2024 MEDICAL & PRESCRIPTION DRUG PLANS AT-A-GLANCE

	POINT OF SERVICE			PERSONAL CHOICE PPO - BASIC			PERSONAL CHOICE PPO - HIGH			CDHP WITH HSA		
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**	**TIER 1 NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
IS A REFERRAL NEEDED TO SEE A SPECIALIST?	Yes			No			No			No		
EMPLOYER HEALTH SAVINGS ACCOUNT CONTRIBUTION	No			No			No			Individual: $500 / Family: $1,000		
INTERNATIONAL TRAVEL	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			BCBS Global Core Included. For more information on the services covered internationally, please call the service center at 1-800-810-2583		
DEDUCTIBLE (INDIVIDUAL/FAMILY)	None	None	$500 / $1,500	None	$300 / $600	$1,000 / $2,000	None	None	$500 / $1,000	$1,600/$3,200	$2,000 / $4,000	$5,000 / $10,000
OUT-OF-POCKET MAXIMUM (INDIVIDUAL/FAMILY)	$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	$6,450 / $12,900	$6,450 / $12,900	$10,000 / $20,000
PREVENTIVE CARE SERVICES	No charge	No charge	Plan pays 70%	No charge	No charge	Plan pays 70%	No charge	No charge	Plan pays 80%	No charge	No charge	Plan pays 50%
PRIMARY CARE PHYSICIAN (PCP)	No charge	$20 copay	Plan pays 70%*	No charge	$20 copay	Plan pays 70%*	No charge	$15 copay	Plan pays 80%*	No charge*	Plan pays 80%*	Plan pays 50%*
TELADOC**	N/A	No charge	N/A	N/A	No Charge	N/A	N/A	No Charge	N/A	N/A	$60 copay	N/A
SPECIALIST OFFICE VISIT	$10 copay	$40 copay	Plan pays 70%*	$10 copay	$30 copay	Plan pays 70%*	$10 copay	$25 copay	Plan pays 80%*	No charge*	Plan pays 80%*	Plan pays 50%*
OUTPATIENT SERVICES (SURGERY)	No charge	$50 copay	Plan pays 70%*	No charge	Plan pays 90%*	Plan pays 70%*	No charge	No charge	Plan pays 80%*	No charge*	Plan pays 80%*	Plan pays 50%*
INPATIENT SERVICES	$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%*	No charge*	:Plan pays 80%*	Plan pays 50%*
DIAGNOSTIC LABORATORY	No charge	No charge	Plan pays 70%*	No charge	No charge	Plan pays 70%*	No charge	No charge	Plan pays 80%*	No charge*	Plan pays 80%*	Plan pays 50%*
DIAGNOSTIC X-RAY	No charge	$20 copay	Plan pays 70%*	No charge	Plan pays 90%*	Plan pays 70%*	No charge	No charge	Plan pays 80%*	No charge*	Plan pays 80%*	Plan pays 50%*
IMAGING (MRI, CT-SCAN)	No charge	$80 copay	Plan pays 70%*	No charge	Plan pays 90%*	Plan pays 70%*	No charge	No charge	Plan pays 80%*	No charge*	Plan pays 80%*	Plan pays 50%*
EMERGENCY ROOM	$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	No charge*	Plan pays 80%*	Covered at in-network level
URGENT CARE CENTER	No charge	$35 copay	Plan pays 70%*	No charge	$35 copay	Plan pays 70%*	No charge	$35 copay	Plan pays 80%*	No charge*	Plan pays 80%*	Plan pays 50%*
OUTPATIENT SERVICES FOR MENTAL HEALTH/BEHAVIORAL/ SUBSTANCE ABUSE	Not available	$20 copay	Plan pays 70%*	Not available	Plan pays 90%*	Plan pays 70%*	Not available	No charge	Plan pays 80%*	Not available	Plan pays 80%*	Plan pays 50%*
PRESCRIPTION DRUG BENEFITS												
RETAIL PHARMACY (UP TO A 30-DAY SUPPLY)	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%	Generic: $10 copay* Preferred Brand: $30 copay* Non-Preferred Brand: $50 copay*		Plan pays 30%*
MAIL ORDER (UP TO A 90-DAY SUPPLY)	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	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