Medical Rx Plan Comparison

Medical Benefits	**2024 Plan Design**			
Carrier	**Anthem (Previously Empire BCBS)**			
In-Network Coverage	**Premium Plan**	**Value Plan**	**HD2800 (HRA)**	**HD5000 (HSA)**
Plan Type	**PPO**	**PPO**	**PPO**	**PPO**
Deductible (Individual / Family)	$1,000 / $2,000 *(Embedded)*	$2,000 / $4,000 *(Embedded)*	$2,800/$5,600 *(Embedded)*	$5,000 / $10,000 *(Embedded)*
Out-of-Pocket Maximum (Individual / Family)	$2,500 / $5,000	$5,000 / $10,000	$5,000 / $10,000	$6,000 / $12,000
Coinsurance	80%	80%	70%	80%
Primary Care Physician Office Visit	$35 Copay	$35 Copay	Ded. & Coins.	Ded. & Coins.
Specialist Office Visit	$50 Copay	$50 Copay	Ded. & Coins.	Ded. & Coins.
Preventive Care	No Charge	No Charge	No Charge	No Charge
Medical Live Health Online	$10 Copay	$10 Copay	Up to $59	Up to $59
Emergency Room *(waived if admitted)*	$350	$350	Ded. & Coins.	Ded. & Coins.
Urgent Care	$50 Copay	$50 Copay	Ded. & Coins.	Ded. & Coins.
Inpatient Hospital	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.
Diagnostic Bloodwork	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.
Outpatient Surgery	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.
X-Ray	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.
Advanced Diagnostic Imaging	$250 Copay	$250 Copay	Ded. & Coins.	Ded. & Coins.
Hospital Indemnity Coverage	N/A	N/A	Included	Included
Employer HRA Contribution	N / A	N / A	$750/$1,500	$0
Employer HSA Contribution	N/A	N/A	$0	$1,000 / $2,000
Prescription Drugs				
Tier 1 & 2 Deductible	$100	$100	Before plan deductible is satisfied: All prescriptions are subject to the plan deductible with the exception of drugs on the preventive generic drug list.	Before plan deductible is satisfied: All prescriptions are subject to the plan deductible with the exception of drugs on the preventive generic drug list.
Tier 3 Deductible	$100	$100		
Tier 4 Deductible	$150	$150		
Prescription Drug Retail (Tier 1/2/3/4)	$10/$35/$75/20% or $100 copay*	$10/$35/$75/20% or $100 copay*	After plan deductible is satisfied: $10/$35/$75/20% or $100 copay*	After plan deductible is satisfied: $10/$35/$75/20% or $100 copay*
Mail Order	$30/$105/$225	$30/$105/$225	$30/$105/$225	$30/$105/$225

**Except for generic drugs on the preventive drug list.*
**Please refer to info on Specialty Drug Copay Program. You must reach out to Accredo if you or a family member utilize a specialty drug.*

Out-of-Network Coverage	**Office-Based Behavioral Health / Substance Abuse ONLY**	**Office-Based Behavioral Health / Substance Abuse ONLY**	**Office-Based Behavioral Health / Substance Abuse ONLY**	**Office- Based Behavioral Health / Substance Abuse ONLY**
Deductible (Individual / Family)	No Deductible	No Deductible	Integrated with In-Network Deductible	Integrated with In-Network Deductible
Coinsurance	80%	80%	70%	80%