Bothwell™
Regional Health Center

# 2024 HEALTH INSURANCE
## Premier Access Premium Plan

| SUMMARY OF MEDICAL BENEFIT | | | | |
|---|---|---|---|---|
| **Benefit** | **Bothwell** | **HCM** | **Freedom Select/Health Link/First Health** | **Out-of-Network** |
| Deductible – Individual/Family | $0/$0 | $1,500/$3,500 | $5,000/$10,000 | $10,000/$20,000 |
| Co-Insurance – Member Pays | 0% | 10% | 30% | 50% |
| Out-of-Pocket Maximum Individual/Family (includes deductible) | $3,500/$7,000 | $3,500/$7,000 | $7,000/$14,000 | $15,000/$30,000 |
| PCP/Specialist Visit | Covered at 100% | $45/$75 | 30% after deductible | 50% after deductible |
| Mental Health Visit | Covered at 100% | $20 Copay | $50 Copay | 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 10% | 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 | Covered at 100% | $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 | $75 Copay | $150 Copay, 10% coinsurance after deductible | $300 Copay, 30% coinsurance after deductible | 50% after deductible |
| Inpatient Hospital Services | 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 | N/A | 10% after deductible | 30% after deductible | 50% after deductible |
| Bothwell Medical Equipment | 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 |

| SUMMARY OF PHARMACY BENEFIT | | |
|---|---|---|
| **Benefit** | **Bothwell** | **Any Other Pharmacy** |
| **Out-of-Pocket Maximum Individual/Family** | **$3,500/$7,000** | |
| **30 Day** | | |
| Tier 1 Generic Drugs | $5 Copay | Greater of $35 copay or 20% |
| Tier 2 Preferred Name Brand Drugs | $20 Copay | Greater of $70 copay or 50% |
| Tier 3 Non-Preferred Name Brand Drugs | $40 Copay | Greater of $125 copay or 60% |
| Specialty Tier | 20% | 40% |
| **90 Day** | | |
| Tier 1 Generic Drugs | $10 Copay | Greater of $70 copay or 20% |
| Tier 2 Preferred Name Brand Drugs | $40 Copay | Greater of $140 copay or 50% |
| Tier 3 Non-Preferred Name Brand Drugs | $80 Copay | Greater of $250 copay or 60% |
| Specialty Tier | Not Covered | Not Covered |

**DME and Imaging – No Prior Auth.* **90-day maintenance medications required to be filled at Employee Pharmacy*

*Rev. 10.25.23*