NEAL GERBER EISENBERG *Benefits*

2023 Medical Plan Comparison

	PPO 1200 with Blue Choice	HD 1500 Plan	HD 3000 Plan	HMO Blue Advantage
Eligibility	Attorney, staff, spouse, domestic partner and child(ren) to age 26			
Type of Deductible	Aggregate	Aggregate	Embedded	Embedded
Deductible	**Blue Choice/In-Network** Individual: **$700/$1,200** Family: **$1,400/$2,400**	Individual: **$1,500** Family: **$3,000**	Individual: **$3,000** Family: **$6,000**	Individual: **$0** Family: **$0**
Out-of-Pocket Expense Limit (OPM) (Includes deductible)	**Out-of-Pocket Expense Limit** (does not include prescriptions) Individual: **$1,500/$2,200** Family: **$3,000/$4,400** **RX Out-of-Pocket Limit** Individual: **$1,000** Family: **$3,000**	Individual: **$2,900** Family: **$5,800**	Individual: **$5,800** Family: **$11,600**	Individual: **$1,500** Family: **$3,000**
Coinsurance	**In-Network: 100%/80%** **Out of Network: 60%** The coinsurance provision is after the deductible has been met and up to your out of pocket limit. After your out of pocket limit, the coinsurance provision is 100%.			**No coinsurance** (see co-pays for services) *Referrals are required for services to be covered.
Preventative Care	**In-Network: 100%**, no deductible **Out of Network:** Deductible, then **60%**			**$0** *Ask your provider if the services are preventative or there may be a co-pay.
*This is not a complete listing of preventative care	**Can include:** Physical exam, Routine OB/GYN (1/year), Colonoscopy (1/10 years, after age 50), Mammography screening (35-39 baseline, 40+ 1/yr), Well-child care (to age 18), includes immunizations.			
Emergency Services	**Emergency Room (Unadmitted):** Deductible, then **100%/80%**			**$250 Per Visit** *Co-pay Waived If Admitted.
Urgent Care Center	**In-Network:** Deductible, then **100%/80%** **Out of Network:** Deductible, then **60%**			**In-Network:** **$30** primary co-pay **$50** specialist co-pay* **Out of Network:** Not covered *referral required

	PPO 1200 with Blue Choice	HD 1500 Plan	HD 3000 Plan	HMO Blue Advantage
Physician's Services / Office Visits	**Blue Choice/In-Network:** **$20/$30** primary co-pay **$40/$50** specialist co-pay **Out of Network:** Deductible, then **60%**	**In-Network:** Deductible, then **80%** **Out of Network:** Deductible, then **60%**		**In-Network:** **$30** primary co-pay **$50** specialist co-pay* **Out of Network:** Not covered *Referral required
Prescription Drug Services	**Retail** (30 day supply) / **(Mail Order** (90 day supply)**)** **Generic:** **$10 ($20)** co-pay **Formulary Brand:** **20%** coinsurance* **Non-Formulary:** **50%** coinsurance* **Retail/Mail order:** **$5 ($10)** minimum **$150 ($300)** maximum co-pay for Formulary and Non-Formulary *no deductible *Mail Order / 90 day supply co-pay in (parentheses)*	**Retail** (30 day supply) / **Mail Order Prescription** (90 day supply) **Generic, Brand & Non-Formulary:** Deductible, then 80%. After Out Of Pocket Maximum (OPM) has been met 100%.		**Retail** (30 day supply) / **(Mail Order** (90 day supply)**)** **Generic:** Preferred: **$0 ($0)** co-pay Non-Preferred: **$10($20)** co-pay **Brand Name:** Preferred: **$50 ($100)** co-pay Non-Preferred: **$100 ($200)** co-pay **Specialty Drugs:** Preferred: **$150** co-pay Non-Preferred: **$250** co-pay *Specialty Drugs Limited To 30 Days Supply *Mail Order/90 day supply co-pay in (parentheses)*
Diagnostic Test (For example, blood work, x-ray, MRI)	**In-Network:** Deductible, then **100%/80%** **Out of Network:** Deductible, then **60%**			**$0** *Referral Required
Rehabilitative Services (Can include physical, occupational and speech therapy)	**In-Network:** Deductible, then **100%/80%** **Out of Network:** Deductible, then **60%** **Annual Limit:** Physical therapy (222 visits/year) Occupational Therapy (140 visits/year) Speech Therapy (100 visits/year)			**In-Network:** $0 **Out Of Network:** Not Covered **Annual Limit:** 60 combined visits per year. Referral Required