# 2024 MISSION PARTNER (MP) PREMIUMS

Part-time: Mission Partners regularly scheduled to work 32-59 hours per pay period
Full-time: Mission Partners regularly scheduled to work 60 hours or more per pay period

FULL-TIME

| FULL-TIME HOURLY RATE | PREMIUM PER PAY PERIOD | |
|---|---|---|
| **BAND 1 (LESS THAN $21.37)** | **SELECT PPO** | **HEALTH SAVINGS HIGH DEDUCTIBLE PLAN** |
| MP | $84.65 | $84.36 |
| MP + Spouse | $177.71 | $177.11 |
| MP + Child(ren) | $163.35 | $162.80 |
| MP + Family | $231.33 | $230.55 |
| **BAND 2 ($21.37 TO $41.20)** | **SELECT PPO** | **HEALTH SAVINGS HIGH DEDUCTIBLE PLAN** |
| MP | $95.56 | $93.85 |
| MP + Spouse | $200.62 | $197.03 |
| MP + Child(ren) | $184.41 | $181.11 |
| MP + Family | $261.16 | $256.48 |
| **BAND 3 ($41.21 TO $57.68)** | **SELECT PPO** | **HEALTH SAVINGS HIGH DEDUCTIBLE PLAN** |
| MP | $112.63 | $111.32 |
| MP + Spouse | $236.45 | $233.70 |
| MP + Child(ren) | $217.35 | $214.82 |
| MP + Family | $307.81 | $304.22 |
| **BAND 4 ($57.69 AND HIGHER)** | **SELECT PPO** | **HEALTH SAVINGS HIGH DEDUCTIBLE PLAN** |
| MP | $125.88 | $125.19 |
| MP + Spouse | $264.27 | $262.83 |
| MP + Child(ren) | $242.92 | $241.59 |
| MP + Family | $344.02 | $342.13 |
| **PART-TIME** | **SELECT PPO** | **HEALTH SAVINGS HIGH DEDUCTIBLE PLAN** |
| MP | $207.36 | $206.47 |
| MP + Spouse | $435.33 | $433.45 |
| MP + Child(ren) | $400.17 | $398.44 |
| MP + Family | $566.71 | $564.25 |

## DENTAL PLAN

| FULL-TIME | |
|---|---|
| MP | $3.88 |
| MP + Spouse | $8.15 |
| MP + Child(ren) | $7.48 |
| MP + Family | $10.59 |
| **PART-TIME** | |
| MP | $14.51 |
| MP + Spouse | $30.46 |
| MP + Child(ren) | $28.00 |
| MP + Family | $39.61 |

## VISION PLAN

| FULL-TIME AND PART-TIME | |
|---|---|
| MP | $2.58 |
| MP + Spouse | $4.68 |
| MP + Child(ren) | $4.92 |
| MP + Family | $7.59 |

**FOR FULL-TIME AND PART-TIME MISSION PARTNERS**

These dental and vision plan premiums apply across all bands for **full-time and part-time Mission Partners** who elect coverage.

# OSF HEALTHCARE MEDICAL PLANS FOR 2024

| | SELECT PPO PLAN | | | HEALTH SAVINGS HIGH DEDUCTIBLE PLAN | | |
|---|---|---|---|---|---|---|
| **PLAN TERMS** | **OSF SELECT NETWORK** Tier 1 | **BCBS NATIONAL NETWORK** Tier 2 | **OUT-OF-NETWORK** Tier 3 | **OSF SELECT NETWORK** Tier 1 | **BCBS NATIONAL NETWORK** Tier 2 | **OUT-OF-NETWORK** Tier 3 |
| **DEDUCTIBLE** | The individual deductible applies per person until the family limit is reached. All services are subject to the deductible, unless noted as a copay service below. | | | The individual deductible only applies when enrolled in individual coverage. For all others, benefits will be paid only after the full family deductible is met by one or more family members. | | |
| INDIVIDUAL | $850 | $1,600 | $2,500 | $1,750 | $3,000 | $5,000 |
| FAMILY | $1,700 | $3,200 | $5,000 | $3,500 | $6,000 | $10,000 |
| **OFFICE VISITS** | | | | | | |
| PREVENTIVE VISITS | You pay $0 (no deductible applies) | | 50% | You pay $0 (no deductible applies) | | 50% |
| PRIMARY AND URGENT CARE | $25 copay | $50 copay | You pay 50% | You pay 10% | You pay 20% | You pay 50% |
| SPECIALIST | $50 copay | $75 copay | You pay 50% | You pay 10% | You pay 20% | You pay 50% |
| EMERGENCY ROOM | $250 copay | $250 copay | $250 copay | You pay 15% | You pay 15% | You pay 15% |
| **VIDEO VISITS** | | | | | | |
| PRIMARY AND URGENT CARE | $15 copay | $50 copay | You pay 50% | You pay 10% | You pay 20% | You pay 50% |
| SPECIALIST | $35 copay | $75 copay | You pay 50% | You pay 10% | You pay 20% | You pay 50% |
| **ALL OTHER SERVICES** *including inpatient hospital stay* | | | | | | |
| COINSURANCE *(what you pay after deductible)* | 15% | 30% | 50% | 15% | 30% | 50% |
| **PRESCRIPTION DRUG** | | | | | | |
| **Retail – 30-day supply**<br>Generic<br>Preferred Brand<br>Non-Preferred Brand<br>Specialty | $15 copay<br>$30 copay<br>$55 copay<br>You pay 10% | $20 copay<br>$45 copay<br>$70 copay<br>You pay 10% | N/A | You pay 15% after deductible (preventive drugs 100% covered) | You pay 20% after deductible (preventive drugs 100% covered) | N/A |
| **90-day supply**<br>Generic<br>Preferred Brand<br>Non-Preferred Brand<br>Specialty | $30 copay<br>$60 copay<br>$110 copay<br>You pay 10% | $40 copay<br>$90 copay<br>$140 copay<br>You pay 10% | N/A | You pay 15% after deductible (preventive drugs 100% covered) | You pay 20% after deductible (preventive drugs 100% covered) | N/A |
| **OUT-OF-POCKET MAXIMUM** | The individual out-of-pocket maximum applies per person until the family limit is reached. | | | The individual out-of-pocket maximum only applies when enrolled in individual coverage. For all others, the out-of-pocket maximum will be met when the entire family out-of-pocket maximum amount is reached. | | |
| INDIVIDUAL | $2,600 | $4,100 | $9,700 | $3,500 | $5,000 | $8,000 |
| FAMILY | $5,200 | $8,200 | $19,400 | $7,000 | $9,100 | $16,000 |
| OFFERS HSA WITH HDHP | N/A (Reminder: Mission Partners can elect to contribute pre-tax dollars to a medical flexible spending account to assist with out-of-pocket expenses throughout the year.) | | | YES | | |
| OSF CONTRIBUTES TO HSA | N/A | | | YES | | |
| **ANNUAL HSA CONTRIBUTION** | N/A | | | $1,000/$2,000 (Contributions will be made on a per pay period basis: $38.46/single; $76.92/family.) | | |