2027 Medical Plan Comparison (In-Network)

Key Costs & Common Care

Covered service	Basic HDHP	Core HDHP	Premier PPO
Individual Deductible	$4,000	$2,000	$2,000
Family* Deductible	$8,000	$4,000	$4,000
Individual Out of Pocket Maximum	$8,000	$4,000	$4,000
Family* Out of Pocket Maximum	$16,000	$8,000	$8,000
Deductible and Out of Pocket Maximum Type	Embedded	Non-Embedded	Non-Embedded
Physician's Office Visit	30% after deductible	20% after deductible	$30 copay Quality & Effective Care “Preferred” Providers $50 copay Other In-Network
Specialist Office Visit	30% after deductible	20% after deductible	$50 copay Quality & Effective Care “Preferred” Providers $80 copay Other In-Network
Behavioral Health Office Visit	30% after deductible	20% after deductible	$50 copay Quality & Effective Care “Preferred” Providers $80 copay Other In-Network

**The Family deductible and out-of-pocket maximum applies to Employee + Child(ren), Employee + Spouse/Domestic Partner and Family coverage*

Virtual Service

Covered service	Basic HDHP	Core HDHP	Premier PPO
Virtual Physician	$0	$0	$0
Virtual Specialist	$0	$0	$0
Virtual Behavioral Health	$0	$0	$0

Preventive Care (Subject to age and frequency limits)

Covered service	Basic HDHP	Core HDHP	Premier PPO
Well Child Visit	$0	$0	$0
Adult Routine Physical Exam	$0	$0	$0
Immunizations	$0	$0	$0
Routine GYN	$0	$0	$0
Routine Mammogram/Breast Cancer Screening	$0	$0	$0
Routine PSA/DRE Cost Sharing	$0	$0	$0
Colorectal Cancer Screening	$0	$0	$0
Lung Cancer Screening	$0	$0	$0
Contraceptive Administration	$0	$0	$0
Pre-Natal Maternity Visits	$0	$0	$0

Therapy Services

Covered service	Basic HDHP	Core HDHP	Premier PPO
Chiropractic	30% after deductible	20% after deductible	$80 copay
Spinal Disorders / Spinal Manipulation Maximum	15 visits per year	15 visits per year	15 visits per year
Outpatient Short-Term Rehabilitation	30% after deductible	20% after deductible	$80 copay
Speech Therapy Maximum	90 visits per year	90 visits per year	90 visits per year
PT/OT Combined Maximum	60 visits per year	60 visits per year	60 visits per year
Acupuncture	30% after deductible	20% after deductible	$80 copay
Acupuncture Visit Limits	26 visits per year	26 visits per year	26 visits per year
Habilitative Services	30% after deductible	20% after deductible	20% after deductible
Autism Spectrum Disorder PT/OT/ST	30% after deductible	20% after deductible	20% after deductible
Autism Spectrum Disorder Behavioral Therapy	30% after deductible	20% after deductible	20% after deductible
Autism Spectrum Disorder Applied Behavioral Analysis (ABA)	30% after deductible	20% after deductible	20% after deductible

Other Physician /Provider Services

Covered service	Basic HDHP	Core HDHP	Premier PPO
Office Based Surgery: Surgeon's Charges	30% after deductible	20% after deductible	20% after deductible
Office Based Diagnostic X-ray and Lab	30% after deductible	20% after deductible	20% after deductible
Outpatient Surgery Facility Charges	30% after deductible	20% after deductible	20% after deductible
Outpatient Surgery: Surgeon's Charges	30% after deductible	20% after deductible	20% after deductible

Diagnostic Procedures

Covered service	Basic HDHP	Core HDHP	Premier PPO
Outpatient Diagnostic X-ray and Lab	30% after deductible	20% after deductible	20% after deductible
Complex Imaging Services: MRIs, CAT Scans, etc.	30% after deductible	20% after deductible	20% after deductible

Emergency Medical Care

Covered service	Basic HDHP	Core HDHP	Premier PPO
Urgent Care Facility	30% after deductible	20% after deductible	$85 copay
Emergency Room	30% after deductible	20% after deductible	$350 Copay
Ambulance: Covers medically necessary transport	30% after deductible	20% after deductible	$350 Copay

Hospital Care

Covered service	Basic HDHP	Core HDHP	Premier PPO
Inpatient Hospital Coinsurance	30% after deductible	20% after deductible	20% after deductible
Outpatient Hospital Expenses	30% after deductible	20% after deductible	20% after deductible
Maternity / Newborn Inpatient Hospital	30% after deductible	20% after deductible	20% after deductible

Inpatient Mental Health & Substance Abuse

Covered service	Basic HDHP	Core HDHP	Premier PPO
Inpatient Mental Disorders	30% after deductible	20% after deductible	20% after deductible
Inpatient Substance Abuse Disorder	30% after deductible	20% after deductible	20% after deductible

Other Covered Services

Covered service	Basic HDHP	Core HDHP	Premier PPO
Skilled Nursing Facility / Convalescent Facility	30% after deductible	20% after deductible	20% after deductible
SNF /CFEB Maximum	180 days per year	180 days per year	180 days per year
Home Health Care	30% after deductible	20% after deductible	20% after deductible
HHC Maximum	180 days per year	180 days per year	180 visits per year
Private Duty Nursing	30% after deductible	20% after deductible	20% after deductible
PDN Maximum	70 shifts per year	70 shifts per year	70 shifts per year
Durable Medical Equipment	30% after deductible	20% after deductible	20% after deductible
Infusion Therapy (in home or office)	30% after deductible	20% after deductible	$80 copay
Infusion Therapy (in outpatient facility)	30% after deductible	20% after deductible	20% after deductible
Allergy Test/Treatment	30% after deductible	20% after deductible	$50 copay at PCP $80 copay at Specialist
Eye Exam Cost Sharing	30% after deductible	20% after deductible	$80 copay
Eye Exam Frequency Limits	1 exam every 24 months	1 exam every 24 months	1 exam every 24 months
Infertility Coverage ***Must utilize Progyny***	30% after deductible	20% after deductible	20% after deductible

Prescription Coverage

Covered service	Basic HDHP	Core HDHP	Premier PPO
Deductible applies first for Non-Preventive Drugs	Yes	Yes	No
Generic	$10 30-day $20 90-day	$10 30-day $20 90-day	$10 30-day $20 90-day
Brand Preferred	25% ($25 min/$65 max) 30-day $70 90-day	25% ($25 min/$65 max) 30-day $70 90-day	25% ($25 min/$65 max) 30-day $70 90-day
Brand Non-Preferred	35% ($40 min/$120 max) 30-day $120 90-day	35% ($40 min/$120 max) 30-day $120 90-day	35% ($40 min/$120 max) 30-day $120 90-day

Health Savings Account (HSA)

Covered service	Basic HDHP	Core HDHP	Premier PPO
HSA Eligibility	Eligible	Eligible	Not Eligible
M&T HSA Contribution Available for frozen earnings under $100,000 and enrolled January 1st	$350-$2,000 Based on salary, tier and hours worked	$350-$2,000 Based on salary, tier and hours worked	-

Important: This is a summary of the medical plans available to eligible M&T Bank employees. It does not include all plan details. In the event of any discrepancy between this summary and the applicable plan documents, the legal plan documents will govern.