

**Plan Year: November 1, 2024 –
October 31, 2025**

**Plan 1
4000 HSA**

**Plan 2
PPO 3500**

IN-NETWORK – Allied using the Cigna network

DEDUCTIBLE

Individual / Family	\$4,000 / \$8,000	\$3,500 / \$7,000
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COINSURANCE

30%

0%

MAXIMUM OUT-OF-POCKET

Individual / Family	\$4,400 / \$8,800	\$5,150 / \$10,300
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PREVENTIVE CARE

Preventive Care – Annual Well Check, Immunizations, and Other Related Services	\$0	\$0
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FACILITY VISITS

Primary Care	\$40 copay after deductible	\$35 copay
Specialist	\$80 copay after deductible	\$75 copay
Urgent Care	You pay 30% after deductible	\$75 copay
Emergency Room	You pay 30% after deductible	\$500 copay
Inpatient Hospital	You pay 30% after deductible	You pay \$0 after deductible
Outpatient Surgery	You pay 30% after deductible	You pay \$0 after deductible

OUTPATIENT DIAGNOSTIC SERVICES

Outpatient Lab/Pathology	You pay 30% after deductible	You pay \$0 after deductible
X-Ray Services, CT/PET Scan, MRI	You pay 30% after deductible	You pay \$0 after deductible

PRESCRIPTIONS – SmithRx

Tier 1 – Generic	\$10 copay after deductible	\$10 copay
Tier 2 – Preferred Brand	\$50 copay after deductible	\$50 copay
Tier 3 – Non-Preferred Brand	\$100 copay after deductible	\$80 copay
Mail Order	2x retail after deductible	2x retail
Tier 4 – Specialty	You pay 20% up to \$250 after deductible	You pay 20% up to \$250

OUT-OF-NETWORK – Refer to Summary of Benefits and Coverage

BI-WEEKLY COST FOR MEDICAL & PRESCRIPTION COVERAGE

Employee Only	\$0.00	\$75.14
Employee + Spouse	\$0.00	\$186.72
Employee + Child(ren)	\$0.00	\$166.29
Employee + Family	\$0.00	\$259.82