

2026 Medical Plan Comparison Sheet			
	Biweekly		
	\$2,500 PPO	\$6,500 PPO	\$4,000 HDHP
Office Visit	\$30.00	\$35.00	Subject to Deductible
Specialist	\$50.00	Subject to Deductible	Subject to Deductible
Urgent Care	\$50.00	Subject to Deductible	Subject to Deductible
Telemedicine	\$30.00	\$35.00	Subject to Deductible
Onsite Clinic	\$0.00	\$0.00	\$45.00
Emergency Room	\$250 Copay/then Deductible	Subject to Deductible	Subject to Deductible
Preventive Visit	\$0.00	\$0.00	\$0.00
Deductible			
Deductible - Individual	\$2,500.00	\$6,500.00	\$4,000.00
Deductible - Family	\$5,000.00	\$12,000.00	\$8,000.00
Out of Pocket Maximum(OOPM)			
OOPM - Individual	\$7,000.00	\$8,500.00	\$7,750.00
OOPM - Family	\$14,000.00	\$17,000.00	\$15,500.00
Premiums - Biweekly			
Employee Only	\$109.03	\$55.02	\$27.04
Emp + Child(ren)	\$226.75	\$76.59	\$48.70
Emp + Spouse	\$298.95	\$134.93	\$73.74
Family	\$441.35	\$205.16	\$115.00
Premiums - Annual			
Employee Only	\$2,834.78	\$1,430.52	\$703.04
Emp + Child(ren)	\$5,895.50	\$1,991.34	\$1,266.20
Emp + Spouse	\$7,772.70	\$3,508.18	\$1,917.24
Family	\$11,475.10	\$5,334.16	\$2,990.00
Maximum Annual Liability^ (OOPM + Premiums)			
Employee Only	\$9,834.78	\$9,930.52	\$8,453.04
Emp + Child(ren)	\$19,895.50	\$18,991.34	\$16,766.20
Emp + Spouse	\$21,772.70	\$20,508.18	\$17,417.24
Family	\$25,475.10	\$22,334.16	\$18,490.00
<small>^ Maximum liability may change dependent upon individual member deductible and out-of-pocket amounts for families with 2+ dependents.</small>			<small>H.S.A Seed Dollars not included in HDHP Max Annual Liability Figures (\$500 Employee Only/ \$1,000 All Dependent Tiers)</small>
Prescriptions - 31 Day			
Tier 1 - Generic	\$20 Copay	\$20 Copay	Subject to Deductible
Tier 2 - Preferred Brand	\$50 Copay	\$50 Copay	Subject to Deductible
Tier 3 - Non-Preferred Brand	\$100 Copay	\$100 Copay	Subject to Deductible
Tier 4 - Specialty	\$200 Copay	\$200 Copay	Subject to Deductible
Prescriptions - 90 Day			
Tier 1 - Generic	\$30 Copay	\$30 Copay	Subject to Deductible
Tier 2 - Preferred Brand	\$110 Copay	\$110 Copay	Subject to Deductible
Tier 3 - Non-Preferred Brand	\$200 Copay	\$200 Copay	Subject to Deductible
Tier 4 - Specialty	Not Covered	Not Covered	Not Covered