

Plan Year: October 1, 2024 – September 30, 2025

PPO HSA \$4,000 PLAN

IN-NETWORK BENEFITS – Independence Blue Cross

ANNUAL DEDUCTIBLE

Individual / Family	\$4,000 / \$8,000*
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*If enrolled as a family, the individual deductible does not apply, and one member can satisfy the full deductible

MAXIMUM OUT-OF-POCKET

Individual / Family	\$6,750 / \$13,500
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REFERRAL NEEDED FOR SPECIALIST

No

PREVENTIVE CARE

Annual Well Check, Immunizations, and Other Related Services	\$0
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VISITS

Primary Care	\$40 copay after deductible
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Specialist	\$70 copay after deductible
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Urgent Care	\$100 copay after deductible
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Emergency Room	\$300 copay after deductible
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Inpatient Hospital	\$250/day after deductible
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Outpatient Surgery – facility fee	\$250 copay after deductible
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Outpatient Surgery – physician fee	\$0 after deductible
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Telemedicine - Teladoc	\$0 after deductible
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OUTPATIENT DIAGNOSTIC SERVICES

Lab Services	Freestanding: \$70 copay after deductible Hospital: \$140 copay after deductible
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X-Ray	\$70 copay after deductible
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CT/PET Scan, MRI	\$300 copay after deductible
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PRESCRIPTIONS

Tier 1 – Lost-Cost Generic	\$3 copay after deductible
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Tier 2 – Generic	\$20 copay after deductible
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Tier 3 – Preferred Brand	\$40 copay after deductible
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Tier 4 – Non-Preferred Brand	\$70 copay after deductible
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Tier 5 – Self-Administered Specialty	50% up to \$500 copay after deductible
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Mail order – 90-Day Supply (does not apply to Tier 5)	2x retail
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OUT-OF-NETWORK - Refer to Summary of Benefits and Coverage found at www.doanebenefits.com

MEDICAL SEMI-MONTHLY PAYROLL DEDUCTIONS (24 PER YEAR)

Employee Only	Up to \$80.33
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Employee + Spouse	Up to \$381.36
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Employee + Child(ren)	Up to \$261.50
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Employee + Family	Up to \$527.83
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