2025 MEDICAL & PRESCRIPTION DRUG PLANS AT-A-GLANCE

	POINT OF SERVICE		PERSONAL CHOICE PPO - BASIC		PERSONAL CHOICE PPO - HIGH		CDHP WITH HSA	
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-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	$500 / $1,500	$300 / $600	$1,000 / $2,000	None	$500 / $1,000	$2,000 / $4,000	$5,000 / $10,000
OUT-OF-POCKET MAXIMUM (INDIVIDUAL/FAMILY)	$2,000 / $4,000	$3,000 / $9,000	$2,000 / $4,000	$3,000 / $6,000	$2,000/ $4,000	$3,000 / $6,000	$6,450 / $12,900	$10,000 / $20,000
PREVENTIVE CARE SERVICES	No charge	Plan pays 70%	No charge	Plan pays 70%	No charge	Plan pays 80%	No charge	Plan pays 50%
PRIMARY CARE PHYSICIAN (PCP)	$20 copay	Plan pays 70%*	$20 copay	Plan pays 70%*	$15 copay	Plan pays 80%*	Plan pays 80%*	Plan pays 50%*
TELADOC**	No charge	N/A	No Charge	N/A	No Charge	N/A	$60 copay*	N/A
SPECIALIST OFFICE VISIT	$40 copay	Plan pays 70%*	$30 copay	Plan pays 70%*	$25 copay	Plan pays 80%*	Plan pays 80%*	Plan pays 50%*
OUTPATIENT SERVICES (SURGERY)	$50 copay	Plan pays 70%*	Plan pays 90%*	Plan pays 70%*	No charge	Plan pays 80%*	Plan pays 80%*	Plan pays 50%*
INPATIENT SERVICES	$100/day copay; max of 5 copays/admission	Plan pays 70%*	Plan pays 90%*	Plan pays 70%*	No charge	Plan pays 80%*	:Plan pays 80%*	Plan pays 50%*
DIAGNOSTIC LABORATORY	No charge	Plan pays 70%*	No charge	Plan pays 70%*	No charge	Plan pays 80%*	Plan pays 80%*	Plan pays 50%*
DIAGNOSTIC X-RAY	$20 copay	Plan pays 70%*	Plan pays 90%*	Plan pays 70%*	No charge	Plan pays 80%*	Plan pays 80%*	Plan pays 50%*
IMAGING (MRI, CT-SCAN)	$80 copay	Plan pays 70%*	Plan pays 90%*	Plan pays 70%*	No charge	Plan pays 80%*	Plan pays 80%*	Plan pays 50%*
EMERGENCY ROOM	$250 copay	Covered at in-network level	$250 copay	Covered at in-network level	$250 copay	Covered at in-network level	Plan pays 80%*	Covered at in-network level
URGENT CARE CENTER	$50 copay	Plan pays 70%*	$50 copay	Plan pays 70%*	$50 copay	Plan pays 80%*	Plan pays 80%*	Plan pays 50%*
OUTPATIENT SERVICES FOR MENTAL HEALTH/ BEHAVIORAL/SUBSTANCE ABUSE	$20 copay	Plan pays 70%*	Plan pays 90%*	Plan pays 70%*	No charge	Plan pays 80%*	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