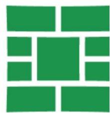

2023 Medical Plan Schedule of Benefits

Medical	Plus Option		Basic Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible One Person Two Person Family	 $500 $1,000 $1,500	 $1,000 $2,000 $3,000	 $1,300 $2,600 $3,900	 $2,600 $5,200 $7,800
Maximum Out-of-Pocket One Person Two Person Family	 $2,200 $4,400 $6,600	 No Maximum Amount No Maximum Amount No Maximum Amount	 $3,400 $6,800 $10,200	 No Maximum Amount No Maximum Amount No Maximum Amount
Coinsurance - EE/ER	20% / 80%	50% / 50%	20% / 80%	50% / 50%
Physician Copay Primary Care Physician Specialist w/ PCP referral Specialist w/o PCP referral	 $15 $25 $50	50% after deductible	 $20 $35 $75	50% after deductible
Ambulance Service	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Chiropractic Care	20% after deductible; limited to 25 visits per calendar year	20% after deductible; limited to 25 visits per calendar year	20% after deductible; limited to 25 visits per calendar year	20% after deductible; limited to 25 visits per calendar year
Hospital Services Inpatient Outpatient	 20% after deductible 20% after deductible	50% after deductible & $500 copay per admission 50% after deductible	 20% after deductible 20% after deductible	50% after deductible & $500 copay per admission 50% after deductible
Emergency Room	20% after deductible and $200 co-pay	20% after deductible and $200 co-pay	20% after deductible and $200 co-pay	20% after deductible and $200 co-pay
Urgent Care	$15 co-pay	50% after deductible	$20 co-pay	50% after deductible
Maternity Physician Hospital	$200 copay and 20%	50% after deductible	$200 copay and 20%	50% after deductible
Mental Health/Substance Abuse Inpatient Outpatient	 20% after deductible $15 copay	 50% after deductible 50% after deductible	 20% after deductible $20 copay	 50% after deductible 50% after deductible
Preventive Care Well Adult Care Well Child Care	100%	No benefits	100%	No benefits
Therapeutic Service (Occupational, Speech, and Physical Therapy)	20% after deductible; limited to 30 visits per calendar year	50% after deductible; limited to 30 visits per calendar year	20% after deductible; limited to 30 visits per calendar year	50% after deductible; limited to 30 visits per calendar year
Prescription Drug Copay	30-day supply	Mail Order / 90-day @ retail	30-day supply	Mail Order / 90-day @ retail
Tier 1 Drug	$5.00 copay	$10.00 copay	$5.00 copay	$10.00 copay
Tier 2 Drug	$25.00 copay	$50.00 copay	$25.00 copay	$50.00 copay
Tier 3 Drug	$50.00 copay	$125.00 copay	$50.00 copay	$125.00 copay
Tier 4 Drug	$75.00 copay	N/A	$75.00 copay	N/A

Plus SAV4HEALTH Premium				Basic SAV4HEALTH Premium			
Weekly		Bi-Weekly		Weekly		Bi-Weekly	
Employee Only	$18.37	Employee Only	$36.74	Employee Only	$11.45	Employee Only	$22.90
Employee +1	$62.49	Employee +1	$124.98	Employee +1	$42.57	Employee +1	$85.14
Family	$114.38	Family	$228.77	Family	$79.39	Family	$158.78

Plus STANDARD Premium				Basic STANDARD Premium			
Weekly		Bi-Weekly		Weekly		Bi-Weekly	
Employee Only	$37.60	Employee Only	$75.20	Employee Only	$30.68	Employee Only	$61.36
Employee +1	$81.72	Employee +1	$163.44	Employee +1	$61.80	Employee +1	$123.61
Family	$133.61	Family	$267.23	Family	$98.62	Family	$197.25