# ALL ACTIVE EMPLOYEES OF MIDDLESEX COUNTY

# **2024 BENEFIT COPAYS**

BENEFITS	HORIZON					OXFORD	
	Traditional	CHOICE		AETNA	CIGNA	OAFORD	
		In-Network	Out-of-Network			In-Network	Out-of-Network
MEDICAL SERVICES							
	Basic benefit at 100%		80% of out of				
	balance at 80% after		network allowance				
Physician - (Surgery)	deductible	100%	after deductible	100%	100%	100%	60% after deductible
			80% of out of network allowance				
Physician - Primary/Specialist (Office Visit)	80% after deductible	100% after \$10 copay	after deductible	100% after \$10 copay	100% after \$10 copay	100% after \$10 copay	60% after deductible
r nysician - r mnary/specianst (Office visit)	80% after deductible	100% arter \$10 copay	80% of out of	100% arter \$10 copay	100% arter \$10 copay	100% arter \$10 copay	00% arter deductible
			network allowance				
Chiropractic	80% after deductible	100% after \$10 copay	after deductible	100% after \$10 copay	100% after \$10 copay	100% after \$10 copay	60% after deductible
	Basic benefit at 100%		80% of out of			\$10 copay for first	
	balance at 80% after	100% after initial \$10	network allowance		100% after \$10 copay	prenatal visit, then	
Maternity	deductible	copay	after deductible	100%	for initial visit	100%	60% after deductible
MISCELLANEOUS SERVICES							
							Deductible and
	Basic benefit at 100%		80% of out of	100% over a 60	100% after \$10 copay;		coinsurance up to 60
	balance at 80% after		network allowance	consecutive day period	maximum 60 visits per	\$10 copay; 60 visits	visits per calendar
Physical and/or Speech Therapy	deductible	100% after \$10 copay	after deductible	per illness or injury	calendar year	per calendar year	year
					100% after \$5 copay for		60% after deductible
		\$50 per calendar year;	\$50 per calendar year;	100%; \$100 lens	annual exam; \$20 to \$75 per year for	\$5 copay for	for exam/\$70 every
		includes lenses and	includes lenses and	reimbursement every 24	hardware at	exam/\$70 every 24	24 months for
Vision Care in Medical Plan	Not covered	frames	frames	months	participating provider	months for hardware	hardware
MENTAL HEALTH							
	Basic benefit at 100%						
	balance at 80% after						
Alcohol Abuse (Inpatient)	deductible; maximum		80% of out of				
	combined hospital		network allowance			Same as any other	Same as any other
	stay is 365 days	100%	after deductible	100%	100%	illness	illness

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		HORIZON				OXFORD	
BENEFITS	Traditional	Traditional CHO		<b>AETNA</b>	CIGNA	OXFORD	
		In-Network	Out-of-Network		 	In-Network	Out-of-Network
			80% of out of				
			network allowance			Same as any other	Same as any other
Drug Abuse (Outpatient)	80% after deductible	100% after \$10 copay	after deductible	100%	100%	illness	illness
	100% for first 120						
	days, balance covered						
	at 80% after						
	deductible, maximum		80% of out of				
	combined hospital		network allowance			Same as any other	Same as any other
Mental Health (Inpatient)	stay is 365 days	100%	after deductible	100%	100%	illness	illness
· • · · · ·			80% of out of				
			network allowance			Same as any other	Same as any other
Mental Health (Outpatient)	80% after deductible	100% after \$10 copay	after deductible	100%	100% after copay	illness	illness
EMERGENCY CARE							
		100% after \$50 copay,				100% after \$50	100% after \$50
		copay waived if		\$50 copay, waived if	\$50 copay, waived if	copay, waived if	copay waived if
Emergency Room (Accidental)	100%	admitted	100% after \$50 copay	admitted	admitted	admitted	admitted
		100% after \$50 copay,				100% after \$50	100% after \$50
		copay waived if		\$50 copay, waived if	\$50 copay, waived if	copay, waived if	copay, waived if
Emergency Room (Other)	100%	admitted	100% after \$50 copay	admitted	admitted	admitted	admitted
		100% after \$20 copay,					100% after \$20
Urgent Care	100%	copay	100% after \$20 copay	\$20 copay	\$20 copay	100% after \$20 copay	copay

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# **2024 BENEFIT COPAYS**

PRESCRIPTION DRUG (Middlesex County and Utility Authority)					
DESCRIPTIONS:					
COPAYS	Brand - Preferred \$15	Brand - Non Preferred \$30	<u>Generic</u> \$0		
PRESCRIPTION DRUG - STEP THERAPY	\$15	\$30	\$0		
PRESCRIPTION DRUG - NATIONAL PREFERRED FORMULARY	\$15	\$30	\$0		