2025—2026 Health Plan Highlights

Key Medical Benefits	EPO—High Plan (No new enrollments) In-Network Only	EPO—HDHP In-Network Only	EPO—Low Plan In-Network Only	HPN—Copay In-Network Only	HPN—HDHP In-Network Only
Deductible (per plan year)					
Individual / Family	$1,200 / $3,600	$3,300 / $6,600	$2,500 / $5,000	$2,500 / $5,000	$3,300 / $6,600
Out-of-Pocket Maximum (per plan year)					
Individual / Family	$6,900 / $13,800	$7,050/ $14,100	$8,150 / $16,300	$8,150 / $16,300	$7,050/ $14,100
Covered Services					
Office Visits Primary Care	$70 copay, $15 clinic	30% coinsurance*, $15 clinic	$70 copay, $15 clinic	$70 copay, $15 clinic	30% coinsurance*, $15 clinic
Virtual Visits	$12 copay, $15 clinic	$42, $15 clinic	$12 copay, $15 clinic	$12 copay, $15 clinic	$42, $15 clinic
Specialist Care	$70 copay	30% coinsurance*	$70 copay	$70 copay	30% coinsurance*
Routine Preventive Care	No charge	No charge	No charge	No charge	No charge
Outpatient Diagnostic (lab/X-ray)	20% coinsurance*	30% coinsurance*	30% coinsurance*	30% coinsurance*	30% coinsurance*
Complex Imaging (MRI, CT Scan, Ultrasound)	20% coinsurance*	30% coinsurance*	30% coinsurance*	30% coinsurance*	30% coinsurance*
Ambulance	20% coinsurance*	30% coinsurance*	30% coinsurance*	30% coinsurance*	30% coinsurance*
Emergency Room	$500 copay (waived if true emergency) per visit plus deductible, then coinsurance				
	Freestanding emergency room $500 copay per visit plus deductible, then coinsurance				
Urgent Care Facility	$50 copay	30% coinsurance*	$50 copay	$50 copay	30% coinsurance*
Inpatient Hospital Stay	20% coinsurance*	30% coinsurance*	30% coinsurance*	30% coinsurance*	30% coinsurance*
Outpatient Surgery	20% coinsurance*	30% coinsurance*	30% coinsurance*	30% coinsurance*	30% coinsurance*
Prescription Drugs (Generic/ Brand Name/ Non-Preferred Brand Name/ Specialty) Routine Prevention Rx—covered in full					
Retail Pharmacy (30-day supply)	**$200 Brand Deductible** $15/ 25%*/ 50%*/ 30%*	20%*/25%*/50%*/ 20%*	$15/ 30%*/ 50%*/ 30%*	$15/ 30%*/ 50%*/ 30%*	20%*/25%*/50%*/ 20%*
Mail Order (90-day supply)	$45/ 25%*/ 50%*	20% */ 25%*/ 50%*	$45/ 30%*/ 50%*	$45/ 30%*/ 50%*	20%*/ 25%*/ 50%*

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
***Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.**