parexel®

2023 Bi-weekly Contribution Rates

Medical Plan (Non-Tobacco Rates)				
Coverage Tier	**$500 Deductible**	**$1,000 Deductible**	**$1,850 Deductible**	**$3,000 Deductible**
Employee only	$130.15	$97.85	$58.15	$50.77
Employee + Spouse	$313.38	$222.92	$142.15	$118.62
Employee + Child(ren)	$261.23	$188.31	$120.00	$101.08
Employee + Family	$471.23	$345.23	$203.08	$177.69

Dental Plan			
Coverage Tier	**Basic Plus**	**Standard**	**Enhanced**
Employee only	$3.69	$6.00	$7.38
Employee + Spouse	$7.85	$13.85	$17.08
Employee + Child(ren)	$8.31	$15.23	$18.92
Employee + Family	$12.92	$23.54	$29.08

Vision Plan		
Coverage Tier	**Materials Only**	**Enhanced**
Employee only	$2.85	$5.28
Employee + Spouse	$5.70	$10.55
Employee + Child(ren)	$7.32	$13.08
Employee + Family	$9.46	$17.49

Medical and Prescription Drug Coverage

Review Your Medical Plan Options

Blue Cross Blue Shield of MA

Network: BlueCard PPO

Medical Plan Summary

The following benefits are included in your plan options. Unless otherwise noted, benefits are per insured person and after deductible.

	$500 DEDUCTIBLE PLAN		$1,000 DEDUCTIBLE PLAN	
HEALTH SAVINGS ACCOUNT				
HSA Eligible	No		No	
HSA Employer Funding	N/A		N/A	
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE				
Individual	$500	$3,000	$1,000	$3,500
Family	$1,000	$6,000	$2,000	$7,500
OUT-OF-POCKET MAXIMUM				
Individual	$3,000	$6,000	$3,500	$7,500
Family	$6,000	$8,800	$7,500	$15,000
MEDICAL BENEFIT COVERAGE				
Plan Coinsurance	80%	60%	80%	60%
Preventive Care	100%*	60%	100%*	60%
Primary/Specialist Visit	$25/$45 copays*	60%	80%	60%
Inpatient Hospital	80%	60%	80%	60%
Outpatient Hospital	80%	60%	80%	60%
Urgent Care	$50 copay*	60%	80%	60%
Emergency Room	$150 copay*, then 80%	$150 copay*, then 80%	80%	80%
RETAIL PRESCRIPTIONS (30-DAY SUPPLY)				
Generic	$10 copay*	$10 copay*	70% ($10 min, $20 max)	70% ($10 min, $20 max)
Preferred Brand	$30 copay*	$30 copay*	70% ($25 min, $50 max)	70% ($25 min, $50 max)
Non-Preferred	$60 copay*	$60 copay*	55% ($40 min, $80 max)	55% ($40 min, $80 max)
MAIL-ORDER PRESCRIPTIONS (90-DAY SUPPLY)				
Generic	$25 copay*	Not covered	70% ($25 min, $50 max)	Not covered
Preferred Brand	$75 copay*	Not covered	70% ($63 min, $125 max)	Not covered
Non-Preferred	$150 copay*	Not covered	55% ($100 min, $200 max)	Not covered

*Deductible does not apply

Medical and Prescription Drug Coverage

Blue Cross Blue Shield of MA
Network: BlueCard PPO

Medical Plan Summary

The following benefits are included in your plan options. Unless otherwise noted, benefits are per insured person and after deductible.

	$1,850 DEDUCTIBLE PLAN		$3,000 DEDUCTIBLE PLAN	
HEALTH SAVINGS ACCOUNT				
HSA Eligible	Yes		Yes	
HSA Employer Funding	Employee Only: $500/year Employee + Dependent(s): $1,000/year		Employee Only: $500/year Employee + Dependent(s): $1,000/year	
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE				
Individual	$1,850	$3,700	$3,000	$6,000
Family	$3,700	$7,400	$6,000	$12,000
OUT-OF-POCKET MAXIMUM				
Individual	$3,500	$7,000	$5,500	$11,000
Family	$6,500	$13,000	$11,000	$22,000
MEDICAL BENEFIT COVERAGE				
Plan Coinsurance	80%	60%	70%	50%
Preventive Care	100%*	60%	100%*	50%
Primary/Specialist Visit	80%	60%	70%	50%
Inpatient Hospital	80%	60%	70%	50%
Outpatient Hospital	80%	60%	70%	50%
Urgent Care	80%	60%	70%	50%
Emergency Room	80%	80%	70%	70%
RETAIL PRESCRIPTIONS (30-DAY SUPPLY)				
Generic	80%**	80%**	70%**	70%**
Preferred Brand	80%**	80%**	70%**	70%**
Non-Preferred	80%**	80%**	70%**	70%**
MAIL-ORDER PRESCRIPTIONS (90-DAY SUPPLY)				
Generic	80%**	Not covered	70%**	Not covered
Preferred Brand	80%**	Not covered	70%**	Not covered
Non-Preferred	80%**	Not covered	70%**	Not covered

*Deductible does not apply

**Deductible waived for some medications

For additional plan details, visit
www.myparexelbenefits.com

Dental Insurance

Regular dental check-ups and good oral hygiene are an essential part of your general health and well-being.

Key Words to Know:

The service examples below are not guarantees of coverage; refer to Plan Documents to confirm covered services.

Annual Maximum Benefit: Maximum total amount the plan will pay during the plan year

Basic Services: Restorations, some oral surgery, endodontics and periodontics

Deductible: The amount you pay before the plan begins to pay

Major Services: Crowns, dentures, implants and some oral surgery

Orthodontia: Straightening or moving misaligned teeth and/or jaws with braces and/or surgery

Preventive Services: Designed to prevent or diagnose dental conditions, including oral evaluations, routine cleanings, X-rays, fluoride treatments and sealants

Review Your Dental Plan Options

Delta Dental*

Network: PPO Plus Premier

Dental Plan Summary

The following benefits are included in your plan options. Unless otherwise noted, benefits are per insured person and after deductible.

	ENHANCED WITH ORTHODONTIA	STANDARD	BASIC PLUS
ANNUAL DEDUCTIBLE			
Individual	$50	$50	$50
Family	$150	$150	$150
BENEFIT MAXIMUM			
Annual Maximum	$2,000	$1,500	$1,000
DENTAL BENEFIT COVERAGE			
Preventive Services	Plan pays 100%**	Plan pays 100%**	Plan pays 100%**
Basic Services	Plan pays 80%	Plan pays 80%	Plan pays 70%
Major Services	Plan pays 50%	Plan pays 50%	Plan pays 50%
ORTHODONTIA			
Benefit Coverage	Plan pays 50%	Not covered	Not covered
Lifetime Maximum	$2,500	Not covered	Not covered
Eligibility	Eligible children and adults	Not covered	Not covered

*If enrolling in a dental plan, you may qualify to participate in the "Rollover Max" – a Delta Dental benefit feature that lets you roll over part of your unused spending in one year to increase your benefits for the following year and beyond

**Deductible does not apply

In-network and out-of-network benefit provisions are the same, but may be applied differently for out-of-network services. Please refer to plan documents for additional details.

Vision Insurance

Regular eye exams can help keep your eyes healthy, while monitoring, preventing and treating easily correctable vision problems, which can cause permanent vision impairment.

Key Words to Know:

Copay: An amount you pay for a covered service each time you use that service

Retail Allowance: Maximum allowance paid toward the cost of vision materials; you are required to pay any amounts in excess of the retail allowance

Review Your Vision Plan Options

VSP

Network: Signature

Vision Plan Summary

The following in-network benefits are included in your plan options. Unless otherwise noted, benefits are per insured person.

	SIGNATURE PPO		MATERIALS ONLY	
	COPAY	**FREQUENCY**	**COPAY**	**FREQUENCY**
Exam	$15	1 per 12 months	Not covered	N/A
Lenses	$15	1 per 12 months	$10	1 per 12 months
Contact Lens Fitting	Not to exceed $60	1 per 12 months	Not to exceed $60	1 per 12 months
	RETAIL ALLOWANCE	**FREQUENCY**	**RETAIL ALLOWANCE**	**FREQUENCY**
Frames	Up to $210**	1 per 12 months	Up to $175**	1 per 12 months
Contact Lenses*	Up to $210**	1 per 12 months	Up to $175**	1 per 12 months

*Contact lens coverage provided in lieu of frames and lenses
**20% off any amount over the retail allowance

Please refer to plan documents for out-of-network benefits and additional details.

For additional plan details, visit
www.myparexelbenefits.com