# MEDICAL PLAN OPTIONS 07/01/2024 - 06/30/2025

| Key Medical Benefits | Blue Classic PPO 12 | Blue Classic PPO 17 | Blue Classic PPO 21 | PPO HSA 28E |
|---|---|---|---|---|
| Deductible (Individual/Family) | $1,500-I/$4,500-F | $2,500-I/$7,500-F | $3,000-I/$9,000-F | $6,350-I/$12,700-F |
| Your Cost after Deductible | 30% | 20% | 30% | 0% |
| Out of Pocket Maximum | $4,500-I/$9,000-F | $6,000-I/$12,000-F | $6,500-I/$13,000-F | $6,350-I/$12,700-F |
| Office Visit (Primary/Specialist) | $30 Copay-PCP/$60 Copay-SPEC | $30 Copay-PCP/$60 Copay-SPEC | $30 Copay-PCP/$60 Copay-SPEC | 0% after deductible |
| Diagnostic Lab & X-Ray | 30% after deductible | 20% after deductible | No Charge | 0% after deductible |
| Urgent Care | $60 Copay | $60 Copay | $60 Copay | 0% after deductible |
| Emergency Room | 30% after Deductible | $250 Copay, 20% after Deductible | $250 Copay, 30% after Deductible | 0% after deductible |
| Pharmacy Benefits | $15/$50/$75/30% up to $350 | $15/$50/$75/30% up to $350 | $15/$50/$75/30% up to $350 | 0% after deductible |

| Enrollment Tier | Monthly Premium | EE Cost | Monthly Premium | EE Cost | Monthly Premium | EE Cost | Monthly Premium | EE Cost |
|---|---|---|---|---|---|---|---|---|
| **Employee Only** | **$880.06** | **$80.06** | **$825.05** | **$25.05** | **$785.78** | **$169.52** | **$582.81** | **$0.00** |
| **Employee + Spouse** | **$1,848.11** | **$1,048.11** | **$1,732.60** | **$932.60** | **$1,650.12** | **$755.06** | **$1,223.88** | **$423.88** |
| **Employee + Child(ren)** | **$1,672.10** | **$872.10** | **$1,567.59** | **$767.59** | **$1,492.96** | **$620.09** | **$1,107.32** | **$307.32** |
| **Employee + Family** | **$2,640.16** | **$1,840.16** | **$2,475.15** | **$1,675.15** | **$2,357.32** | **$1,671.23** | **$1,748.41** | **$948.41** |

# DENTAL AND VISION PLAN OPTIONS 07/01/2024 - 06/30/2025

East Otero offers a second dental plan that is not shown below. Please see the Ease portal for more information

| Dental | Delta Dental |
|---|---|
| Deductible (Individual/Family) | $25-I/$75-F |
| Preventive Services | 100% |
| Basic Services | 80% |
| Major Services | 50% |
| Annual Maximum Benefit Per Person | $1,000 |
| Endo/Perio | Basic |
| Ortho | 50% / $1500 max |
| | |
| Employee Only | **$38.28** |
| Employee + Spouse | **$73.49** |
| Employee + Child(ren) | **$85.66** |
| Employee + Family | **$133.10** |

| Vision | EyeMed |
|---|---|
| Exams | $10 Copay |
| Frames | $120 allowance / 80% of balance over $120 |
| Contact Lens Fit and Follow up (Fit and Follow up visit available after comprehensive eye exam) | Up to $40 Copay |
| Contact Lenses | $135 allowance: 15% off balance over $135 |
| **Frequency**<br>Examination<br>Lenses or Contact Lenses<br>Frame | <br>Once every 12 months<br>Once every 12 months<br>Once every 24 months |
| | |
| Employee Only | **$6.14** |
| Employee + Spouse | **$11.66** |
| Employee + Child(ren) | **$12.28** |
| Employee + Family | **$18.05** |