MEDICAL PLANS

EMPLOYEE CONTRIBUTIONS FOR MEDICAL INSURANCE ARE AUTOMATICALLY DEDUCTED FROM YOUR PAYCHECK ON A PRE-TAX BASIS

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

YOUR SHARE	STANDARD PLAN ($2,750)		WELLNESS PLAN ($1,750)	
When you exhaust the funds in your HRA account, you pay for all of your health care expenses until you meet the annual deductible – the amount you must pay for eligible health care expenses before your health plan begins to pay. Only services covered by your health plan count toward your deductible (see your coverage details for plan specific information). *Please note, you must complete your biometrics to receive your HRA funds. (See page 8)*				
TOTAL ANNUAL DEDUCTIBLE	**IN-NETWORK***		**IN-NETWORK**	**OUT-OF-NETWORK**
Employee	$2,750		$1,750	$7,000
Employee +1	$4,250		$3,250	$14,000
Family	$4,250		$3,250	$14,000

* With the Standard Plan option, participating employees receive coverage only when they receive care from an in-network provider.

YOUR HEALTH PLAN				
Once you meet your deductible, you pay a coinsurance (the percentage of the cost of your eligible medical expenses after you meet your deductible) for your eligible expenses and the plan pays the rest. When you meet your out-of-pocket maximum (the most you can pay in a plan year) your plan pays eligible expenses at 100%.				
SHARED EXPENSES (COINSURANCE)	**IN-NETWORK**		**IN-NETWORK**	**OUT-OF-NETWORK**
YOU PAY	25%		20%	50%
Plan Pays	75%		80%	50%
PHARMACY (DEDUCTIBLE DOES NOT APPLY)	**RETAIL**	**MAIL ORDER**	**RETAIL**	**MAIL ORDER**
Generic* (Tier 1)	$15 Copay	$30 Copay	$15 Copay	$30 Copay
Preferred Brand (Tier 2)	50% up to $300	50% up to $600	50% up to $300	50% up to $600
Non-Preferred Brand (Tier 3)	50% up to $300	50% up to $600	50% up to $300	50% up to $600
Specialty Medications (Tier 4)	50% up to $500	50% up to $1,000	50% up to $500	50% up to $1,000
* 100% coverage for generic maintenance medications for diabetes, high blood pressure and cholesterol filled at retail and mail order.				
ANNUAL OUT-OF-POCKET MAX[1]	**IN-NETWORK**		**IN-NETWORK**	**OUT-OF-NETWORK**
Employee	$7,150		$7,150	Unlimited
Employee +1	$14,300		$14,300	Unlimited
Family	$14,300		$14,300	Unlimited
PREVENTIVE CARE	**COVERED AT 100%**		**COVERED AT 100%**	
EMERGENCY ROOM COPAY	$300 Copay, waived if admitted		$300 Copay, waived if admitted	
URGENT CARE COPAY	$75 - Deductible Waived		$75 - Deductible Waived	50%
BLUECARE ANYWHERE TELEHEALTH SERVICES	$0 per Virtual Visit (See page 11 for more information)			

RATES

STANDARD & WELLNESS	WEEKLY	BI-WEEKLY	MONTHLY
Employee	$44.27	$88.54	$191.84
Employee +1	$105.21	$210.41	$455.89
Family	$113.97	$227.93	$493.85

To remove surcharges, you must complete a biometric screening and either meet the health requirements or complete the alternate options laid out on page 8.

PREMIUM SURCHARGES	WEEKLY	BI-WEEKLY	MONTHLY	WELLNESS PLAN ONLY
Nicotine	+ $34.62	+ $69.23	+ $150.00	To participate in this plan, you must complete the biometric screening and meet the required health metrics (see page 8)
Cholesterol	+ $11.00	+ $22.00	+ $47.67	

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1 - Deductible and HRA funds apply.