The Vernon Company / Home Office Wellmark BC/BS Benefit and Cost Comparison
Effective 4/1/24

Plan	Wellmark RED PPO Plan		Wellmark WHITE HMO Plan	Wellmark BLUE HMO Plan	Wellmark BLUE PPO Plan		Wellmark HDHP / HSA PPO Plan	
	In Network	Out of Network	In Network Only Benefits	In Network Only Benefits	In Network	Out of Network	In Network	Out of Network
Plan Considerations	In and Out of Network Services Available. Alliance Select PPO Network.		Must select an in-network Blue Advantage HMO primary care physician (PCP). Must visit selected PCP for all routine/preventive care (women can also select OB/GYN) . You can self refer to any other in network provider for all other services. No coverage out of network except for emergencies and Wellmark approved referrals.	Must select an in-network Blue Advantage HMO primary care physician (PCP). Must visit selected PCP for all routine/preventive care (women can also select OB/GYN) . You can self refer to any other in network provider for all other services. No coverage out of network except for emergencies and Wellmark approved referrals.	In and Out of Network Services Available. Alliance Select PPO Network.		In and Out of Network Services Available. Alliance Select PPO Network.	
Deductible	$2,000 Single $5,550 Family	$3,000 Single $6,000 Family	$2,000 Single $5,550 Family	$5,000 Single $10,000 Family	$5,000 Single $10,000 Family	$10,000 Single $20,000 Family	$5,000 Single $10,000 Family	$10,000 Single $20,000 Family
Coinsurance	20%	30%	20%	30%	30%	50%	10%	40%
***Out of Pocket Maximum (OPM)**	$4,500 Single $9,000 Family	$6,000 Single $12,000 Family	$4,500 Single $9,000 Family	$6,600 Single $13,200 Family	$6,600 Single $13,200 Family	$13,000 Single $26,000 Family	$6,900 Single $13,800 Family	$20,000 Single $40,000 Family
Lifetime Maximum	Unlimited		Unlimited	Unlimited	Unlimited		Unlimited	
****Office Visit**	$25 Copay PCP $45 Copay Specialist	Deductible then 30%	$20 Designated PCP Copay $25 Copay PCP $45 Copay Specialist	$35 Designated PCP Copay $40 Copay PCP $80 Copay Specialist	$40 Copay PCP $80 Copay Specialist	Deductible then 50%	Deductible then 10%	Deductible then 40%
Doctor On Demand / Virtual Office Visit	$10 Copay	N/A	$10 Copay	$10 Copay	$10 Copay	N/A	Deductible then 10%	N/A
Preventive Services	Paid In Full	Not Covered	Paid In Full	Paid In Full	Paid In Full	Not Covered	Paid In Full	Not Covered
Urgent Care	$25 Copay	Deductible then 30%	$25 Copay	$40 Copay	$40 Copay	Deductible then 50%	Deductible then 10%	Deductible then 40%
Emergency Room	$100 Copay	$100 Copay (if true emergency; subject to UCR fees.)	$100 Copay	$250 Copay	$250 Copay	$250 Copay (if true emergency; subject to UCR fees.)	Deductible then 10%	Deductible then 40%
Hospital Services Outpatient, Inpatient	Deductible then 20%	Deductible then 30%	Deductible then 20%	Deductible then 30%	Deductible then 30%	Deductible then 50%	Deductible then 10%	Deductible then 40%
Chiropractic Care	$25 Copay	Deductible then 30%	$25 Copay	$40 Copay	$40 Copay	Deductible then 50%	Deductible then 10%	Deductible then 40%
Annual Vision Exam	$25 Copay	Deductible then 30%	$25 Copay	$40 Copay	$40 Copay	Deductible then 50%	Deductible then 10%	Deductible then 40%
Retail Rx (Blue Rx Value Plus Formulary List) (30 Day Supply)	$200 Single/$400 Family Ded Tier 1: $10 Copay (Ded Waived) Tier 2: $30 Copay Tier 3: $50 Copay Preferred Specialty: $100 Copay Non-Preferred Specialty: 50%		$200 Single/$400 Family Ded Tier 1: $10 Copay (Ded Waived) Tier 2: $30 Copay Tier 3: $50 Copay Preferred Specialty: $100 Copay Non-Preferred Specialty: 50%	$200 Single/$400 Family Ded Tier 1: $10 Copay (Ded Waived) Tier 2: $35 Copay Tier 3: $70 Copay Preferred Specialty: $150 Copay Non-Preferred Specialty: 50%	$200 Single/$400 Family Ded Tier 1: $10 Copay (Ded Waived) Tier 2: $35 Copay Tier 3: $70 Copay Preferred Specialty: $150 Copay Non-Preferred Specialty: 50%		Deductible then 10%	Deductible then 40%
Mail Order Rx *(90 Day Supply)*	2.5 x Retail		2.5 x Retail	2.5 x Retail	2.5 x Retail		N/A	
Monthly Employee Cost								
Employee Only	$314.00		$206.00	$49.00	$105.00		$30.00	
Employee + Spouse	$827.00		$600.00	$280.00	$435.00		$239.00	
Employee + Child(ren)	$751.00		$536.00	$242.00	$387.00		$217.00	
Family	$1,492.00		$1,157.00	$670.00	$942.00		$626.00	

NOTE: If you elect to have your spouse (who is eligible for their own employer sponsored medical plan) covered under Vernon's plan you will be charged an additional $125 per month.

***All copays including RX deductible and copays apply to the medical OPM.**

****The PCP office visit copayment apply to family practioners, pediatrics, internal medicine, OBGYN, mental health providers, routine vision exam providers and manipulative treatment providers such as chiropractors and physical therapist. The specialist office visit copayment will apply to all other types of physicians.**

This is only a Summary of Benefits. Refer to the Carrier's Benefit Summaries for details.