2026 MEDICAL & PRESCRIPTION DRUG PLANS AT-A-GLANCE

	POINT OF SERVICE		PERSONAL CHOICE PPO - BASIC		PERSONAL CHOICE PPO - HIGH		CDHP WITH HSA	
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
IS A REFERRAL NEEDED TO SEE A SPECIALIST?	Yes		No		No		No	
EMPLOYER HEALTH SAVINGS ACCOUNT CONTRIBUTION	No		No		No		Individual: $500 / Family: $1,000	
INTERNATIONAL TRAVEL	BCBS Global Core Included. For more information on the services covered internationally, please call the service center at 1-800-810-2583		BCBS Global Core Included. For more information on the services covered internationally, please call the service center at 1-800-810-2583		BCBS Global Core Included. For more information on the services covered internationally, please call the service center at 1-800-810-2583		BCBS Global Core Included. For more information on the services covered internationally, please call the service center at 1-800-810-2583	
DEDUCTIBLE (INDIVIDUAL/FAMILY)	$200 / $400	$600 / $1,200	$300 / $600	$1,000 / $2,000	None	$500 / $1,000	$2,000 / $4,000	$5,000 / $10,000
OUT-OF-POCKET MAXIMUM (INDIVIDUAL/FAMILY)	$3,000 / $6,000	$6,000 / $12,000	$2,000 / $4,000	$3,000 / $6,000	$2,000 / $4,000	$3,000 / $6,000	$6,450 / $12,900	$10,000 / $20,000
PREVENTIVE CARE SERVICES	No Charge	Plan pays 70%	No Charge	Plan pays 70%	No Charge	Plan pays 80%	No Charge	Plan pays 50%
PRIMARY CARE PHYSICIAN (PCP)	$20 copay	Plan pays 70%*	$20 copay	Plan pays 70%*	$15 copay	Plan pays 80%*	Plan pays 80%*	Plan pays 50%*
TELADOC**	No Charge	N/A	No Charge	N/A	No Charge	N/A	$60 copay*	N/A
SPECIALIST OFFICE VISIT	$40 copay	Plan pays 70%*	$30 copay	Plan pays 70%*	$25 copay	Plan pays 80%*	Plan pays 80%*	Plan pays 50%*
OUTPATIENT SERVICES (SURGERY)	$50 copay	Plan pays 70%*	Plan pays 90%*	Plan pays 70%*	No Charge	Plan pays 80%*	Plan pays 80%*	Plan pays 50%*
INPATIENT SERVICES	$100/day copay; max of 5 copays/ admission	Plan pays 70%*	Plan pays 90%*	Plan pays 70%*	No Charge	Plan pays 80%*	Plan pays 80%*	Plan pays 50%*
DIAGNOSTIC LABORATORY	$20 copay	Plan pays 70%*	No Charge	Plan pays 70%*	No Charge	Plan pays 80%*	Plan pays 80%*	Plan pays 50%*
DIAGNOSTIC X-RAY	$20 copay	Plan pays 70%*	Plan pays 90%*	Plan pays 70%*	No Charge	Plan pays 80%*	Plan pays 80%*	Plan pays 50%*
IMAGING (MRI, CT-SCAN)	$80 copay	Plan pays 70%*	Plan pays 90%*	Plan pays 70%*	No Charge	Plan pays 80%*	Plan pays 80%*	Plan pays 50%*
EMERGENCY ROOM	$250 copay	Covered at in-network level	$250 copay	Covered at in-network level	$250 copay	Covered at in-network level	Plan pays 80%*	Covered at in-network level
URGENT CARE CENTER	$50 copay	Plan pays 70%*	$50 copay	Plan pays 70%*	$50 copay	Plan pays 80%*	Plan pays 80%*	Plan pays 50%*
OUTPATIENT SERVICES FOR MENTAL HEALTH/ BEHAVIORAL/SUBSTANCE ABUSE	$20 copay	Plan pays 70%*	Plan pays 90%*	Plan pays 70%*	No Charge	Plan pays 80%*	Plan pays 80%*	Plan pays 50%*
PRESCRIPTION DRUG BENEFITS								
RETAIL PHARMACY (UP TO A 30-DAY SUPPLY)	Generic: $15 copay Preferred Brand: $35 copay Non-Preferred Brand: $55 copay Specialty: $75 copay	Plan pays 30%	Generic: $15 copay Preferred Brand: $35 copay Non-Preferred Brand: $55 copay Specialty: $75 copay	Plan pays 30%	Generic: $15 copay Preferred Brand: $35 copay Non-Preferred Brand: $55 copay Specialty: $75 copay	Plan pays 30%	Generic: $15 copay* Preferred Brand: $35 copay* Non-Preferred Brand: $55 copay* Specialty: $75 copay*	Plan pays 30%*
MAIL ORDER (UP TO A 90-DAY SUPPLY)	Generic: $30 copay Preferred Brand: $70 copay Non-Preferred Brand: $110 copay Specialty; N/A	Not available	Generic: $30 copay Preferred Brand: $70 copay Non-Preferred Brand: $110 copay Specialty: N/A	Not available	Generic: $30 copay Preferred Brand: $70 copay Non-Preferred Brand: $110 copay Specialty: N/A	Not available	Generic: $30 copay* Preferred Brand: $70 copay* Non-Preferred Brand: $110 copay* Specialty: N/A	Not available

* The plan year deductible must be satisfied before the plan will pay for services.
** Includes Teledermatology and Telebehavioral health