

2026 Medical Plan Comparison Sheet				
	Monthly			
	\$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 - Monthly				
Employee Only	\$236.24	\$119.21	\$58.59	
Emp + Child(ren)	\$491.29	\$165.94	\$105.53	
Emp + Spouse	\$647.73	\$292.35	\$159.76	
Family	\$956.26	\$444.52	\$249.16	
Premiums - Annual				
Employee Only	\$2,834.88	\$1,430.52	\$703.08	
Emp + Child(ren)	\$5,895.48	\$1,991.28	\$1,266.36	
Emp + Spouse	\$7,772.76	\$3,508.20	\$1,917.12	
Family	\$11,475.12	\$5,334.24	\$2,989.92	
Maximum Annual Liability^ (OOPM + Premiums)				
Employee Only	\$9,834.88	\$9,930.52	\$8,453.08	
Emp + Child(ren)	\$19,895.48	\$18,991.28	\$16,766.36	
Emp + Spouse	\$21,772.76	\$20,508.20	\$17,417.12	
Family	\$25,475.12	\$22,334.24	\$18,489.92	
<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	