2023-24 Medical Benefit Plan Comparisons and Costs

Benefit	B1 EPO COPAY ($$$)		B2 HIGH DEDUCTIBLE ($)		B3 EPO SPIRA CARE($$)	
	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	No Member Cost Share for Office Visit Only	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	*$1,900/ $3,800 (Aggregate)	*$3,800/ $7,600 (Aggregate)	*$1,550/ $3,100 (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	*$1,550 / $3,100	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	$250 Copay	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	No Coverage
Hospital Inpatient/ Outpatient Surgery	$600 Copay per Admit	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	No Coverage
Emergency Room	$250 Copay	$250 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

Any discrepancy between this document and the Plan Certificate, the Plan Certificate will prevail.

Benefit	B1 EPO COPAY ($$$)		B2 HIGH DEDUCTIBLE ($)		B3 EPO SPIRA CARE($$)	
	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 and 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 and 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 and 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 and 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 Retiree Cost*	Employee Monthly Contribution Paid By District	Employee Monthly Cost*	*Retiree Over Age 65 Monthly Cost*	*Cobra Monthly Cost*
Employee	$895.60	$807.00	$88.60	$985.16	$913.52
Employee + Spouse	$1,850.22	$807.00	$1,043.22	$2,035.24	$1,887.22
Employee + Child(ren)	$1,587.08	$807.00	$780.08	$1,745.80	$1,618.82
Family	$2,023.64	$807.00	$1,216.64	$2,226.00	$2,064.12
Family Split Premium**	$2,023.64	$1,614.00	$409.64		

B2 High Deductible ($)	Total EE Monthly Plan Cost; *Total Monthly Retiree Cost*	Employee Monthly Contribution Paid By District	Employee Monthly Cost*	Employee Monthly HSA Contribution Paid By District *(Retiree Not Eligible)*	*Retiree Over Age 65 Monthly Cost*	*Cobra Monthly Cost*
Employee	$757.72	$757.72	$0.00	$49.28	$833.50	$772.88
Employee + Spouse	$1,565.36	$757.72	$807.64	$49.28	$1,721.90	$1,596.68
Employee + Child(ren)	$1,342.74	$757.72	$585.02	$49.28	$1,477.00	$1,369.60
Family	$1,712.08	$757.72	$954.36	$49.28	$1,883.28	$1,746.32
Family Split Premium**	$1,712.08	$1,515.44	$196.64	$98.56		

B3 EPO/SPIRA Care ($$)	Total EE Monthly Plan Cost; *Total Monthly Retiree Cost*	Employee Monthly Contribution Paid By District	Employee Monthly Cost*	*Retiree Over Age 65 Monthly Cost*	*Cobra Monthly Cost*
Employee	$827.14	$807.00	$20.14	$909.86	$843.68
Employee + Spouse	$1,708.78	$807.00	$901.78	$1,879.66	$1,742.96
Employee + Child(ren)	$1,465.72	$807.00	$658.72	$1,612.30	$1,495.04
Family	$1,868.96	$807.00	$1,061.96	$2,055.86	$1,906.34
Family Split Premium**	$1,868.96	$1,614.00	$254.96		

**With Wellness Credit (Complete Biometric Screening, HRA and Total Points) **Both spouse work for NKC Schools electing Family Tier*

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