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 – Transcarent (Excludes Hatfield)	$0 per visit	$0 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.