Benefits at a Glance

MEDICAL

Plan Year 01/01/2024 - 12/31/2024	High Deductible Health Plan One	High Deductible Health Plan Two	80/20	Copay
Calendar Year Deductible The amount you must pay before the Plan begins to pay for most services	**In-network:** $3,200/individual - $6,000/family **Out-of-network:** $6,000/individual - $12,000/family	**In-network:** $2,000/individual - $3,500/family (Ind Ded for Emp Only coverage) **Out-of-network:** $4,000/individual - $8,000/family	**In-network:** $1,000/individual - $3,000/family **Out-of-network:** $2,000/individual - $6,000/family	**In-network:** $1,000/individual - $3,000/family **Out-of-network:** $2,000/individual - $6,000/family
Calendar Year Out-of Pocket Maximum (includes deductible) The most that you will pay in coinsurance in one plan year, after which the Plan pays 100%	**In-network:** $5,000/individual - $10,000/family **Out-of-network:** $10,000/individual - $20,000/family	**In-network:** $3,500/individual - $7,000/family **Out-of-network:** $7,000/individual - $14,000/family	**In-network:** $3,500/individual - $10,500/family **Out-of-network:** $7,000/individual - $21,000/family	**In-network:** $3,000/individual - $9,000/family **Out-of-network:** $6,000/individual - $18,000/family
Coinsurance (applies after deductible is met)	Employee Pays 20%	Employee Pays 20%	Employee Pays 20%	Employee Pays 20%
Office Visits				
Preventive	FREE	FREE	FREE	FREE
Physician	Plan pays 80% of Allowable Amount after CY Deductible	Plan pays 80% of Allowable Amount after CY Deductible	Plan pays 80% of Allowable Amount after CY Deductible	Primary Care: $75 Specialty Care: $100
Prescriptions				
Copay Amounts for: 30 Day Supply - Tier 1 / Tier 2 / Tier 3 **Mail Order** 90 Day Supply - Tier 1 / Tier 2 / Tier 3 Tier 1 - Generic Tier 2 - Preferred Brand Name Tier 3 - Non-Preferred Brand Name	**Participating Pharmacy** 30 day - $10 / $35 / $60 (after CY deductible) Mail Order - $20 / $70 / $120 (after CY deductible) **Non-Participating Pharmacy** 30 day - Pays 80% of Allowable Amount minus Copayment Mail Order not available	**Participating Pharmacy** 30 day - $10 / $35 / $60 (after CY deductible) Mail Order - $20 / $70 / $120 (after CY deductible) **Non-Participating Pharmacy** 30 day - Pays 80% of Allowable Amount minus Copayment Mail Order not available	**Participating Pharmacy** 30 day - $10 / $35 / $60 Mail Order - $20 / $70 / $120 **Non-Participating Pharmacy** 30 day - Pays 80% of Allowable Amount minus Copayment Mail Order not available	**Participating Pharmacy** 30 day - $10 / $35 / $60 Mail Order - $20 / $70 / $120 **Non-Participating Pharmacy** 30 day - Pays 80% of Allowable Amount minus Copayment Mail Order not available
Hospital Visits				
Emergency Room	Plan pays 80% of Allowable Amount after CY Deductible	Plan pays 80% of Allowable Amount after CY Deductible	Plan pays 80% of Allowable Amount after CY Deductible	Plan pays 80% of Allowable Amount after CY Deductible
In-Patient	Plan pays 80% of Allowable Amount after CY Deductible	Plan pays 80% of Allowable Amount after CY Deductible	Plan pays 80% of Allowable Amount after CY Deductible and $200 per Admission Deductible	Plan pays 80% of Allowable Amount after CY Deductible and $200 per Admission Deductible
Company Match for HSA Accounts	Employee Only - $600 Employee Plus - $1,200	Employee Only - $500 Employee Plus - $1,000	--	--
Employee Cost (per paycheck)				
Employee Only	$16.05	$39.39	$72.23	$151.75
Employee plus Child(ren)	$66.39	$96.30	$159.05	$340.71
Employee plus Spouse	$84.63	$117.46	$202.09	$415.86
Employee plus Family	$113.09	$193.34	$266.30	$573.94

VISION

Type of Service	Benefit
Exam	Once every 12 months
Lenses	Once every 12 months
Adult Frames	Once every 24 months
Kid Frames	Once every 12 months
Copayment	
Exam	$15
Materials	$20

	In-Network	Out Of Network
Exam	Covered in full after copay	Reimbursed up to $50
Single Vision Lenses	Covered in full after copay	Reimbursed up to $50
Bifocal Lenses	Covered in full after copay*	Reimbursed up to $75
Trifocal Lenses	Covered in full after copay*	Reimbursed up to $100
Frame	$150 Retail Allowance	Reimbursed up to $70

Employee Portion Snapshot (Cost Per Pay Period)	
Employee Only	$3.78
Employee + Family	$8.06

** Progressive bifocal/trifocal lenses are considered upgrades and may not be covered in full.*

DENTAL

Type of Service	Benefit
Calendar Year Deductible (Single/Family)	$50 Individual / $150 Family
Calendar Year Maximum per Participant	$1,500
Preventative & Diagnostic Services (deductible waived)	100%
Basic Services	80%
Major Services	50%
Orthodontic Treatment	50%
Orthodontic Benefit available to Adults & Children (maximum lifetime benefit)	$1,000
Employee Portion Snapshot (Cost Per Pay Period)	
Employee Only	$13.44
Employee + Spouse	$27.32
Employee + Child(ren)	$30.47
Employee + Family	$44.37