

Benefits at a Glance

MEDICAL			
Plan Year 01/01/2027 - 12/31/2027	High Deductible Health Plan One	High Deductible Health Plan Two	80/20
Calendar Year Deductible The amount you must pay before the Plan begins to pay for most services	In-network: \$3,500/individual - \$6,000/family Out-of-network: \$6,000/individual - \$12,000/family	In-network: \$2,000/individual - \$3,500/family (Ind Ded for Emp Only coverage) Out-of-network: \$4,000/individual - \$8,000/family	In-network: \$1,000/individual - \$3,000/family Out-of-network: \$2,000/individual - \$6,000/family
Calendar Year Out-of-Pocket Maximum (includes deductible) The most that you will pay in coinsurance in one plan year, after which the Plan pays 100%	In-network: \$5,000/individual - \$10,000/family Out-of-network: \$10,000/individual - \$20,000/family	In-network: \$3,500/individual - \$7,000/family Out-of-network: \$7,000/individual - \$14,000/family	In-network: \$3,500/individual - \$10,500/family Out-of-network: \$7,000/individual - \$21,000/family
Coinsurance (applies after deductible is met)	Employee Pays 20%	Employee Pays 20%	Employee Pays 20%
Office Visits			
Preventive	FREE	FREE	FREE
Physician	Plan pays 80% of Allowable Amount after CY Deductible	Plan pays 80% of Allowable Amount after CY Deductible	Plan pays 80% of Allowable Amount after CY Deductible
Telehealth	\$20 copay through MDLive	\$20 copay through MDLive	\$20 copay through MDLive
Prescriptions			
Copay Amounts for: 30 Day Supply - Tier 1 / Tier 2 / Tier 3 Mail Order 90 Day Supply - Tier 1 / Tier 2 / Tier 3 Tier 1 - Generic Tier 2 - Preferred Brand Name Tier 3 - Non-Preferred Brand Name	Participating Pharmacy 30 day - \$10 / \$35 / \$60 (after CY deductible) Mail Order - \$20 / \$70 / \$120 (after CY deductible) Non-Participating Pharmacy 30 day - Pays 80% of Allowable Amount minus Copayment Mail Order not available	Participating Pharmacy 30 day - \$10 / \$35 / \$60 (after CY deductible) Mail Order - \$20 / \$70 / \$120 (after CY deductible) Non-Participating Pharmacy 30 day - Pays 80% of Allowable Amount minus Copayment Mail Order not available	Participating Pharmacy 30 day - \$10 / \$35 / \$60 Mail Order - \$20 / \$70 / \$120 Non-Participating Pharmacy 30 day - Pays 80% of Allowable Amount minus Copayment Mail Order not available
Hospital Visits			
Emergency Room	Plan pays 80% of Allowable Amount after CY Deductible	Plan pays 80% of Allowable Amount after CY Deductible	Plan pays 80% of Allowable Amount after CY Deductible
In-Patient	Plan pays 80% of Allowable Amount after CY Deductible	Plan pays 80% of Allowable Amount after CY Deductible	Plan pays 80% of Allowable Amount after CY Deductible and \$200 per Admission Deductible
Company Match for HSA Accounts	Employee Only - \$600 Employee Plus - \$1,200	Employee Only - \$500 Employee Plus - \$1,000	--
Employee Cost (per paycheck)			
Employee Only	\$20.61	\$50.57	\$92.73
Employee plus Child(ren)	\$85.21	\$123.63	\$204.16
Employee plus Spouse	\$108.64	\$150.78	\$259.41
Employee plus Family	\$145.17	\$248.18	\$341.82

VISION		
Type of Service		Benefit
Exam		Once per calendar year
Lenses		Once per calendar year
Adult Frames		Once every other calendar year
Kid Frames		Once per calendar year
Copayment		
Exam		\$15
Materials		\$20
In-Network		Out Of Network
Exam	Covered in full after copay	Reimbursed up to \$50
Single Vision Lenses	Covered in full after copay	Reimbursed up to \$50
Bifocal Lenses	Covered in full after copay*	Reimbursed up to \$75
Trifocal Lenses	Covered in full after copay*	Reimbursed up to \$100
Frame	\$150 Retail Allowance	Reimbursed up to \$70
Employee Portion Snapshot (Cost Per Pay Period)		
Employee Only		\$3.78
Employee + Family		\$8.06

* Progressive bifocal/trifocal lenses are considered upgrades and may not be covered in full.

DENTAL	
Type of Service	Benefit
Calendar Year Deductible (Single/Family)	\$50 Individual / \$150 Family
Calendar Year Maximum per Participant	\$1,500
Preventative & Diagnostic Services (deductible waived)	100%
Basic Services	80%
Major Services	50%
Orthodontic Treatment	50%
Orthodontic Benefit available to Adults & Children (maximum lifetime benefit)	\$1,000
Employee Portion Snapshot (Cost Per Pay Period)	
Employee Only	\$14.67
Employee + Child(ren)	\$33.27
Employee + Spouse	\$29.83
Employee + Family	\$48.44