Plan Year: October 1, 2025 – September 30, 2026	BASE PLAN (with HSA)	PREMIUM PLAN
IN-NETWORK – Allied		
DEDUCTIBLE		
Individual / Family	$3,300 / $6,600*	$1,500 / $3,000*
*If enrolled as a family, each covered member only needs to satisfy their individual deductible / out-of-pocket max		
MAXIMUM OUT-OF-POCKET		
Individual / Family	$5,000 / $10,000*	$3,000 / $6,000*
PREVENTIVE CARE		
Preventive Care – Annual Well Check, Immunizations, and Other Related Services	$0	
Diabetic Medications – Select Diagnostic Products, Antidiabetics, and Medical Devices	$0	
FACILITY VISITS		
Teladoc	$0	$0
Primary Care	You pay 15% after deductible	$30 copay
Specialist Visits	You pay 15% after deductible	$50 copay
Inpatient Hospital	You pay 15% after deductible	$250 copay per day; 5-day max.
Outpatient Surgery	You pay 15% after deductible	You pay 5% after deductible
Emergency Room	You pay 15% after deductible	$250 copay for emergency or $350 for non-emergency; waived if admitted
Urgent Care	You pay 15% after deductible	$50 Copay
Imaging or Procedure through KISx Card	You pay $0 after deductible	$0
OUTPATIENT DIAGNOSTIC SERVICES (Freestanding)		
X-Ray Services	You pay 15% after deductible	$50 copay
CT/PET Scan, MRI	You pay 15% after deductible	US Imaging: $0 Other Provider: $200 copay
PRESCRIPTIONS		
Maximum Out-of-Pocket for Prescriptions	Combined with medical	$1,000 / $2,000
Rx Deductible – Retail	Combined with medical	$100 per family unit
Tier 1 – Generic	You pay $15 after deductible	You pay $15 after deductible
Tier 2 – Preferred	You pay $35 after deductible	You pay $35 after deductible
Tier 3 – Nonpreferred	You pay $60 after deductible	You pay $60 after deductible
Specialty**	You pay 20% or $250 copay after deductible (whichever is greater) per prescription	You pay 20% or $250 copay (whichever is greater) per prescription
OUT-OF-NETWORK – Refer to Summary of Benefits and Coverage		
BI-WEEKLY COST FOR MEDICAL, VISION & PRESCRIPTION COVERAGE		
Team Member Only	$73.75	$131.10
Team Member + Spouse	$182.32	$311.01
Team Member + Child(ren)	$145.40	$256.77
Team Member + Family	$257.44	$432.29

Successful completion of the Journey Wellness Program allows you to save $38.46 per pay ($1,000 per year) on your medical, vision & prescription coverage.

**May require a small manufacturer's copay.