JBI Medical Plan Comparison Effective 9/1/2024	Gold (Based on 26 pay periods)		Silver	
EE Contributions (Per Pay Period/ MDV)	**Current (G652CHC) - 820**	**New (G652CHC) - 820**	**Current (S665CHC) - 834**	**New (S665CHC) - 834**
Employee Only	$107.14	$114.26	$57.87	$62.51
Employee + Spouse	$310.07	$332.03	$211.53	$228.52
Employee + Child(ren)	$313.78	$335.78	$215.24	$232.27
Employee + Family	$521.44	$558.33	$373.63	$403.06

In Network Benefits	**Current (G652CHC) - 820**	**New (G652CHC) - 820**	**Current (S665CHC) - 834**	**New (S665CHC) - 834**
Deductible (Family)	$1,500 ($4,500)	$1,500 ($4,500)	$3,500 ($10,500)	$3,500 ($10,500)
Primary Care Visit / Specialist Copay	$45 / $80	$45 / $90	$50 / $80	$50 / $90
Coinsurance % Plan (You)	80% (20%)	80% (20%)	60% (40%)	60% (40%)
Out of Pocket Max (Family)	$5,250 ($10,500)	$5,250 ($10,500)	$9,000 ($18,000)	$9,000 ($18,000)
Lab / Xray	80% after deductible	80% after deductible	40% after deductible	40% after deductible
Imaging (CT, MRI)	$300 no deductible	$300 no deductible	40% after deductible	40% after deductible
Inpatient Hospital	80% after deductible	80% after deductible	$250, then deductible / 40%	$250, then deductible / 40%
Outpatient Surgery	80% after deductible	80% after deductible	$200, then deductible / 40%	$200, then deductible / 40%
Urgent Care Visit Copay	$100	$100	$100	$100
Emergency Room Care	$500, then deductible / 20%	$500, then deductible / 20%	$500, then deductible / 40%	$500, then deductible / 40%
Pharmacy Network (**Preferred Pharmacy in Network (PPN) / Non-Preferred Pharmacy in Network**)	Locate a Preferred Pharmacy in Network (PPN) at www.myprime.com *Preferred Pharmacy in Network (PPN): Walgreens, Walmart, Tom Thumb, & HEB*			
Preferred Generic	$0 / $10	$0 / $10	$0 / $10	$0 / $10
Non-Preferred Generic	$10 / $20	$10 / $20	$10 / $20	$10 / $20
Preferred Brand Name	$50 / $70	$50 / $70	$50 / $70	$50 / $70
Non-Preferred Brand Name	$100 / $120	$100 / $120	$100 / $120	$100 / $120
Specialty (Preferred Specialty)	$150	$150	$150	$150
Non-Preferred Specialty	$250	$250	$250	$250
Mail Order	$0/$30/$150/$300	$0/$30/$150/$300	$0/$30/$150/$300	$0/$30/$150/$300

Out of Network Benefits (Subject to Allowable Amount)	**Current (G652CHC) - 820**	**New (G652CHC) - 820**	**Current (S665CHC) - 834**	**New (S665CHC) - 834**
Deductible (Family)	$3,000 ($9,000)	$3,000 ($9,000)	$7,000 ($21,000)	$7,000 ($21,000)
Out of Pocket Max (Family)	Unlimited - NA	Unlimited - NA	Unlimited - NA	Unlimited - NA
Coinsurance % Plan (You)	60% (40%)	60% (40%)	60% (40%)	60% (40%)
Inpatient Hospital	deductible / 60%	deductible / 60%	$350, then deductible / 60%	$350, then deductible / 60%
Outpatient Surgery	deductible / 60%	deductible / 60%	$300, then deductible / 60%	$300, then deductible / 60%