	$15,000
RETAIL		***AFTER DEDUCTIBLE**	***AFTER DEDUCTIBLE**
Generic	Plan pays 80% $4 min; $25 max	*Plan pays 80% $4 min; $25 max	*Plan pays 70% $4 min; $25 max
Preferred Brand	Plan pays 80% $25 min; $70 max	*Plan pays 80% $25 min; $70 max	*Plan pays 70% $25 min; $70 max
Non-Preferred Brand	Plan pays 80% $40 min; $100 max	*Plan pays 80% $40 min; $100 max	*Plan pays 70% $40 min; $100 max
MAIL ORDER		***AFTER DEDUCTIBLE**	***AFTER DEDUCTIBLE**
Generic	Plan pays 80% $8 min; $50 max	*Plan pays 80% $8 min; $50 max	*Plan pays 70% $8 min; $50 max
Preferred Brand	Plan pays 80% $50 min; $140 max	*Plan pays 80% $50 min; $140 max	*Plan pays 70% $50 min; $140 max
Non-Preferred Brand	Plan pays 80% $80 min; $200 max	*Plan pays 80% $80 min; $200 max	*Plan pays 70% $80 min; $200 max

KEY WORDS TO KNOW

Deductible: The amount **you pay** before the plan begins to pay.

Copay: The amount **you pay** for a covered service each time you use that service; does not apply toward the deductible.

Coinsurance: Percentage of the charge that **your plan will pay**, typically after you have met the deductible.

Out-of-Pocket Maximum: The maximum amount **you pay** for covered services in a year (you may need to pay additional amounts if coverage is received from an out-of-network provider). This includes expenses you pay yourself, such as **deductibles**, **copays**, and **coinsurance**.

HELPFUL INFORMATION ABOUT DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

When electing coverage for any family members in addition to yourself, be sure to understand how deductibles and out-of-pocket maximums apply under each plan.

PLAN	DEDUCTIBLE	OUT-OF-POCKET MAXIMUM
Network Only Plan	Once one family member meets the Individual Deductible, benefits begin to be paid for that individual. After two or more family members satisfy the Family Deductible, benefits will be paid for all family members.	Once one family member meets the Individual Out-of-Pocket Maximum, the plan pays covered benefits in full for that individual.
Choice Lower Deductible Plan, Choice Higher Deductible Plan	The entire Family Deductible must be met before benefits begin to pay out for any family member.	Once one family member meets the Individual Out-of-Pocket Maximum, the plan pays covered benefits in full for that individual.

This summary provides a high-level overview of your in-network medical and prescription drug benefits. See plan documents for details, restrictions, and out-of-network benefits. See Kaiser plan documents for details on the Kaiser medical plans.

2025 Xerox Monthly Benefit Cost

MEDICAL MONTHLY CONTRIBUTION RATES*	NETWORK ONLY PLAN	CHOICE LOWER DEDUCTIBLE PLAN	CHOICE HIGHER DEDUCTIBLE PLAN
If your 2024 salary is less than $59,999			
Employee Only	$185.00	$135.00	$0.00
Employee + Spouse	$450.00	$300.00	$220.00
Employee + Child(ren)	$370.00	$250.00	$185.00
Family	$640.00	$425.00	$315.00
If your 2024 salary is $60,000 or more			
Employee Only	$185.00	$135.00	$10.00
Employee + Spouse	$450.00	$300.00	$220.00
Employee + Child(ren)	$370.00	$250.00	$185.00
Family	$640.00	$425.00	$315.00

*Rates do not include the tobacco surcharge.
For Xerox employees: These rates are based on your salary as of September 1, 2024, or your date of hire, whichever is later. For XBS employees: These rates are based on your salary as of September 1, 2024, or your date of hire, whichever is later. For XBS Sales employees, an Annual Benefit Base Rate (ABBR) will be used to determine your rates. The ABBR is based on gross wages from September 2023 through August 2024, or base pay as of September 2024, whichever is higher.

DENTAL MONTHLY CONTRIBUTION RATES			
	BASIC DENTAL	ENHANCED DENTAL	DMO
Employee Only	$15.16	$20.57	$8.70
Employee + Spouse	$31.83	$43.20	$18.27
Employee + Child(ren)	$37.89	$51.43	$21.75
Family	$51.53	$69.94	$28.71

VISION MONTHLY CONTRIBUTION RATES		
	BASIC VISION	BUY-UP VISION
Employee Only	$5.59	$10.23
Employee + Spouse	$11.18	$20.48
Employee + Child(ren)	$11.74	$21.51
Family	$17.33	$31.74