

# 2023 MEDICAL & PRESCRIPTION DRUG PLANS AT-A-GLANCE

## POINT OF SERVICE

## PERSONAL CHOICE PPO - BASIC

## PERSONAL CHOICE PPO - HIGH

BENEFIT DESCRIPTION	TIER 1 NETWORK	IN-NETWORK	OUT-OF-NETWORK	TIER 1 NETWORK	IN-NETWORK	OUT-OF-NETWORK	TIER 1 NETWORK	IN-NETWORK	OUT-OF-NETWORK
<b>IS A REFERRAL NEEDED TO SEE A SPECIALIST?</b>		Yes			No			No	
<b>EMPLOYER HEALTH SAVINGS ACCOUNT CONTRIBUTION</b>		No			No			No	
<b>INTERNATIONAL TRAVEL</b>		Covers Emergency Medical Care Only		BCBS Global Core Included. For more information on the services covered internationally, please call the service center at 1-800-810-2583			BCBS Global Core Included. For more information on the services covered internationally, please call the service center at 1-800-810-2583		
<b>DEDUCTIBLE (INDIVIDUAL/FAMILY)</b>	None	None	\$500 / \$1,500	None	\$300 / \$600	\$1,000 / \$2,000	None	None	\$500 / \$1,000
<b>OUT-OF-POCKET MAXIMUM (INDIVIDUAL/FAMILY)</b>	\$1,500 / \$3,000	\$2,000 / \$4,000	\$3,000 / \$9,000	\$1,000 / \$2,000	\$2,000 / \$4,000	\$3,000 / \$6,000	\$1,000 / \$2,000	\$2,000 / \$4,000	\$3,000 / \$6,000
<b>PREVENTIVE CARE SERVICES</b>	No charge	No charge	Plan pays 70%	No charge	No charge	Plan pays 70%	No charge	No charge	Plan pays 80%
<b>PRIMARY CARE PHYSICIAN (PCP)</b>	No charge	\$20 copay	Plan pays 70%*	No charge	\$20 copay	Plan pays 70%*	No charge	\$15 copay	Plan pays 80%*
<b>MDLive**</b>	N/A	No charge	N/A	N/A	No Charge	N/A	N/A	No Charge	N/A
<b>SPECIALIST OFFICE VISIT</b>	\$10 copay	\$40 copay	Plan pays 70%*	\$10 copay	\$30 copay	Plan pays 70%*	\$10 copay	\$25 copay	Plan pays 80%*
<b>OUTPATIENT SERVICES (SURGERY)</b>	No charge	\$50 copay	Plan pays 70%*	No charge	Plan pays 90%*	Plan pays 70%*	No charge	No charge	Plan pays 80%*
<b>INPATIENT SERVICES</b>	\$240 copay per admission	\$100/day copay; max of 5 copays/admission	Plan pays 70%*	No charge	Plan pays 90%*	Plan pays 70%*	No charge	No charge	Plan pays 80%*
<b>DIAGNOSTIC LABORATORY</b>	No charge	No charge	Plan pays 70%*	No charge	No charge	Plan pays 70%*	No charge	No charge	Plan pays 80%*
<b>DIAGNOSTIC X-RAY</b>	No charge	\$20 copay	Plan pays 70%*	No charge	Plan pays 90%*	Plan pays 70%*	No charge	No charge	Plan pays 80%*
<b>IMAGING (MRI, CT-SCAN)</b>	No charge	\$80 copay	Plan pays 70%*	No charge	Plan pays 90%*	Plan pays 70%*	No charge	No charge	Plan pays 80%*
<b>EMERGENCY ROOM</b>	\$100 copay	\$100 copay	Covered at in-network level	\$100 copay	\$100 copay	Covered at in-network level	\$100 copay	\$100 copay	Covered at in-network level
<b>URGENT CARE CENTER</b>	No charge	\$35 copay	Plan pays 70%*	No charge	\$35 copay	Plan pays 70%*	No charge	\$35 copay	Plan pays 80%*
<b>OUTPATIENT SERVICES FOR MENTAL HEALTH/BEHAVIORAL/SUBSTANCE ABUSE</b>	Not available	\$20 copay	Plan pays 70%*	Not available	Plan pays 90%*	Plan pays 70%*	Not available	No charge	Plan pays 80%*
<b>PRESCRIPTION DRUG BENEFITS</b>									
<b>RETAIL PHARMACY (UP TO A 30-DAY SUPPLY)</b>	Generic: \$10 copay Preferred Brand: \$30 copay Non-Preferred Brand: \$50 copay		Plan pays 30%	Generic: \$10 copay Preferred Brand: \$30 copay Non-Preferred Brand: \$50 copay		Plan pays 30%	Generic: \$10 copay Preferred Brand: \$30 copay Non-Preferred Brand: \$50 copay		Plan pays 30%
<b>MAIL ORDER (UP TO A 90-DAY SUPPLY)</b>	Generic: \$20 copay Preferred Brand: \$60 copay Non-Preferred Brand: \$100 copay		Not available	Generic: \$20 copay Preferred Brand: \$60 copay Non-Preferred Brand: \$100 copay		Not available	Generic: \$20 copay Preferred Brand: \$60 copay Non-Preferred Brand: \$100 copay		Not available

\*The plan year deductible must be satisfied before the plan will pay for services.

\*\* Includes Teledermatology and Telebehavioral health