HEALTH SUMMARY CHART

HEALTH PLAN SUMMARY COMPARISON CHART (EXCLUDING MA-PD PLANS)

COSTS	STANDARD			HIGH DEDUCTIBLE (PAIR WITH HEALTH SAVINGS ACCOUNT)	
	HMO	PPO		HMO and PPO	PPO Only
		In Network	Out-of-Network		
Annual Deductible	None	$250 $500 Single Family	$750 $1,500 Single Family	$1,700 $3,400 Single Family	$2,500 $5,000 Single Family
Global In-Network Annual Out-of-Pocket Maximum	$10,150 $20,300 Per Indiv. Per Family Combined Pharmacy and Medical	$10,150 $20,300 Per Indiv. Per Family Combined Pharmacy and Medical	N/A	$4,700 $9,400 $3,000 $6,000 (HMO) Per Indiv. Per Family Combined Pharmacy and Medical	NA
Preventive Care[1]	No Charge	No Charge No Deductible	Amount between charge and out-of-network allowance; no deductible	No Charge; No Deductible	Amount between charge and out-of-network allowance; no deductible
Primary Care	$20 Copayment	$15 Copayment	40% of out-of-network allowance plus the amount between the charge and the out-of-network allowance	Deductible then 20% of network allowed amount	Deductible then 40% of out-of-network allowance plus the amount between the charge and the out-of-network allowance
Specialist	$40 Copayment	$25 Copayment			
Urgent Care	$25 Copayment	$25 Copayment	$25 Copayment		Deductible then 20% of out-of-network allowance
Emergency Room	$100 Copayment	$100 Copayment	$100 Copayment		
Hospital Stay	$250 Copayment	20% after $250 Copayment	40% of out-of-network allowance plus the amount between the charge and the out-of-network allowance	Deductible then 20% of network allowed amount	Deductible, $100 copayment; then 40% of out-of-network allowance plus the amount between charge and out-of-network allowance
Prescription Drug	$7 Generic $30 Generic $50 Generic	$7 $30 $50 Generic | Preferred | Non-Preferred	Pay in Full; File Claim for Reimbursement	After Paying Deductible, Network – 30% Retail – 30% Mail Order – 50%	Pay in Full; File Claim for Reimbursement
Up to 90-Day Supply	$14 Generic $60 Generic $100 Generic	$14 $60 $100 Generic | Preferred | Non-Preferred			

MONTHLY PREMIUM[2]	STANDARD						HIGH DEDUCTIBLE HEALTH PLAN					
	Single	Spouse	Family	Over Age Dependent (Age 26-30)	COBRA	Retiree <Age 65	Single	Spouse	Family	Over Age Dependent (Age 26-30)	COBRA	Retiree <Age 65
Career Service	$50	$30	$180	$813.46	$994.86 Single $2,239.39 Family	$813.46 Single $1,831.08 Family	$15	$30	$64.30	$736.80	$916.66 Single $2,036.38 Family	$813.46 Single $1,831.08 Family
Select Exempt/ Sr. Mngmt. Service	$8.34	$30	$30				$8.34	$30	$30			

MEDICARE TIERS[3]	MEDICARE I	MEDICARE II	MEDICARE III	MEDICARE I	MEDICARE II	MEDICARE III
Retiree > 65 or SSI Disability	$430.18	$1,243.63	$860.35	$324.26	$1,061.06	$648.52
Capital Health Plan	$319.44	$1,345.02	$638.88	$290.74	$1,202.94	$581.48

1 Preventive care based on age and gender.
2 We deduct your premium in advance (e.g., December 2025 for Jan. 1, 2026 coverage).
3 Medicare I = single coverage for retired participant eligible for Medicare. Medicare II = family coverage for two or more and at least one is Medicare eligible. Medicare III = family coverage for retiree and one dependent, and both are Medicare eligible.