

Plan Year: May 1, 2026 – April 30, 2027

Low Deductible Plan

High Deductible Plan with HSA

IN-NETWORK BENEFITS – Independence Administrators		
ANNUAL DEDUCTIBLE		
	\$500 individual / \$1,000 family	\$2,000 individual* / \$4,000 family*
*If enrolled as a family, the individual deductible does not apply, and one member can satisfy the full deductible		
MAXIMUM OUT-OF-POCKET		
	\$1,750 individual / \$5,000 family	\$3,500 individual* / \$7,000 family*
Maximum Out-of-Pocket Includes: Deductible, Coinsurance & Copayments (including prescription copays)		
PREVENTIVE CARE		
Annual Well Check, Immunizations, and Other Related Services		\$0
VISITS		
Family Wellness Center Primary Care Sick Visits	\$10 copay with no additional billing, deductible waived	\$10 copay with no additional billing, deductible waived
Primary Care (other than the Family Wellness Center)	\$20 copay, deductible waived	Covered 100%, after deductible
Specialist Visits	\$40 copay, deductible waived	Covered 100%, after deductible
Urgent Care	\$40 copay (non-emergency diagnosis) \$80 copay (emergency diagnosis)	Covered 100%, after deductible
Telemedicine – 98point6 (Excludes Hatfield)	\$0 per visit	\$8 per visit
Outpatient Imaging (X-ray, MRI, CT Scan)	Covered 100% after deductible	Covered 100%, after deductible
Outpatient + Inpatient Surgery (Physician charge)	Covered 100% after deductible	Covered 100%, after deductible
Outpatient Surgery (Facility charge)	\$100 copay	Covered 100%, after deductible
Inpatient Hospital (Facility charge)	\$200 per day copay for the first 5 days; thereafter covered 100%	Covered 100% after deductible
Emergency Room	\$500 copay	100% after deductible
Preventive Colonoscopy (facility, physician, anesthesia fees + some generic prep)	Covered at 100% No deductible applies	Covered at 100% No deductible applies
PRESCRIPTIONS - SmithRx		
Tier 1 - Generic	10%	\$5 after deductible
Tier 2 – Preferred Brand	20%	\$20 after deductible
Tier 3 – Non-Preferred Brand	30%	\$45 after deductible
Mail Order	2x retail	2x retail
Tier 4 – Specialty**	\$50 copay or less**	\$50 copay or less, after deductible**
MEDICAL AND VISION WEEKLY PAYROLL DEDUCTIONS		
Team Member Only	\$61.71	\$37.45
Team Member + Spouse	\$129.36	\$77.27
Team Member + Child	\$101.26	\$61.51
Team Member + Child(ren)	\$102.35	\$63.33
Team Member + Family	\$163.22	\$96.70

**May qualify for additional savings.