2027 Medical Plan Comparison Sheet

Monthly (Less than $50k)

	$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	$13,000.00	$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
^ Maximum liability may change dependent upon individual member deductible and out-of-pocket amounts for families with 2+ dependents.			**H.S.A Seed Dollars not included in HDHP Max Annual Liability Figures ($500 Employee Only/ $1,000 All Dependent Tiers)**
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

2027 Medical Plan Comparison Sheet

Monthly ($50k - <$155k)

	$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	$13,000.00	$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	$250.42	$126.36	$62.11
Emp + Child(ren)	$520.77	$175.90	$111.86
Emp + Spouse	$686.59	$309.89	$169.36
Family	$1,013.64	$471.19	$264.10
Premiums - Annual			
Employee Only	$3,005.04	$1,516.32	$745.32
Emp + Child(ren)	$6,249.24	$2,110.80	$1,342.32
Emp + Spouse	$8,239.08	$3,718.68	$2,032.32
Family	$12,163.68	$5,654.28	$3,169.20
Maximum Annual Liability^ (OOPM + Premiums)			
Employee Only	$10,005.04	$10,016.32	$8,495.32
Emp + Child(ren)	$20,249.24	$19,110.80	$16,842.32
Emp + Spouse	$22,239.08	$20,718.68	$17,532.32
Family	$26,163.68	$22,654.28	$18,669.20
^ Maximum liability may change dependent upon individual member deductible and out-of-pocket amounts for families with 2+ dependents.			**H.S.A Seed Dollars not included in HDHP Max Annual Liability Figures ($500 Employee Only/ $1,000 All Dependent Tiers)**
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