MEDICAL AND PRESCRIPTION PLAN OPTIONS
7/1/2022 - 6/30/2023

Benefit	Base		Buy-Up		HDHP/HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
MEDICAL – BLUE CROSS BLUE SHIELD						
Deductible						
Employee Only	**$1,000**	**$2,000**	**$750**	**$1,500**	**$1,750** (Medical and Rx)	
Employee + 1	**$2,000**	**$4,000**	**$1,500**	**$1,500**	**$3,500** (Medical and Rx)	
Family	**$2,000**	**$4,000**	**$1,500**	**$3,000**	**$3,500** (Medical and Rx)	
Coinsurance	20%	40%	20%	40%	20%	40%
Out-of-Pocket Limit						
Employee Only	$4,750	$7,500	$4,500	$7,000	$5,000	$7,000
Employee +1	$9,500	$15,000	$9,000	$14,000	$10,000	$14,000
Family (2X)	$9,500	$15,000	$9,000	$14,000	$10,000	$14,000
Employee Only – RX	$2,350	N/A	$2,350	N/A	Included Above	N/A
Employee + 1 - RX	$4,700	N/A	$4,700	N/A	Included Above	N/A
Family (2X) – RX	$4,700	N/A	$4,700	N/A	Included Above	N/A
Office Visit	$45 PCP $60 Specialist	40%	$35 PCP $45 Specialist	40%	20% after deductible	40% after deductible
Inpatient-Hospital	$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
Outpatient Services	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Emergency Room	$300 then 20%	$300 then 40%	$200 then 20%	$200 then 20%	$150 then 20%	$150 then 20%
Urgent Care	$80 access fee	40%	$60 access fee	40%	20% after deductible	40% after deductible
Telemedicine	Free	Free	Free	Free	$49 Medical, $80-95 Counseling, $175 Psychiatry (Initial), $90 Psychiatry (Follow-Up)	

CVS PRESCRIPTION DRUGS						
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)
VERA CLINIC						
Office Visits	Free		Free		$75 – 1st visit; $50 until deductible is met	