2026—2027 Health Plan Highlights

Key Medical Benefits	EPO—Copay In-Network Only	EPO—HDHP In-Network Only	HPN—Copay In-Network Only+	HPN—HDHP In-Network Only+
Deductible (per plan year)				
Individual / Family	$2,500 / $5,000	$3,400 / $6,800	$2,500 / $5,000	$3,400 / $6,800
Out-of-Pocket Maximum (per plan year)				
Individual / Family	$8,150 / $16,300	$7,050/ $14,100	$8,150 / $16,300	$7,050/ $14,100
Covered Services				
Office Visits Primary Care	$70 copay, $15 MEHC	30% coinsurance*, $15 MEHC	$70 copay, $15 MEHC	30% coinsurance*, $15 MEHC
Virtual Visits	$12 copay, $15 MEHC	$42, $15 MEHC	$12 copay, $15 MEHC	$42, $15 MEHC
Specialist Care	$70 copay	30% coinsurance*	$70 copay	30% coinsurance*
Routine Preventive Care	No charge	No charge	No charge	No charge
Outpatient Diagnostic (lab/X-ray)	30% coinsurance*	30% coinsurance*	30% coinsurance*	30% coinsurance*
Complex Imaging (MRI, CT Scan, Ultrasound)	30% coinsurance*	30% coinsurance*	30% coinsurance*	30% coinsurance*
Ambulance	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	30% coinsurance*
Inpatient Hospital Stay	30% coinsurance*	30% coinsurance*	30% coinsurance*	30% coinsurance*
Outpatient Surgery	30% coinsurance*	30% coinsurance*	30% coinsurance*	30% coinsurance*
Prescription Drugs (Generic/ Brand Name/ Non-Preferred Brand Name/ Specialty)				
Retail Pharmacy (30-day supply)	$15 / 30%*/ 50%*/ 30%*	20%* / 25%* / 50%* / 20%*	$15 / 30%*/ 50%*/ 30%*	20%* / 25%*/ 50%*/ 20%*
Mail Order (90-day supply)	$45 / 30%*/ 50%*	20%*/ 25%*/ 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.**
+No out-of-network coverage except for emergency or urgent care –both inside and outside the HPN service area.

Monthly Premiums

	EPO—Copay		EPO—HDHP		HPN—Copay		HPN—HDHP	
	Total Premium	Your Premium	Total Premium	Your Premium	Total Premium	Your Premium	Total Premium	Your Premium
Employee only	$789.37	$213.13	$769.00	$207.63	$734.11	$183.64	$715.17	$178.90
HSA Contributions			$20/mo				$40/mo	
Employee & Spouse	$1,657.66	$1,432.66	$1,614.88	$1,389.88	$1,541.63	$1,316.63	$1,501.84	$1,276.84
Employee & Child(ren)	$1,529.52	$841.24	$1,490.04	$819.52	$1,422.46	$782.35	$1,385.74	$762.15
Employee & Family	$2,546.69	$1,910.02	$2,480.95	$1,860.72	$2,368.42	$1,776.32	$2,307.29	$1,730.47