2024 Medical Plan Comparison Sheet

	Plus Plan	Basic Plan	HDHP Plan*
Office Visit	$30.00	$30.00	Subject to Deductible
Specialist	$50.00	Subject to Deductible	Subject to Deductible
Urgent Care	$50.00	Subject to Deductible	Subject to Deductible
Telemedicine	$30.00	$30.00	$65.00
Onsite Clinic	$0.00	$0.00	$45.00
Emergency Room	$250 Copay/then Deductible	Subject to Deductible	Subject to Deductible
Preventative Visit	$0.00	$0.00	$0.00
Deductible			
Deductible - Individual	$800.00	$1,500.00	$3,200.00
Deductible - Family	$1,600.00	$3,000.00	$6,000.00
Out of Pocket Maximum(OOPM)			
OOPM - Individual	$4,000.00	$6,000.00	$6,750.00
OOPM - Family	$8,000.00	$12,000.00	$13,500.00
Premiums - Monthly			
Employee Only	$199.93	$100.89	$49.59
Emp + Child(ren)	$387.59	$130.92	$83.05
Emp + Spouse	$511.00	$230.64	$126.04
Family	$754.42	$350.69	$196.57
Premiums - Annual			
Employee Only	$2,399.16	$1,210.68	$595.08
Emp + Child(ren)	$4,651.08	$1,571.04	$996.60
Emp + Spouse	$6,132.00	$2,767.68	$1,512.48
Family	$9,053.04	$4,208.28	$2,358.84
Maximum Annual Liability (OOPM + Premiums)			
Employee Only	$6,399.16	$7,210.68	$7,345.08
Emp + Child(ren)	$12,651.08	$13,571.04	$14,496.60
Emp + Spouse	$14,132.00	$14,767.68	$15,012.48
Family	$17,053.04	$16,208.28	$15,858.84
			***H.S.A Seed Dollars ($500 Employee Only/ $1,000 All Dependent Tiers)**
Prescriptions - 30 Day			
Generic	$15 Copay	$15 Copay	Subject to Deductible
Preferred Brand	$40 Copay	$40 Copay	Subject to Deductible
Non-Preferred Brand	$70 Copay	$70 Copay	Subject to Deductible
Specialty	$125 Copay	$125 Copay	Subject to Deductible
Prescriptions - 90 Day(Retail)			
Generic*	$45 Copay	$45 Copay	Subject to Deductible
*90 day refills only available for generics at retail locations.			
Prescriptions - 90 Day(BCBS Home Delivery)			
Generic	$25 Copay	$25 Copay	Subject to Deductible
Preferred Brand	$90 Copay	$90 Copay	Subject to Deductible
Non-Preferred Brand	$175 Copay	$175 Copay	Subject to Deductible
Specialty	Not Covered	Not Covered	Not Covered