



MEDICAL AND PRESCRIPTION PLAN OPTIONS

7/1/2023 - 6/30/2024

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 – 1 st visit, \$50 for each after until deductible is met; Free for preventative care		