

2024-25 Medical Benefit Plan Comparisons and Costs

| Benefit | B1 EPO COPAY (\$\$\$) | | B2 HIGH DEDUCTIBLE HEALTH PLAN(\$) | | B3 EPO SPIRA CARE(\$\$) | |
|---|-----------------------------|-------------|------------------------------------|-------------------------------|-----------------------------------|-------------|
| | In-Network | Non-Network | In-Network | Non-Network | In-Network | Non-Network |
| Network | BlueSelect Plus | No Coverage | BlueSelect Plus | N/A | BlueSelect Plus | No Coverage |
| Emergency Care Treated as In-Network | Yes | Yes | Yes | Yes | Yes | Yes |
| Access to Meritas Primary Care Providers | Yes - No Office Visit Copay | No Coverage | Deductible/Coinsurance | Deductible/Coinsurance | Yes- No Cost for Office Visit | No Coverage |
| Access to SPIRA Care Facilities | N/A | No Coverage | Yes | N/A | Yes | No Coverage |
| Deductible (individual/family) *Calendar Year | N/A | No Coverage | *\$2,100/ \$4,200 (Aggregate) | *\$4,200/ \$8,400 (Aggregate) | *\$1,700/ \$3,400 (Embedded) | No Coverage |
| Coinsurance | N/A | No Coverage | 20% After Deductible | 50% After Deductible | N/A | No Coverage |
| Out of Pocket Maximum (individual/family) *Calendar Year | *\$6,500 / \$13,000 | No Coverage | *\$4,500 / \$9,000 | *\$25,000 / \$50,000 | *\$1,700 / \$3,400 | No Coverage |
| PCP Office Visit (Non Meritas/SPIRA)/ Specialist Office Visit | \$40/\$80 Copay | No Coverage | Deductible/Coinsurance | Deductible/Coinsurance | Deductible | No Coverage |
| Urgent Care Office Visit | \$80 Copay | No Coverage | Deductible/Coinsurance | Deductible/Coinsurance | Deductible | No Coverage |
| BlueKC Virtual Care Office Visit/Behavioral Health Visit | \$10 Copay/ \$40 Copay | No Coverage | Deductible/Coinsurance | No Coverage | No Member Cost Share/\$40 Copay | No Coverage |
| Mental Health Office Visit/Therapy | \$0/\$0 Copay | No Coverage | Deductible/Coinsurance | Deductible/Coinsurance | Deductible/No Member Cost Share | No Coverage |
| Other Radiology (MRI, CT, PET, MRA)-Non SPIRA Locations | \$300 Copay | No Coverage | Deductible/Coinsurance | Deductible/Coinsurance | Deductible | No Coverage |
| Hospital Inpatient/ Outpatient Surgery | \$750 Copay per Admit | No Coverage | Deductible/Coinsurance | Deductible/Coinsurance | Deductible | No Coverage |
| Emergency Room | \$300 Copay | \$300 Copay | Deductible/Coinsurance | Deductible/Coinsurance | Deductible | Deductible |
| Chiropractic Care Office Visit/Spinal Manipulation | \$40 Copay/Covered at 100% | No Coverage | Deductible/Coinsurance | Deductible/Coinsurance | Deductible/Covered at 100% | No Coverage |
| Routine Eye Exam | \$10 Copay | No Coverage | Covered at 100%/Deductible Waived | Deductible/Coinsurance | Covered at 100%/Deductible Waived | No Coverage |
| Speech, Hearing, Physical & Occupational Therapy | No Member Cost Share | No Coverage | Deductible/Coinsurance | Deductible/Coinsurance | No Member Cost Share | No Coverage |

| Benefit | B1 EPO COPAY (\$\$\$) | | B2 HIGH DEDUCTIBLE HEALTH PLAN(\$) | | B3 EPO SPIRA CARE(\$\$) | |
|--|--|-------------|--|---|--|-------------|
| | In-Network | Non-Network | In-Network | Non-Network | In-Network | Non-Network |
| Rx Generic (Up to 34 Day Supply) | \$10 Copay | No Coverage | \$10 Copay After Deductible | 50% of Submitted Costs After Deductible then Applicable Copay | \$5 Copay | No Coverage |
| Rx Preferred (Up to 34 Day Supply) | \$50 Copay | No Coverage | \$50 Copay After Deductible | 50% of Submitted Costs After Deductible then Applicable Copay | \$50 Copay | No Coverage |
| Rx Non-Preferred (Up to 34 Day Supply) | \$70 Copay | No Coverage | \$70 Copay After Deductible | 50% of Submitted Costs After Deductible then Applicable Copay | \$55 Copay | No Coverage |
| Rx Mail Order (35-102 Day Supply) | \$30 generic / \$150 preferred brand/\$210 non-preferred brand | No Coverage | \$30 generic/\$150 preferred brand/\$210 non-preferred brand | 50% of Submitted Costs After Deductible then Applicable Copay | \$15 generic / \$125 preferred brand / \$165 non-preferred brand | No Coverage |

Pharmacy Network: Premium Formulary

| B1 EPO Copay (\$\$\$) | Total EE Monthly Plan Cost; Total Monthly <i>Retiree</i> Cost | Employee Monthly Contribution Paid By District | Employee Monthly Cost* | | Retiree Over Age 65 Monthly Cost | Cobra Monthly Cost |
|------------------------|---|--|------------------------|--|----------------------------------|--------------------|
| Employee | \$945.20 | \$858.00 | \$87.20 | | \$1,039.72 | \$964.10 |
| Employee + Spouse | \$1,963.32 | \$858.00 | \$1,105.32 | | \$2,159.66 | \$2,002.60 |
| Employee + Child(ren) | \$1,696.24 | \$858.00 | \$838.24 | | \$1,865.86 | \$1,730.16 |
| Family | \$2,199.38 | \$858.00 | \$1,341.38 | | \$2,419.32 | \$2,243.38 |
| Family Split Premium** | \$2,199.38 | \$1,716.00 | \$241.70 | | n/a | n/a |

| B2 High Deductible (\$) | Total EE Monthly Plan Cost; Total Monthly <i>Retiree</i> Cost | Employee Monthly Contribution | Employee Monthly Cost* | Employee Monthly HSA Contribution | Retiree Over Age 65 Monthly Cost | Cobra Monthly Cost |
|-------------------------|---|-------------------------------|------------------------|-----------------------------------|----------------------------------|--------------------|
| Employee | \$799.68 | \$799.68 | \$0.00 | \$58.32 | \$879.66 | \$815.68 |
| Employee + Spouse | \$1,661.04 | \$799.68 | \$861.36 | \$58.32 | \$1,827.16 | \$1,694.26 |
| Employee + Child(ren) | \$1,435.10 | \$799.68 | \$635.42 | \$58.32 | \$1,578.62 | \$1,463.80 |
| Family | \$1,860.76 | \$799.68 | \$1,061.08 | \$58.32 | \$2,046.84 | \$1,897.98 |
| Family Split Premium** | \$1,860.76 | \$1,599.36 | \$130.70 | \$116.64 | n/a | n/a |

| B3 EPO/SPIRA Care (\$\$) | Total EE Monthly Plan Cost; Total Monthly <i>Retiree</i> Cost | Employee Monthly Contribution Paid By District | Employee Monthly Cost* | | Retiree Over Age 65 Monthly Cost | Cobra Monthly Cost |
|--------------------------|---|--|------------------------|--|----------------------------------|--------------------|
| Employee | \$872.94 | \$858.00 | \$14.94 | | \$960.24 | \$890.40 |
| Employee + Spouse | \$1,813.24 | \$858.00 | \$955.24 | | \$1,994.56 | \$1,849.50 |
| Employee + Child(ren) | \$1,566.52 | \$858.00 | \$708.52 | | \$1,723.18 | \$1,597.86 |
| Family | \$2,031.26 | \$858.00 | \$1,173.26 | | \$2,234.40 | \$2,071.90 |
| Family Split Premium** | \$2,031.26 | \$1,716.00 | \$157.64 | | n/a | n/a |

*With Wellness Credit (Complete Biometric Screening, HRA and Total Points) **Both spouse work for Nk n