

Plan Year: October 1, 2025 – September 30, 2026

OPTION 1

OPTION 2

IN-NETWORK – Independence Blue Cross

DEDUCTIBLE

Individual / Family \$3,000 / \$6,000* \$2,000 / \$4,000*

*If enrolled with family members, one person can be responsible for the family amount.

PRIMARY CARE PHYSICIAN ELECTION AND REFERRALS REQUIRED

No _____ No _____

HSA COMPATIBLE

Yes Yes

MAXIMUM OUT-OF-POCKET

Individual / Family \$6,750 / \$13,500 \$6,750 / \$13,500

Maximum Out-of-Pocket Includes: Deductible and Copayments (including prescription copays)

PREVENTIVE CARE AT PREVENTIVE PLUS PROVIDERS

Annual Well Check, Immunizations, and Other Related Services \$0 \$0

FACILITY VISITS

Telehealth	\$0 after deductible	\$0 after deductible
Primary Care	\$30 copay after deductible	\$0 after deductible
Specialist Visits	\$60 copay after deductible	\$0 after deductible
Inpatient Hospital	\$500 per day + deductible	\$0 after deductible
Outpatient Surgery	\$500 after deductible	\$0 after deductible
Emergency Room	\$300 copay after deductible	\$0 after deductible
Urgent Care	\$100 copay after deductible	\$0 after deductible

OUTPATIENT DIAGNOSTIC SERVICES

CT/PET Scan, MRI \$200 after deductible \$0 after deductible

PRESCRIPTIONS

Tier 1	\$20 copay after deductible	\$20 copay after deductible
Tier 2	\$40 copay after deductible	\$40 copay after deductible
Tier 3	\$70 copay after deductible	\$70 copay after deductible
Tier 4	50% copay after deductible	50% copay after deductible
Mail Order	2x retail	2x retail

OUT-OF-NETWORK – Included, please refer to Summary of Benefits and Coverage

BI-WEEKLY COST FOR MEDICAL & PRESCRIPTION COVERAGE**

Employee Only	\$83.93	\$184.48
Employee + Spouse	\$232.52	\$488.13
Employee + Child(ren)	\$172.29	\$328.30
Employee + Family	\$235.60	\$495.24

**Smokers pay an additional \$20/pay surcharge.