



## MEDICAL AND PRESCRIPTION PLAN OPTIONS

7/1/21-6/30/22

Benefit	Base		Buy-Up		HDHP/HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>MEDICAL – BLUE CROSS BLUE SHIELD</b>						
<b>Deductible</b>						
Individual	<b>\$1,000</b>	<b>\$2,000</b>	<b>\$750</b>	<b>\$1,500</b>	<b>\$1,750</b> (Medical and Rx)	
Family	<b>\$2,000</b>	<b>\$4,000</b>	<b>\$1,500</b>	<b>\$3,000</b>	<b>\$3,500</b> (Medical and Rx)	
<b>Coinsurance</b>	20%	40%	20%	40%	20%	40%
<b>Out-of-Pocket Limit</b>						
Individual	\$4,750	\$7,500	\$4,500	\$7,000	\$5,000	\$7,000
Family (2X)	\$9,500	\$15,000	\$9,000	\$14,000	\$10,000	\$14,000
Individual – RX	\$2,350	N/A	\$2,350	N/A	Included Above	N/A
Family (2X) – RX	\$4,700	N/A	\$4,700	N/A	Included Above	N/A
<b>Office Visit</b>	\$45 PCP \$60 Specialist	40%	\$35 PCP \$45 Specialist	40%	20% after deductible	40% after deductible
<b>Inpatient-Hospital</b>	\$100 access fee 20% after deductible	\$100 access fee 40% after deductible	\$100 access fee 20% after deductible	\$100 access fee 40% after deductible	\$100 access fee 20% after deductible	\$100 access fee 40% after deductible
<b>Outpatient Services</b>	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
<b>Emergency Room</b>	\$200 then 20%	\$200 then 40%	\$150 then 20%	\$150 then 20%	\$150 then 20%	\$150 then 20%
<b>Urgent Care</b>	\$80 access fee	40%	\$60 access fee	40%	20% after deductible	40% after deductible
<b>Telemedicine</b>	Free	Free	Free	Free	\$49 Medical, \$80-95 Counseling, \$175 Psychiatry (Initial), \$90 Psychiatry (Follow-Up)	
<b>CVS PRESCRIPTION DRUGS</b>						
Retail	\$8/\$35/\$55	Not covered	\$8/\$35/\$55	Not covered	No tiered copay 20% after deductible	Not covered
Mail Order (90-day supply)	\$16/70/110		\$16/70/110			
In-Network Retail Pharmacy (up to a 90-day supply)	Copays: Generic: \$20 Formulary: \$87.50 Non-Formulary: \$137.50	Not covered	Copays: Generic: \$20 Formulary: \$87.50 Non-Formulary: \$137.50	Not covered	20% after deductible (\$8 min copay)	20% after deductible (\$8 min copay)
Specialty Drug Program (up to a 30-day supply)	Copays: Generic: \$65.00 Formulary: \$65.00 Non-Formulary: \$65.00	Not Covered	Copays: Generic: \$65.00 Formulary: \$65.00 Non-Formulary: \$65.00	Not Covered	20% after ded (\$8 min copay)	20% after ded (\$8 min copay)
<b>VERA CLINIC</b>						
Office Visits	Free		Free		\$75 – 1 <sup>st</sup> visit; \$50 until deductible is met	