



2023 HEALTH INSURANCE Standard Plan

SUMMARY OF MEDICAL BENEFIT

Benefit	Bothwell	HCM	Freedom Select/Health Link/First Health	Out-of-Network
Deductible – Individual/Family	\$0/\$0	\$2,000/\$4,000	\$5,000/\$10,000	\$10,000/\$20,000
Co-Insurance – Member Pays	0%	10%	30%	50%
Out-of-Pocket Maximum Individual/Family (includes deductible)	\$4,000/\$8,000	\$4,000/\$8,000	\$10,000/\$20,000	\$20,000/\$40,000
PCP/Specialist Visit	\$20/\$35	\$45/\$75	30% after deductible	50% after deductible
Preventive Care	Covered at 100%	Covered at 100%	30% after deductible	50% after deductible
Diagnostic Lab Performed in Physicians Office or Independent Lab	Covered at 100%	Covered at 100%	30% after deductible	50% after deductible
Diagnostic Lab Performed in a Hospital or Outpatient Facility	Covered at 100%	10% after deductible	30% after deductible	50% after deductible
Chiropractic/Spinal Manipulation	N/A	\$60 Copay	30% after deductible	50% after deductible
Outpatient Surgery	Covered at 100%	10% after deductible	30% after deductible	50% after deductible
Walk in Clinic	\$20	\$45	30% after deductible	50% after deductible
Urgent Care	N/A	\$150 Copay, 10% coinsurance after deductible	30% after deductible	50% after deductible
Emergency Room Visit	\$150 Copay	\$150 Copay, 10% coinsurance after deductible	\$300 Copay, 30% coinsurance after deductible	50% after deductible
Inpatient Hospital Services/Outpatient Surgery	Covered at 100%	10% after deductible	30% after deductible	50% after deductible
Inpatient or Outpatient	Covered at 100%	10% after deductible	30% after deductible	50% after deductible
Mental Health/Substance Abuse	Covered at 100%	10% after deductible	30% after deductible	50% after deductible
Home Health (CY Limit: 60 visits)	Covered at 100%	10% after deductible	30% after deductible	50% after deductible
Physical and Occupational Therapy (CY Limit: 60 combined visits)	Covered at 100%	10% after deductible	30% after deductible	50% after deductible
Speech Therapy (CY Limit: 20 visits)	Covered at 100%	10% after deductible	30% after deductible	50% after deductible
Skilled Nursing (CY Limit: 30 days)	Covered at 100%	10% after deductible	30% after deductible	50% after deductible

SUMMARY OF PHARMACY BENEFIT

Benefit	Bothwell	Any Other Pharmacy
Out-of-Pocket Maximum Individual/Family	\$4,000/\$8,000	
30 Day		
Tier 1 Generic Drugs	\$5 Copay	Greater of \$40 copay or 20%
Tier 2 Preferred Name Brand Drugs	\$20 Copay	Greater of \$80 copay or 50%
Tier 3 Non-Preferred Name Brand Drugs	\$40 Copay	Greater of \$150 copay or 60%
Specialty Tier	20%	40%
90 Day		
Tier 1 Generic Drugs	\$10 Copay	Greater of \$80 copay or 20%
Tier 2 Preferred Name Brand Drugs	\$40 Copay	Greater of \$160 copay or 50%
Tier 3 Non-Preferred Name Brand Drugs	\$80 Copay	Greater of \$300 copay or 60%
Specialty Tier	Not Covered	Not Covered

*DME – No Prior Auth.

*90-day maintenance medications required to be filled at Employee Pharmacy