Medical and Prescription Drug Coverage

Review Your Medical Plan Options

Blue Cross Blue Shield of MA

Network: BlueCard PPO

Benefits are per insured person and after deductible.

	$1,000 DEDUCTIBLE PLAN		$1,500 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	$1,000	$3,500	$1,500	$4,000
Family	$2,000	$7,000	$3,000	$8,000
OUT-OF-POCKET MAXIMUM				
Individual	$3,500	$7,000	$4,000	$8,000
Family	$7,000	$14,000	$8,000	$16,000
MEDICAL BENEFIT COVERAGE				
Plan Coinsurance	80%	60%	80%	60%
Preventive Care	100%	60%	100%*	60%
Primary/Specialist Visit	$25/$45 copay*	60%	80%	60%
Urgent Care	$50 copay*	60%	80%	60%
Inpatient Hospital	80%	60%	80%	60%
Outpatient Hospital	80%	60%	80%	60%
Emergency Room	$150, then 80%	$150, then 80%	80%	80%
RETAIL PRESCRIPTIONS (30-DAY SUPPLY)				
Generic	$10 copay*	$10 copay*	70% (min $10, max $20)	70% (min $10, max $20)
Preferred Brand	$30 copay*	$30 copay*	70% (min $25, max $50)	70% (min $25, max $50)
Non-Preferred	$60 copay*	$60 copay*	55% (min $40, max $80)	55% (min $40, max $80)
MAIL-ORDER PRESCRIPTIONS (90-DAY SUPPLY)				
Generic	$25 copay*	Not covered	70% (min $25, max $50)	Not covered
Preferred Brand	$75 copay*	Not covered	70% (min $63, max $125)	Not covered
Non-Preferred	$150 copay*	Not covered	55% (min $100, max $200)	Not covered

*Deductible does not apply

For additional plan details, visit
https://myparexelbenefits.com

Medical and Prescription Drug Coverage

Blue Cross Blue Shield of MA

Network: BlueCard PPO

Benefits are per insured person and after deductible.

	$2,000 DEDUCTIBLE PLAN		$3,300 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	$2,000	$4,000	$3,300	$6,600
Family	$4,000	$8,000	$6,600	$13,200
OUT-OF-POCKET MAXIMUM				
Individual	$4,000	$8,000	$5,500	$11,000
Family	$8,000	$16,000	$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%
Urgent Care	80%	60%	70%	50%
Inpatient Hospital	80%	60%	70%	50%
Outpatient Hospital	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

Tobacco Surcharge

Parexel is committed to helping you achieve your best health. You will pay a lower cost for benefits if you do not use tobacco products. Your benefit selection will be displayed as you proceed through the enrollment process. All tobacco responses will be calculated and reflected on your confirmation statement following your benefits enrollment. Please contact Parexel for more information, including any reasonable alternative standard that accommodates the recommendation of your personal physician. To participate in a smoking cessation program, please visit guidanceresources.com to register and use PXLEAP when prompted for the company web ID.

Dental Insurance

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

Delta Dental*

Network: PPO Plus Premier

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 to age 19 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

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

For additional plan details, visit
https://myparexelbenefits.com

Vision Insurance

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

VSP

Network: Choice

Benefits are per insured person and after deductible.

	ENHANCED		MATERIALS ONLY	
	COPAY	**FREQUENCY**	**COPAY**	**FREQUENCY**
Exam	$15	1 per 12 months	Not covered	1 per 12 months
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 24 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.

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2025 Bi-weekly Contribution Rates

Medical Plan (Non-Tobacco Rates) – Under $100K				
Coverage Tier	**$1,000 Deductible**	**$1,500 Deductible**	**$2,000 Deductible**	**$3,300 Deductible**
Employee only	$147.90	$109.16	$62.22	$53.54
Employee + Spouse	$362.58	$253.31	$154.95	$125.54
Employee + Child(ren)	$296.84	$210.08	$126.00	$106.62
Employee + Family	$545.20	$392.28	$225.42	$188.31

Medical Plan (Non-Tobacco Rates) – Over $100K				
Coverage Tier	**$1,000 Deductible**	**$1,500 Deductible**	**$2,000 Deductible**	**$3,300 Deductible**
Employee only	$147.90	$109.16	$64.28	$55.31
Employee + Spouse	$362.58	$253.31	$160.06	$129.68
Employee + Child(ren)	$296.84	$210.08	$130.16	$110.13
Employee + Family	$545.20	$392.28	$232.86	$194.52

Dental Plan			
Coverage Tier	**Basic Plus**	**Standard**	**Enhanced**
Employee only	$3.97	$6.46	$7.95
Employee + Spouse	$8.45	$14.90	$18.38
Employee + Child(ren)	$8.94	$16.39	$20.37
Employee + Family	$13.91	$25.33	$31.29

Vision Plan		
Coverage Tier	**Materials Only**	**Enhanced**
Employee only	$2.77	$5.13
Employee + Spouse	$5.54	$10.26
Employee + Child(ren)	$7.12	$12.72
Employee + Family	$9.20	$17.01