

**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 Valenz	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.