INSURANCE PLAN COMPARISON

JULY 1, 2024 - JUNE 30, 2025

MEDICAL PLAN OPTIONS	BCBS HDHP w/HSA*			BCBS PPO*		
Participation Level	**Total Prem**	**EE Monthly**	**EE Annual**	**Total Prem**	**EE Monthly**	**EE Annual**
Employee Only	$630.64	$0.00	$0.00	$728.47	$0.00	$0.00
Employee + Spouse	$1,288.27	$257.66	$3,091.92	$1,540.45	$308.10	$3,697.20
Employee + Child(ren)	$1,215.43	$243.10	$2,917.20	$1,453.11	$290.62	$3,487.44
Family	$1,892.52	$378.50	$4,542.00	$2,265.09	$453.02	$5,436.24
Dual Family	$1,892.52	$189.26	$2,271.12	$2,265.09	$226.52	$2,718.24
HSA Employer Contribution		**ER Monthly**	**ER Annual**	***HSA Only Available with HDHP***		
Employee Only		$211.32	$2,535.84			
Family		$369.44	$4,433.28			
Dual Family		$422.16	$5,065.92			

SUMMARY OF BENEFITS (In Network)	BCBS HDHP w/HSA | Blue Choice Preferred-Care Blue Network |	BCBS PPO | Blue Choice Preferred-Care Blue Network |
Deductible (Single / Family)	$2,000 / $4,000	$1,000 / $2,000
Out of Pocket Maximum (OPM)	$3,400 / $6,800 *(aggregate if family)*	$6,500 / $13,000 *(medical & RX copays apply to OPM)*
Physician Care		
Preventative Care	$0	$0
Primary Care Physician	20% after deductible	$30 office visit copay
Specialist	20% after deductible	$45 office visit copay
Physical Therapy / Mental Health		
Primary Care Physician	20% after deductible	$30 office visit copay
Specialist	20% after deductible	$45 office visit copay
Hospital / Facility		
Inpatient	20% after deductible	$0 after deductible
Outpatient	20% after deductible	$0 after deductible
Emergency Room	20% after deductible	$250 copay
Urgent Care	20% after deductible	$75 copay
Diagnostic Lab & X-ray		
Dr. Office / Independent Lab	20% after deductible	$0 (plan pays 100%)
Outpatient Hospital	20% after deductible	$0 (plan pays 100%)
Advanced Imaging	20% after deductible	$0 after deductible
Maternity		
Physician Care - global bill	20% after deductible	$0 copay
Hospital Care	20% after deductible	$0 after deductible
Telehealth Services (Amwell)		
Primary or Behavioral Care	20% after deductible	$30 copay

PRESCRIPTION BENEFITS (In Network)	BCBS HDHP w/HSA	BCBS PPO
Retail Pharmacy - 30 days		
Level 1	20% after deductible	$10 (or actual cost if less)
Level 2	20% after deductible	$40
Level 3	20% after deductible	$70
Specialty - Level 4	20% after deductible	25%
Max out of Pocket	Combined with Medical	Combined with Medical

******Employee monthly premium rates reflect participation in the county wellness program.******

DELTA DENTAL PREMIUMS			
Participation Level	Total Prem	EE Monthly	EE Annual
Employee Only	$36.19	$0.00	$0.00
Family	$90.48	$18.10	$217.20
Dual Family	$90.48	$9.06	$108.72

VSP VISION PREMIUMS			
Participation Level	Total Prem	EE Monthly	EE Annual
Employee Only	$7.49	$0.00	$0.00
Employee + Spouse	$11.99	$0.00	$0.00
Employee + Child(ren)	$12.23	$0.00	$0.00
Family	$19.72	$0.00	$0.00