Medical Policy # 00125981-0001-0001 ***Renewal Date: 11/1/2025***	**Current Plan** **BCN HMO $500 100%** **(Current Billed Ages)**		**Renewal Plan - BCN HMO $500 100%** **(Renewal Billed Ages)**		**Platinum** **BCN HMO 90% $0 Deductible**		**Gold** **BCN HMO 20% $500 Deductible**	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	**$0**	N/A	$500	N/A
Family	$1,000	N/A	$1,000	N/A	**$0**	N/A	$1,000	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	**90%**	N/A	**80%**	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	**$1,000**	N/A	**$5,000**	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	**$2,000**	N/A	**$10,000**	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	$1,500	N/A	**$5,000**	N/A	**$9,100**	N/A
Family	$3,000	N/A	$3,000	N/A	**$10,000**	N/A	**$18,200**	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		$20		**$30**	
Virtual Care Visit	$0*		$0*		$0*		$0*	
Specialist Visit	$30		$30		$30		**$50**	
Urgent Care	$35		$35		$35		**$50**	
Emergency Room	$150 after Deductible		$150 after Deductible		**$150**		**$350 after Deductible**	
Hospital Admission	0% after Deductible		0% after Deductible		**10% after Deductible**		**20% after Deductible**	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		**$6 / $25**		**$15 / $40**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**$50** / $80		**$80 / $100**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		BCN Platinum Option 1		BCN Gold Option 1	
Monthly / Annual Premium	**$30,119.51**	**$361,434.12**	**$35,063.70**	**$420,764.40**	**$35,109.03**	**$421,308.36**	**$28,214.73**	**$338,576.76**
$ Change from Current			**$4,944.19**	**$59,330.28**	**$4,989.52**	**$59,874.24**	**($1,904.78)**	**($22,857.36)**
% Change from Current			**16.42%**		**16.57%**		**-6.32%**	

Medical Policy # 00125981-0001-0001 ***Renewal Date: 11/1/2025*** **Provider Network:**	**Current Plan BCN HMO $500 100%** **(Current Billed Ages)**		**Renewal Plan - BCN HMO $500 100%** **(Renewal Billed Ages)**		**Gold BCN HMO $1000 Deductible**		**Gold BCN HMO $1500 Deductible**	
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	$1,000	N/A	$1,500	N/A
Family	$1,000	N/A	$1,000	N/A	$2,000	N/A	$3,000	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	80%	N/A	80%	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	$3,500	N/A	$2,500	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	$7,000	N/A	$5,000	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	$1,500	N/A	$8,150	N/A	$8,150	N/A
Family	$3,000	N/A	$3,000	N/A	$16,300	N/A	$16,300	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		$20		$20	
Virtual Care Visit	$0*		$0*		$0*		$0*	
Specialist Visit	$30		$30		$40		$40	
Urgent Care	$35		$35		$50		$50	
Emergency Room	$150 after Deductible		$150 after Deductible		$250 after Deductible		$250 after Deductible	
Hospital Admission	0% after Deductible		0% after Deductible		20% after Deductible		20% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		$15 / $40		$10 / $30	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$80 / $100		$60 / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		BCN Gold Option 2		BCN Gold Option 3	
Monthly / Annual Premium	$30,119.51	$361,434.12	$35,063.70	$420,764.40	$28,005.51	$336,066.12	$27,826.32	$333,915.84
$ Change from Current			**$4,944.19**	**$59,330.28**	**($2,114.00)**	**($25,368.00)**	**($2,293.19)**	**($27,518.28)**
% Change from Current			**16.42%**		**-7.02%**		**-7.61%**	

Medical Policy # 00125981-0001-0001 ***Renewal Date: 11/1/2025***	**Current Plan BCN HMO $500 100%** **(Current Billed Ages)**		**Renewal Plan - BCN HMO $500 100%** **(Renewal Billed Ages)**		**Gold BCN HMO $2000 Deductible**		**Gold BCN HMO $2500 Deductible**	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	**$2,000**	N/A	**$2,500**	N/A
Family	$1,000	N/A	$1,000	N/A	**$4,000**	N/A	**$5,000**	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	**80%**	N/A	**80%**	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	**$2,000**	N/A	**$2,000**	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	**$4,000**	N/A	**$4,000**	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	$1,500	N/A	**$9,100**	N/A	**$7,350**	N/A
Family	$3,000	N/A	$3,000	N/A	**$18,200**	N/A	**$14,700**	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		$20		**$30**	
Virtual Care Visit	$0*		$0*		$0*		$0*	
Specialist Visit	$30		$30		**$40**		**$50**	
Urgent Care	$35		$35		**$50**		**$50**	
Emergency Room	$150 after Deductible		$150 after Deductible		$150 after Deductible		$150 after Deductible	
Hospital Admission	0% after Deductible		0% after Deductible		**20% after Deductible**		**20% after Deductible**	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		**$10 / $30**		$4 / $15	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**$60** / $80		$40 / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		BCN Gold Option 4		BCN Gold Option 5	
Monthly / Annual Premium	**$30,119.51**	**$361,434.12**	**$35,063.70**	**$420,764.40**	**$27,299.41**	**$327,592.92**	**$27,121.83**	**$325,461.96**
$ Change from Current			**$4,944.19**	**$59,330.28**	**($2,820.10)**	**($33,841.20)**	**($2,997.68)**	**($35,972.16)**
% Change from Current			**16.42%**		**-9.36%**		**-9.95%**	

Medical Policy # 00125981-0001-0001 ***Renewal Date: 11/1/2025***	**Current Plan** **BCN HMO $500 100%** **(Current Billed Ages)**		**Renewal Plan - BCN HMO $500 100%** **(Renewal Billed Ages)**		**Platinum** **BCN HMO HSA $1650 Deductible** **Aggregate**		**Gold** **BCN HMO HSA $2500 100% Deductible** **Aggregate**	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	**$1,650**	N/A	**$2,500**	N/A
Family	$1,000	N/A	$1,000	N/A	**$3,300**	N/A	**$5,000**	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	100%	N/A	100%	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	$1,500	N/A	**$1,650**	N/A	**$4,500**	N/A
Family	$3,000	N/A	$3,000	N/A	**$3,300**	N/A	**$9,000**	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		**0% after Deductible**		**0% after Deductible**	
Virtual Care Visit	$0*		$0*		**0% after Deductible**		**0% after Deductible**	
Specialist Visit	$30		$30		**0% after Deductible**		**0% after Deductible**	
Urgent Care	$35		$35		**0% after Deductible**		**0% after Deductible**	
Emergency Room	$150 after Deductible		$150 after Deductible		**0% after Deductible**		**0% after Deductible**	
Hospital Admission	0% after Deductible		0% after Deductible		0% after Deductible		0% after Deductible	
Employee In-Network RX Copay:					Rx Copays after Deductible		Rx Copays after Deductible	
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		**0% after Deductible**		**$15 / $40**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**0% after Deductible**		**$80 / $100**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		**0% after Deductible**		**20% $200 Max. / 20% $300 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		BCN H.S.A. Platinum		BCN H.S.A. Gold Option 2	
Monthly / Annual Premium	$30,119.51	$361,434.12	$35,063.70	$420,764.40	$28,528.41	$342,340.92	$25,038.24	$300,458.88
$ Change from Current			**$4,944.19**	**$59,330.28**	**($1,591.10)**	**($19,093.20)**	**($5,081.27)**	**($60,975.24)**
% Change from Current			**16.42%**		**-5.28%**		**-16.87%**	

Medical Policy # 00125981-0001-0001 ***Renewal Date: 11/1/2025***	Current Plan BCN HMO $500 100% (Current Billed Ages)		Renewal Plan - BCN HMO $500 100% (Renewal Billed Ages)		Gold BCN HMO HSA $3300 100% Deductible Embedded		Silver BCN HMO HSA $4000 Deductible Embedded	
Provider Network:	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**	
In State / Out of State Residents								
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	$3,300	N/A	$4,000	N/A
Family	$1,000	N/A	$1,000	N/A	$6,600	N/A	$8,000	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	100%	N/A	90%	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	$1,500	N/A	$3,300	N/A	$7,050	N/A
Family	$3,000	N/A	$3,000	N/A	$6,600	N/A	$14,100	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		0% after Deductible		10% after Deductible	
Virtual Care Visit	$0*		$0*		0% after Deductible		10% after Deductible	
Specialist Visit	$30		$30		0% after Deductible		10% after Deductible	
Urgent Care	$35		$35		0% after Deductible		10% after Deductible	
Emergency Room	$150 after Deductible		$150 after Deductible		0% after Deductible		10% after Deductible	
Hospital Admission	0% after Deductible		0% after Deductible		0% after Deductible		10% after Deductible	
Employee In-Network RX Copay:					Rx Copays after Deductible		Rx Copays after Deductible	
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		0% after Deductible		$15 / $40	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		0% after Deductible		$80 / $100	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		0% after Deductible		20% $200 Max. / 20% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		BCN H.S.A. Gold Option 3		BCN H.S.A. Silver Option 2	
Monthly / Annual Premium	$30,119.51	$361,434.12	$35,063.70	$420,764.40	$24,067.09	$288,805.08	$21,129.74	$253,556.88
$ Change from Current			**$4,944.19**	**$59,330.28**	**($6,052.42)**	**($72,629.04)**	**($8,989.77)**	**($107,877.24)**
% Change from Current			**16.42%**		**-20.09%**		**-29.85%**	

Medical Policy # 00125981-0001-0001 ***Renewal Date: 11/1/2025***	**Current Plan BCN HMO $500 100%**		**Renewal Plan - BCN HMO $500 100%**		**Platinum BCN HMO Elect Plus POS $0**		**Platinum BCN HMO Elect Plus POS $250**	
Provider Network:	**(Current Billed Ages)**		**(Renewal Billed Ages)**					
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / Blue Card Traditional**		**BCN HMO / Blue Card Traditional**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	**$0**	**$250**	**$250**	**$500**
Family	$1,000	N/A	$1,000	N/A	**$0**	**$500**	**$500**	**$1,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	**80%**	**60%**	**80%**	**60%**
Coinsurance Max - Single	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	$1,500	N/A	**$3,000**	**$6,000**	**$4,500**	**$9,000**
Family	$3,000	N/A	$3,000	N/A	**$6,000**	**$12,000**	**$9,000**	**$18,000**
In-Network Employee Copay:								
Office Visit	$20		$20		$20		$20	
Virtual Care Visit	$0*		$0*		$0*		$0*	
Specialist Visit	$30		$30		$30		$30	
Urgent Care	$35		$35		$35		**$50**	
Emergency Room	$150 after Deductible		$150 after Deductible		**$150**		**$150**	
Hospital Admission	0% after Deductible		0% after Deductible		**20% after Deductible**		**20% after Deductible**	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		$4 / $15		$4 / $15	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$40 / $80		$40 / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		Blue Elect POS Platinum Option 1		Blue Elect POS Platinum Option 2	
Monthly / Annual Premium	**$30,119.51**	**$361,434.12**	**$35,063.70**	**$420,764.40**	**$35,103.41**	**$421,240.92**	**$32,993.04**	**$395,916.48**
$ Change from Current			**$4,944.19**	**$59,330.28**	**$4,983.90**	**$59,806.80**	**$2,873.53**	**$34,482.36**
% Change from Current			**16.42%**		**16.55%**		**9.54%**	

Medical Policy # 00125981-0001-0001 ***Renewal Date: 11/1/2025***	**Current Plan** **BCN HMO $500 100%** **(Current Billed Ages)**		**Renewal Plan - BCN HMO $500 100%** **(Renewal Billed Ages)**		**Gold** **BCN HMO Elect Plus POS $500**		**Gold** **BCN HMO Elect Plus POS $1000**	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / Blue Card Traditional**		**BCN HMO / Blue Card Traditional**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	$500	**$1,000**	**$1,000**	**$2,000**
Family	$1,000	N/A	$1,000	N/A	$1,000	**$2,000**	**$2,000**	**$4,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	**80%**	**60%**	**80%**	**60%**
Coinsurance Max - Single	N/A	N/A	N/A	N/A	**$5,000**	**$10,000**	**$5,000**	**$10,000**
Coinsurance Max - Family	N/A	N/A	N/A	N/A	**$10,000**	**$20,000**	**$10,000**	**$20,000**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	$1,500	N/A	**$9,100**	**$18,200**	**$9,100**	**$18,200**
Family	$3,000	N/A	$3,000	N/A	**$18,200**	**$36,400**	**$18,200**	**$36,400**
In-Network Employee Copay:								
Office Visit	$20		$20		**$30**		**$30**	
Virtual Care Visit	$0*		$0*		$0*		$0*	
Specialist Visit	$30		$30		**$50**		**$50**	
Urgent Care	$35		$35		**$50**		**$50**	
Emergency Room	$150 after Deductible		$150 after Deductible		**$250**		**$250**	
Hospital Admission	0% after Deductible		0% after Deductible		**30% after Deductible**		**20% after Deductible**	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		**$10 / $30**		**$10 / $30**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**$60** / $80		**$60** / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		Blue Elect POS Gold Option 1		Blue Elect POS Gold Option 2	
Monthly / Annual Premium	$30,119.51	$361,434.12	$35,063.70	$420,764.40	$29,279.11	$351,349.32	$28,350.05	$340,200.60
$ Change from Current			**$4,944.19**	**$59,330.28**	**($840.40)**	**($10,084.80)**	**($1,769.46)**	**($21,233.52)**
% Change from Current			**16.42%**		**-2.79%**		**-5.87%**	

Medical Policy # 00125981-0001-0001 ***Renewal Date: 11/1/2025***	**Current Plan BCN HMO $500 100%** **(Current Billed Ages)**		**Renewal Plan - BCN HMO $500 100%** **(Renewal Billed Ages)**		**Gold BCN HMO Elect Plus POS $1500**		**Gold BCN HMO Elect Plus POS $2000**	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / Blue Card Traditional**		**BCN HMO / Blue Card Traditional**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	$1,500	$3,000	$2,000	$4,000
Family	$1,000	N/A	$1,000	N/A	$3,000	$6,000	$4,000	$8,000
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	80%	60%	80%	60%
Coinsurance Max - Single	N/A	N/A	N/A	N/A	$5,000	$10,000	N/A	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	$10,000	$20,000	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	$1,500	N/A	$9,100	$18,200	$7,350	$14,700
Family	$3,000	N/A	$3,000	N/A	$18,200	$36,400	$14,700	$29,400
In-Network Employee Copay:								
Office Visit	$20		$20		$30		$30	
Virtual Care Visit	$0*		$0*		$0*		$0*	
Specialist Visit	$30		$30		$50		$50	
Urgent Care	$35		$35		$50		$50	
Emergency Room	$150 after Deductible		$150 after Deductible		$250		$250	
Hospital Admission	0% after Deductible		0% after Deductible		20% after Deductible		20% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		$10 / $30		$15 / $40	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$60 / $80		$80 / $100	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		Blue Elect POS Gold Option 3		Blue Elect POS Gold Option 4	
Monthly / Annual Premium	$30,119.51	$361,434.12	$35,063.70	$420,764.40	$27,656.89	$331,882.68	$27,254.00	$327,048.00
$ Change from Current			**$4,944.19**	**$59,330.28**	**($2,462.62)**	**($29,551.44)**	**($2,865.51)**	**($34,386.12)**
% Change from Current			**16.42%**		**-8.18%**		**-9.51%**	

Medical Policy # 00125981-0001-0001 ***Renewal Date: 11/1/2025***	Current Plan BCN HMO $500 100% (Current Billed Ages)		Renewal Plan - BCN HMO $500 100% (Renewal Billed Ages)		Gold BCN HMO Elect Plus POS $3000		Gold BCN HMO Elect Plus POS $4000	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / Blue Card Traditional**		**BCN HMO / Blue Card Traditional**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	**$3,000**	**$6,000**	**$4,000**	**$8,000**
Family	$1,000	N/A	$1,000	N/A	**$6,000**	**$12,000**	**$8,000**	**$16,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	**80%**	**60%**	**80%**	**60%**
Coinsurance Max - Single	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	$1,500	N/A	**$7,350**	**$14,700**	**$9,200**	**$18,400**
Family	$3,000	N/A	$3,000	N/A	**$14,700**	**$29,400**	**$18,400**	**$36,800**
In-Network Employee Copay:								
Office Visit	$20		$20		**$30**		**$30**	
Virtual Care Visit	$0*		$0*		$0*		$0*	
Specialist Visit	$30		$30		**$50**		**$50**	
Urgent Care	$35		$35		**$50**		**$60**	
Emergency Room	$150 after Deductible		$150 after Deductible		**$250**		**$250**	
Hospital Admission	0% after Deductible		0% after Deductible		**20% after Deductible**		**20% after Deductible**	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		**$15 / $40**		$4 / $15	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**$80 / $100**		$40 / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		Blue Elect POS Gold Option 5		Blue Elect POS Gold Option 6	
Monthly / Annual Premium	$30,119.51	$361,434.12	$35,063.70	$420,764.40	$26,594.84	$319,138.08	$26,386.48	$316,637.76
$ Change from Current			**$4,944.19**	**$59,330.28**	**($3,524.67)**	**($42,296.04)**	**($3,733.03)**	**($44,796.36)**
% Change from Current			**16.42%**		**-11.70%**		**-12.39%**	

Medical Policy # 00125981-0001-0001 ***Renewal Date: 11/1/2025***	**Current Plan BCN HMO $500 100%** **(Current Billed Ages)**		**Renewal Plan - BCN HMO $500 100%** **(Renewal Billed Ages)**		**Platinum BCN Elect Plus POS HSA $1650 Deductible ($0)** **Aggregate**		**Gold BCN Elect Plus POS HSA $2500 Deductible ($0)** **Aggregate**	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / Blue Card Traditional**		**BCN HMO / Blue Card Traditional**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	**$1,650**	**$3,300**	**$2,500**	**$5,000**
Family	$1,000	N/A	$1,000	N/A	**$3,300**	**$6,600**	**$5,000**	**$10,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	100%	**80%**	100%	**80%**
Coinsurance Max - Single	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	$1,500	N/A	**$1,650**	**$3,300**	**$4,500**	**$9,000**
Family	$3,000	N/A	$3,000	N/A	**$3,300**	**$6,600**	**$9,000**	**$18,000**
In-Network Employee Copay:								
Office Visit	$20		$20		**0% after Deductible**		**0% after Deductible**	
Virtual Care Visit	$0*		$0*		**0% after Deductible**		**0% after Deductible**	
Specialist Visit	$30		$30		**0% after Deductible**		**0% after Deductible**	
Urgent Care	$35		$35		**0% after Deductible**		**0% after Deductible**	
Emergency Room	$150 after Deductible		$150 after Deductible		**0% after Deductible**		**0% after Deductible**	
Hospital Admission	0% after Deductible		0% after Deductible		0% after Deductible		0% after Deductible	
Employee In-Network RX Copay:					Rx Copays after Deductible		Rx Copays after Deductible	
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		**0% after Deductible**		**$15 / $40**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**0% after Deductible**		**$80 / $100**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		**0% after Deductible**		**20% $200 Max. / 20% $300 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		Blue Elect Plus H.S.A. POS Platinum		Blue Elect Plus H.S.A. POS Gold Option	
Monthly / Annual Premium	$30,119.51	$361,434.12	$35,063.70	$420,764.40	$28,803.27	$345,639.24	$25,144.44	$301,733.28
$ Change from Current			**$4,944.19**	**$59,330.28**	**($1,316.24)**	**($15,794.88)**	**($4,975.07)**	**($59,700.84)**
% Change from Current			**16.42%**		**-4.37%**		**-16.52%**	

Medical Policy # 00125981-0001-0001 ***Renewal Date: 11/1/2025***	**Current Plan BCN HMO $500 100%** **(Current Billed Ages)**		**Renewal Plan - BCN HMO $500 100%** **(Renewal Billed Ages)**		**Platinum HAP HMO 500**		**Gold HAP HMO 1200**	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**HAP HMO / ER Services Only**		**HAP HMO / ER Services Only**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	$500	N/A	**$1,200**	N/A
Family	$1,000	N/A	$1,000	N/A	$1,000	N/A	**$2,400**	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	100%	N/A	100%	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	$1,500	N/A	**$2,500**	N/A	**$8,000**	N/A
Family	$3,000	N/A	$3,000	N/A	**$5,000**	N/A	**$16,000**	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		$20		**$35**	
Virtual Care Visit	$0*		$0*		$0**		$0**	
Specialist Visit	$30		$30		**$40**		**$60**	
Urgent Care	$35		$35		**$65**		**$65**	
Emergency Room	$150 after Deductible		$150 after Deductible		**$200**		**$300**	
Hospital Admission	0% after Deductible		0% after Deductible		0% after Deductible		0% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**N/A**		**N/A**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		**$5** / $15		**$5 / $30**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**$30 / $60**		$40 / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max / **50% $500 Max**		20% $200 Max / **50% $500 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		HMO Platinum A050		HMO Gold B12	
Monthly / Annual Premium	$30,119.51	$361,434.12	$35,063.70	$420,764.40	$34,696.82	$416,361.84	$28,249.18	$338,990.16
$ Change from Current			**$4,944.19**	**$59,330.28**	**$4,577.31**	**$54,927.72**	**($1,870.33)**	**($22,443.96)**
% Change from Current			**16.42%**		**15.20%**		**-6.21%**	

Medical Policy # 00125981-0001-0001 ***Renewal Date: 11/1/2025***	**Current Plan BCN HMO $500 100%** **(Current Billed Ages)**		**Renewal Plan - BCN HMO $500 100%** **(Renewal Billed Ages)**		**Gold Priority Health HMO 500**		**Gold Priority Health HMO 1200**	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**Priority Health HMO / ER Services Only**		**Priority Health HMO / ER Services Only**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	$500	N/A	**$1,200**	N/A
Family	$1,000	N/A	$1,000	N/A	$1,000	N/A	**$2,400**	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	**80%**	N/A	100%	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	**$5,500**	N/A	N/A	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	**$11,000**	N/A	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	$1,500	N/A	**$9,100**	N/A	**$8,150**	N/A
Family	$3,000	N/A	$3,000	N/A	**$18,200**	N/A	**$16,300**	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		**$30**		**$30**	
Virtual Care Visit	$0*		$0*		**$10**		**$10**	
Specialist Visit	$30		$30		**$50**		**$60**	
Urgent Care	$35		$35		**$85**		**$85**	
Emergency Room	$150 after Deductible		$150 after Deductible		**$250 after Deductible**		**$250 after Deductible**	
Hospital Admission	0% after Deductible		0% after Deductible		**20% after Deductible**		0% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**N/A**		**N/A**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		**$5 / $35**		**$5 / $30**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**$80 / $95**		$40 / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		**20% $250 Max / 20% $450 Max**		**20% $250 Max / 20% $450 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		PriorityHMO Gold G50		PriorityHMO Gold G121	
Monthly / Annual Premium	$30,119.51	$361,434.12	$35,063.70	$420,764.40	$29,468.04	$353,616.48	$30,361.50	$364,338.00
$ Change from Current			**$4,944.19**	**$59,330.28**	**($651.47)**	**($7,817.64)**	**$241.99**	**$2,903.88**
% Change from Current			**16.42%**		**-2.16%**		**0.80%**	

Medical Policy # 00125981-0001-0001 ***Renewal Date: 11/1/2025***	**Current Plan BCN HMO $500 100%** **(Current Billed Ages)**		**Renewal Plan - BCN HMO $500 100%** **(Renewal Billed Ages)**		**United Healthcare DX-2R**		**United Healthcare DX-2P**	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**United Healthcare Choice / ER**		**United Healthcare Choice / ER**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	$500	N/A	**$1,000**	N/A
Family	$1,000	N/A	$1,000	N/A	$1,000	N/A	**$2,000**	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	100%	N/A	100%	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	$1,500	N/A	**$2,500**	N/A	**$2,000**	N/A
Family	$3,000	N/A	$3,000	N/A	**$5,000**	N/A	**$4,000**	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		**$15**		**$10**	
Virtual Care Visit	$0*		$0*		**$15**		**$10**	
Specialist Visit	$30		$30		**$50 or $100**		**$40 or $80**	
Urgent Care	$35		$35		**$25**		**$25**	
Emergency Room	$150 after Deductible		$150 after Deductible		**$500 Copay after Deductible**		**$500 after Deductible**	
Hospital Admission	0% after Deductible		0% after Deductible		0% after Deductible		0% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**N/A**		**N/A**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		**$10**		**$10**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$40 / **$105**		$40 / **$105**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		**$250 / $500**		**$250 / $500**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		**End of Month Age 26**		**End of Month Age 26**	
Pediatric Dental	Not Included		Not Included		Automatically Included		Automatically Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		N/A		N/A	
Monthly / Annual Premium	**$30,119.51**	**$361,434.12**	**$35,063.70**	**$420,764.40**	**$38,085.17**	**$457,022.04**	**$37,576.90**	**$450,922.80**
$ Change from Current			**$4,944.19**	**$59,330.28**	**$7,965.66**	**$95,587.92**	**$7,457.39**	**$89,488.68**
% Change from Current			**16.42%**		**26.45%**		**24.76%**	

BCN HMO Plan Disclaimers

1) Employee headcounts obtained from July 2025 census.
2) The Embedded Coinsurance Maximum excludes the deductible, office visit copay, prescription drug copays and private duty nursing coinsurance.
3) Final premium cost subject to change based on employee enrollment.
4) Dependent (Child) Cap - Health Care Reform regulations require a child rate cap of no more than three children under the age of 21, on a family contract. For example, a family with five children under the age of 21 would only be charged for the three oldest children. All dependents 21 and older will be rated.
5) The benefits shown in this section are not an insurance contract. The information provided is for illustrative purposes only. Please refer to the contract for the exact description and details.
6) United Healthcare Core Essential Plans are Only Available to Groups in Wayne, Oakland and Macomb Counties

*BCBSM Virtual Care Visit - Copay applies to Members 18 years of age or older, by a BCBSM Selected Vendor. Virtual Primary Care Visits by a non-BCBSM selected vendor are not covered
*BCN Medical Online Visits are covered 100% when received by a BCN Participating Provider or BCN Designated Online Vendor. Not all services virtually care considered an online visit but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.
**HAP Telehealth Visit is covered 100% when there contracted telehealth services provider is used

H.S.A. Plans
Aggregate - The Total Deductible or Out of Pocket Limit does not contain an individual limit. An individual is covered when the family deductible or out of pocket limit is met
Embedded - The plan contains and individual limit (stop) within the family total. The embeded stop occurs when an individuals deductible or out of pocket limit has been satisfied, but the family deductible or our of pocket limit hasn't

Benefit Improvements Benefit Reductions

Medical Policy # 007005509-0000 ***Renewal Date: 11/1/2025***	**Current Plan** **BCBSM Simply Blue PPO $250** **(Current Billed Ages)**		**Renewal Plan - BCBSM Simply Blue PPO $250** **(Renewal Billed Ages)**		**Gold** **BCBSM Simply Blue PPO $500**		**Gold** **BCBSM Simply Blue PPO $1000**	
Provider Network:								
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**BCBS National PPO**		**BCBS National PPO**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	**$500**	**$1,000**	**$1,000**	**$2,000**
Family	$500	$1,000	$500	$1,000	**$1,000**	**$2,000**	**$2,000**	**$4,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	**70%**	**50%**	80%	60%
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	**$5,000**	**$10,000**	**$5,000**	**$10,000**
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	**$10,000**	**$20,000**	**$10,000**	**$20,000**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	**$8,150**	**$16,300**	**$8,150**	**$16,300**
Family	$13,200	$26,400	$13,200	$26,400	**$16,300**	**$32,600**	**$16,300**	**$32,600**
In-Network Employee Copay:								
Office Visit	$20		$20		**$30**		**$30**	
Virtual Care Visit	$20		$20		**$30**		**$30**	
Specialist Visit	$40		$40		**$50**		**$50**	
Urgent Care	$60		$60		$60		$60	
Emergency Room	$150		$150		**$250**		**$250**	
Hospital Admission	20% after Deductible		20% after Deductible		**30% after Deductible**		20% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$10		$10		**$20**		**$20**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**$60 / $100**		**$60 / $100**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		**20% $200 Max** / 25% $300 Max		**20% $200 Max** / 25% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		SB PPO Gold Option 1		SB PPO Gold Option 2	
Monthly / Annual Premium	$3,244.09	$38,929.08	$3,701.49	$44,417.88	$3,041.67	$36,500.04	$3,013.27	$36,159.24
$ Change from Current			**$457.40**	**$5,488.80**	**($202.42)**	**($2,429.04)**	**($230.82)**	**($2,769.84)**
% Change from Current			**14.10%**		**-6.24%**		**-7.12%**	

Medical Policy # 007005509-0000 ***Renewal Date: 11/1/2025***	**Current Plan BCBSM Simply Blue PPO $250** **(Current Billed Ages)**		**Renewal Plan - BCBSM Simply Blue PPO $250** **(Renewal Billed Ages)**		**Gold BCBSM Simply Blue PPO $1500**		**Gold BCBSM Simply Blue PPO $2000**	
Provider Network:	**BCBS National PPO**		**BCBS National PPO**		**BCBS National PPO**		**BCBS National PPO**	
In State / Out of State Residents								
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	$1,500	$3,000	$2,000	$4,000
Family	$500	$1,000	$500	$1,000	$3,000	$6,000	$4,000	$8,000
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	80%	60%	80%	60%
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	$4,000	$8,000	N/A	N/A
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	$8,000	$16,000	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	$8,150	$16,300	$7,350	$14,700
Family	$13,200	$26,400	$13,200	$26,400	$16,300	$32,600	$14,700	$29,400
In-Network Employee Copay:								
Office Visit	$20		$20		$30		$30	
Virtual Care Visit	$20		$20		$30		$30	
Specialist Visit	$40		$40		$50		$50	
Urgent Care	$60		$60		$60		$60	
Emergency Room	$150		$150		$250		$150	
Hospital Admission	20% after Deductible		20% after Deductible		20% after Deductible		20% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$10		$10		$20		$20	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$60 / $100		$60 / $100	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		20% $200 Max / 25% $300 Max		20% $200 Max / 25% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		SB PPO Gold Option 3		SB PPO Gold Option 4	
Monthly / Annual Premium	**$3,244.09**	**$38,929.08**	**$3,701.49**	**$44,417.88**	**$2,935.81**	**$35,229.72**	**$2,881.94**	**$34,583.28**
$ Change from Current			**$457.40**	**$5,488.80**	**($308.28)**	**($3,699.36)**	**($362.15)**	**($4,345.80)**
% Change from Current			**14.10%**		**-9.50%**		**-11.16%**	

Medical Policy # 007005509-0000 ***Renewal Date: 11/1/2025***	**Current Plan BCBSM Simply Blue PPO $250** **(Current Billed Ages)**		**Renewal Plan - BCBSM Simply Blue PPO $250** **(Renewal Billed Ages)**		**Gold BCBSM Simply Blue PPO $2500**		**Gold BCBSM Simply Blue PPO $3000**	
Provider Network:	**BCBS National PPO**		**BCBS National PPO**		**BCBS National PPO**		**BCBS National PPO**	
In State / Out of State Residents								
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	**$2,500**	**$5,000**	**$3,000**	**$6,000**
Family	$500	$1,000	$500	$1,000	**$5,000**	**$10,000**	**$6,000**	**$12,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	80%	60%	80%	60%
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	**N/A**	**N/A**	**N/A**	**N/A**
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	**N/A**	**N/A**	**N/A**	**N/A**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	**$7,000**	**$14,000**	**$6,600**	**$13,200**
Family	$13,200	$26,400	$13,200	$26,400	**$14,000**	**$28,000**	**$13,200**	**$26,400**
In-Network Employee Copay:								
Office Visit	$20		$20		**$30**		**$30**	
Virtual Care Visit	$20		$20		**$30**		**$30**	
Specialist Visit	$40		$40		**$50**		**$50**	
Urgent Care	$60		$60		$60		$60	
Emergency Room	$150		$150		$150		$150	
Hospital Admission	20% after Deductible		20% after Deductible		20% after Deductible		20% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$10		$10		**$20**		**$20**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**$60 / $100**		**$60 / $100**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		**20% $200 Max** / 25% $300 Max		**20% $200 Max** / 25% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		SB PPO Gold Option 5		SB PPO Gold Option 6	
Monthly / Annual Premium	**$3,244.09**	**$38,929.08**	**$3,701.49**	**$44,417.88**	**$2,837.82**	**$34,053.84**	**$2,812.12**	**$33,745.44**
$ Change from Current			**$457.40**	**$5,488.80**	**($406.27)**	**($4,875.24)**	**($431.97)**	**($5,183.64)**
% Change from Current			**14.10%**		**-12.52%**		**-13.32%**	

Medical Policy # 007005509-0000 ***Renewal Date: 11/1/2025***	**Current Plan BCBSM Simply Blue PPO $250** **(Current Billed Ages)**		**Renewal Plan - BCBSM Simply Blue PPO $250** **(Renewal Billed Ages)**		**Platinum $1650 100% BCBSM Simply Blue PPO HSA** **Aggregate Deductible & OOPM**		**Gold $2500 100% BCBSM Simply Blue PPO HSA** **Aggregate Deductible & OOPM**	
Provider Network:								
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**BCBS National PPO**		**BCBS National PPO**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	$1,650	$3,300	$2,500	$5,000
Family	$500	$1,000	$500	$1,000	$3,300	$6,600	$5,000	$10,000
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	100%	80%	100%	80%
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	N/A	N/A	N/A	N/A
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	$1,650	$3,300	$4,500	$9,000
Family	$13,200	$26,400	$13,200	$26,400	$3,300	$6,600	$9,000	$18,000
In-Network Employee Copay:								
Office Visit	$20		$20		0% after Deductible		0% after Deductible	
Virtual Care Visit	$20		$20		0% after Deductible		0% after Deductible	
Specialist Visit	$40		$40		0% after Deductible		0% after Deductible	
Urgent Care	$60		$60		0% after Deductible		0% after Deductible	
Emergency Room	$150		$150		0% after Deductible		0% after Deductible	
Hospital Admission	20% after Deductible		20% after Deductible		0% after Deductible		0% after Deductible	
Employee In-Network RX Copay:					Rx Copays after Deductible		Rx Copays after Deductible	
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$10		$10		0% after Deductible		$20	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		0% after Deductible		$60 / $150	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		0% after Deductible		20% $300 Max / 25% $500 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		SB H.S.A. PPO Platinum		SB H.S.A. PPO Gold Option 2	
Monthly / Annual Premium	$3,244.09	$38,929.08	$3,701.49	$44,417.88	$3,137.54	$37,650.48	$2,741.42	$32,897.04
$ Change from Current			**$457.40**	**$5,488.80**	**($106.55)**	**($1,278.60)**	**($502.67)**	**($6,032.04)**
% Change from Current			**14.10%**		**-3.28%**		**-15.49%**	

Medical Policy # 007005509-0000 ***Renewal Date: 11/1/2025***	**Current Plan BCBSM Simply Blue PPO $250**		**Renewal Plan - BCBSM Simply Blue PPO $250**		**Gold $3300 100% BCBSM Simply Blue PPO HSA**		**Silver $4500 100% BCBSM Simply Blue PPO HSA**	
Provider Network:	**(Current Billed Ages)**		**(Renewal Billed Ages)**		**Embedded Deductible & OOPM**		**Embedded Deductible & OOPM**	
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**BCBS National PPO**		**BCBS National PPO**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	**$3,300**	**$6,600**	**$4,500**	**$9,000**
Family	$500	$1,000	$500	$1,000	**$6,600**	**$13,200**	**$9,000**	**$18,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	**100%**	**80%**	**100%**	**80%**
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	**N/A**	**N/A**	**N/A**	**N/A**
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	**N/A**	**N/A**	**N/A**	**N/A**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	**$3,300**	**$8,600**	**$7,000**	**$14,000**
Family	$13,200	$26,400	$13,200	$26,400	**$6,600**	**$17,200**	**$14,000**	**$28,000**
In-Network Employee Copay:								
Office Visit	$20		$20		**0% after Deductible**		**0% after Deductible**	
Virtual Care Visit	$20		$20		**0% after Deductible**		**0% after Deductible**	
Specialist Visit	$40		$40		**0% after Deductible**		**0% after Deductible**	
Urgent Care	$60		$60		**0% after Deductible**		**0% after Deductible**	
Emergency Room	$150		$150		**0% after Deductible**		**0% after Deductible**	
Hospital Admission	20% after Deductible		20% after Deductible		**0% after Deductible**		**0% after Deductible**	
Employee In-Network RX Copay:					Rx Copays after Deductible		Rx Copays after Deductible	
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$10		$10		**0% after Deductible**		**$20**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**0% after Deductible**		**$60 / $150**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		**0% after Deductible**		**20% $300 Max / 25% $500 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		SB H.S.A. PPO Gold Option 3		SB H.S.A. PPO Silver Option 2	
Monthly / Annual Premium	$3,244.09	$38,929.08	$3,701.49	$44,417.88	$2,650.64	$31,807.68	$2,375.38	$28,504.56
$ Change from Current			**$457.40**	**$5,488.80**	**($593.45)**	**($7,121.40)**	**($868.71)**	**($10,424.52)**
% Change from Current			**14.10%**		**-18.29%**		**-26.78%**	

Medical Policy # 007005509-0000	**Current Plan** BCBSM Simply Blue PPO $250		**Renewal Plan -** BCBSM Simply Blue PPO $250		**Platinum** BCN HMO Elect Plus POS $0		**Platinum** BCN HMO Elect Plus POS $250	
Renewal Date: ***11/1/2025***								
Provider Network:	(Current Billed Ages)		(Renewal Billed Ages)					
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**BCN HMO / Blue Card Traditional**		**BCN HMO / Blue Card Traditional**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	**$0**	**$250**	$250	$500
Family	$500	$1,000	$500	$1,000	**$0**	**$500**	$500	$1,000
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	80%	60%	80%	60%
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	**N/A**	**N/A**	**N/A**	**N/A**
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	**N/A**	**N/A**	**N/A**	**N/A**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	**$3,000**	**$6,000**	**$4,500**	**$9,000**
Family	$13,200	$26,400	$13,200	$26,400	**$6,000**	**$12,000**	**$9,000**	**$18,000**
In-Network Employee Copay:								
Office Visit	$20		$20		$20		$20	
Virtual Care Visit	$20		$20		**$0***		**$0***	
Specialist Visit	$40		$40		**$30**		**$30**	
Urgent Care	$60		$60		**$35**		**$50**	
Emergency Room	$150		$150		$150		$150	
Hospital Admission	20% after Deductible		20% after Deductible		20% after Deductible		20% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$10		$10		**$4 / $15**		**$4 / $15**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$40 / $80		$40 / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		**20% $200 Max. / 20% $300 Max**		**20% $200 Max. / 20% $300 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		Blue Elect POS Platinum Option 1		Blue Elect POS Platinum Option 2	
Monthly / Annual Premium	$3,244.09	$38,929.08	$3,701.49	$44,417.88	$2,854.71	$34,256.52	$2,683.07	$32,196.84
$ Change from Current			**$457.40**	**$5,488.80**	**($389.38)**	**($4,672.56)**	**($561.02)**	**($6,732.24)**
% Change from Current			**14.10%**		**-12.00%**		**-17.29%**	

Medical Policy # 007005509-0000	**Current Plan BCBSM Simply Blue PPO $250**		**Renewal Plan - BCBSM Simply Blue PPO $250**		**Gold BCN HMO Elect Plus POS $500**		**Gold BCN HMO Elect Plus POS $1000**	
Renewal Date: 11/1/2025								
Provider Network:	**(Current Billed Ages)**		**(Renewal Billed Ages)**					
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**BCN HMO / Blue Card Traditional**		**BCN HMO / Blue Card Traditional**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	**$500**	**$1,000**	**$1,000**	**$2,000**
Family	$500	$1,000	$500	$1,000	**$1,000**	**$2,000**	**$2,000**	**$4,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	80%	60%	80%	60%
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	**$5,000**	**$10,000**	**$5,000**	**$10,000**
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	**$10,000**	**$20,000**	**$10,000**	**$20,000**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	**$9,100**	**$18,200**	**$9,100**	**$18,200**
Family	$13,200	$26,400	$13,200	$26,400	**$18,200**	**$36,400**	**$18,200**	**$36,400**
In-Network Employee Copay:								
Office Visit	$20		$20		**$30**		**$30**	
Virtual Care Visit	$20		$20		**$0***		**$0***	
Specialist Visit	$40		$40		**$50**		**$50**	
Urgent Care	$60		$60		**$50**		**$50**	
Emergency Room	$150		$150		**$250**		**$250**	
Hospital Admission	20% after Deductible		20% after Deductible		20% after Deductible		20% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$10		$10		$10 / **$30**		$10 / **$30**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**$60** / $80		**$60** / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		**20% $200 Max. / 20% $300 Max**		**20% $200 Max. / 20% $300 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		Blue Elect POS Gold Option 1		Blue Elect POS Gold Option 2	
Monthly / Annual Premium	$3,244.09	$38,929.08	$3,701.49	$44,417.88	$2,381.06	$28,572.72	$2,305.50	$27,666.00
$ Change from Current			**$457.40**	**$5,488.80**	**($863.03)**	**($10,356.36)**	**($938.59)**	**($11,263.08)**
% Change from Current			**14.10%**		**-26.60%**		**-28.93%**	

Medical Policy # 007005509-0000 ***Renewal Date: 11/1/2025***	**Current Plan** **BCBSM Simply Blue PPO $250** **(Current Billed Ages)**		**Renewal Plan -** **BCBSM Simply Blue PPO $250** **(Renewal Billed Ages)**		**Gold** **BCN HMO Elect Plus POS $1500**		**Gold** **BCN HMO Elect Plus POS $2000**	
Provider Network:								
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**BCN HMO / Blue Card Traditional**		**BCN HMO / Blue Card Traditional**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	$1,500	$3,000	$2,000	$4,000
Family	$500	$1,000	$500	$1,000	$3,000	$6,000	$4,000	$8,000
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	80%	60%	80%	60%
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	$5,000	$10,000	N/A	N/A
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	$10,000	$20,000	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	$9,100	$18,200	$7,350	$14,700
Family	$13,200	$26,400	$13,200	$26,400	$18,200	$36,400	$14,700	$29,400
In-Network Employee Copay:								
Office Visit	$20		$20		$30		$30	
Virtual Care Visit	$20		$20		$0*		$0*	
Specialist Visit	$40		$40		$50		$50	
Urgent Care	$60		$60		$50		$50	
Emergency Room	$150		$150		$250		$250	
Hospital Admission	20% after Deductible		20% after Deductible		20% after Deductible		20% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$10		$10		$10 / $30		$15 / $40	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$60 / $80		$80 / $100	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		Blue Elect POS Gold Option 3		Blue Elect POS Gold Option 4	
Monthly / Annual Premium	**$3,244.09**	**$38,929.08**	**$3,701.49**	**$44,417.88**	**$2,249.14**	**$26,989.68**	**$2,216.37**	**$26,596.44**
$ Change from Current			**$457.40**	**$5,488.80**	**($994.95)**	**($11,939.40)**	**($1,027.72)**	**($12,332.64)**
% Change from Current			**14.10%**		**-30.67%**		**-31.68%**	

Medical Policy # 007005509-0000 ***Renewal Date: 11/1/2025***	**Current Plan** **BCBSM Simply Blue PPO $250** **(Current Billed Ages)**		**Renewal Plan -** **BCBSM Simply Blue PPO $250** **(Renewal Billed Ages)**		**Platinum** **BCN Elect Plus POS HSA $1650 Deductible ($0)** **Aggregate**		**Gold** **BCN Elect Plus POS HSA $2500 Deductible ($0)** **Aggregate**	
Provider Network:								
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**BCN HMO / Blue Card Traditional**		**BCN HMO / Blue Card Traditional**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	**$1,650**	**$3,300**	**$2,500**	**$5,000**
Family	$500	$1,000	$500	$1,000	**$3,300**	**$6,600**	**$5,000**	**$10,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	**100%**	**80%**	**100%**	**80%**
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	**N/A**	**N/A**	**N/A**	**N/A**
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	**N/A**	**N/A**	**N/A**	**N/A**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	**$1,650**	**$3,300**	**$4,500**	**$9,000**
Family	$13,200	$26,400	$13,200	$26,400	**$3,300**	**$6,600**	**$9,000**	**$18,000**
In-Network Employee Copay:								
Office Visit	$20		$20		**0% after Deductible**		**0% after Deductible**	
Virtual Care Visit	$20		$20		**0% after Deductible**		**0% after Deductible**	
Specialist Visit	$40		$40		**0% after Deductible**		**0% after Deductible**	
Urgent Care	$60		$60		**0% after Deductible**		**0% after Deductible**	
Emergency Room	$150		$150		**0% after Deductible**		**0% after Deductible**	
Hospital Admission	20% after Deductible		20% after Deductible		**0% after Deductible**		**0% after Deductible**	
Employee In-Network RX Copay:					Rx Copays after Deductible		Rx Copays after Deductible	
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$10		$10		**0% after Deductible**		**$15 / $40**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**0% after Deductible**		**$80 / $100**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		**0% after Deductible**		**20% $200 Max. / 20% $300 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		Blue Elect Plus H.S.A. POS Platinum		Blue Elect Plus H.S.A. POS Gold Option	
Monthly / Annual Premium	$3,244.09	$38,929.08	$3,701.49	$44,417.88	$2,342.36	$28,108.32	$2,044.81	$24,537.72
$ Change from Current			**$457.40**	**$5,488.80**	**($901.73)**	**($10,820.76)**	**($1,199.28)**	**($14,391.36)**
% Change from Current			**14.10%**		**-27.80%**		**-36.97%**	

Medical Policy # 007005509-0000	**Current Plan BCBSM Simply Blue PPO $250**		**Renewal Plan - BCBSM Simply Blue PPO $250**		**Platinum $500 HAP PPO**		**Gold HAP PPO 1000**	
Renewal Date: ***11/1/2025***								
Provider Network:	**(Current Billed Ages)**		**(Renewal Billed Ages)**					
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**HAP PPO / Aetna PPO**		**HAP PPO / Aetna PPO**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	$500	$3,000	$1,000	$2,000
Family	$500	$1,000	$500	$1,000	$1,000	$6,000	$2,000	$4,000
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	100%	50%	80%	50%
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	N/A	N/A	N/A	N/A
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	$2,500	$20,000	$7,500	$20,000
Family	$13,200	$26,400	$13,200	$26,400	$5,000	$40,000	$15,000	$40,000
In-Network Employee Copay:								
Office Visit	$20		$20		$20		$35	
Virtual Care Visit	$20		$20		$0**		$0**	
Specialist Visit	$40		$40		$40		$60	
Urgent Care	$60		$60		$65		$65	
Emergency Room	$150		$150		$200		$300	
Hospital Admission	20% after Deductible		20% after Deductible		0% after Deductible		20% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**N/A**		**N/A**	
Tier 1 / 1A: Generic	$10		$10		$5 / $15		$5 / $25	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$30 / $60		$40 / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		20% $200 Max / 50% $500 Max		20% $200 Max / 50% $500 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		PPO Platinum A050		PPO Gold B1	
Monthly / Annual Premium	$3,244.09	$38,929.08	$3,701.49	$44,417.88	$3,360.81	$40,329.72	$2,665.00	$31,980.00
$ Change from Current			**$457.40**	**$5,488.80**	**$116.72**	**$1,400.64**	**($579.09)**	**($6,949.08)**
% Change from Current			**14.10%**		**3.60%**		**-17.85%**	

Medical Policy # 007005509-0000 ***Renewal Date: 11/1/2025***	**Current Plan** **BCBSM Simply Blue PPO $250** **(Current Billed Ages)**		**Renewal Plan - BCBSM Simply Blue PPO $250** **(Renewal Billed Ages)**		**Platinum** **Priority Health PPO 250 90%**		**Gold** **Priority Health PPO 500**	
Provider Network:								
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**Priority Health PPO / Cigna PPO**		**Priority Health PPO / Cigna PPO**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	$250	$500	**$500**	**$1,000**
Family	$500	$1,000	$500	$1,000	$500	$1,000	**$1,000**	**$2,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	**90%**	**70%**	80%	60%
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	**$2,000**	**$4,000**	**$5,500**	**$11,000**
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	**$4,000**	**$8,000**	**$11,000**	**$22,000**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	**$5,000**	**$10,000**	**$9,100**	**$18,200**
Family	$13,200	$26,400	$13,200	$26,400	**$10,000**	**$20,000**	**$18,200**	**$36,400**
In-Network Employee Copay:								
Office Visit	$20		$20		$20		**$30**	
Virtual Care Visit	$20		$20		**$10**		**$10**	
Specialist Visit	$40		$40		**$35**		**$50**	
Urgent Care	$60		$60		**$75**		**$85**	
Emergency Room	$150		$150		**$250 after Deductible**		**$250 after Deductible**	
Hospital Admission	20% after Deductible		20% after Deductible		**10% after Deductible**		20% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**N/A**		**N/A**	
Tier 1 / 1A: Generic	$10		$10		**$5 / $15**		**$5 / $35**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$40 / $80		**$80 / $95**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		**20% $200 Max / 20% $300 Max**		**20% $250 Max / 20% $450 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		PriorityPPO Platinum P259		PriorityPPO Gold G50	
Monthly / Annual Premium	**$3,244.09**	**$38,929.08**	**$3,701.49**	**$44,417.88**	**$3,749.16**	**$44,989.92**	**$3,179.61**	**$38,155.32**
$ Change from Current			**$457.40**	**$5,488.80**	**$505.07**	**$6,060.84**	**($64.48)**	**($773.76)**
% Change from Current			**14.10%**		**15.57%**		**-1.99%**	

Medical Policy # 007005509-0000 ***Renewal Date: 11/1/2025***	**Current Plan BCBSM Simply Blue PPO $250** **(Current Billed Ages)**		**Renewal Plan - BCBSM Simply Blue PPO $250** **(Renewal Billed Ages)**		**United Healthcare DX-1X**		**United Healthcare DX-1I**	
Provider Network:								
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**United Healthcare ChoicePlus**		**United Healthcare ChoicePlus**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	$500	$5,000	$1,000	$5,000
Family	$500	$1,000	$500	$1,000	$1,000	$10,000	$2,000	$10,000
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	80%	50%	80%	50%
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	N/A	N/A	N/A	N/A
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	$2,000	$10,000	$7,000	$10,000
Family	$13,200	$26,400	$13,200	$26,400	$4,000	$20,000	$14,000	$20,000
In-Network Employee Copay:								
Office Visit	$20		$20		$0		$0	
Virtual Care Visit	$20		$20		$0		$0	
Specialist Visit	$40		$40		$100		$100	
Urgent Care	$60		$60		$50		$50	
Emergency Room	$150		$150		$750 per Occ Ded, then 20% after		$750 Copay + 20% Coinsurance	
Hospital Admission	20% after Deductible		20% after Deductible		20% after Deductible		20% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**N/A**		**N/A**	
Tier 1 / 1A: Generic	$10		$10		$10		$10	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$40 / $105		$40 / $105	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		$250 / $500		$250 / $500	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Month Age 26		End of Month Age 26	
Pediatric Dental	Not Included		Not Included		Automatically Included		Automatically Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		N/A		N/A	
Monthly / Annual Premium	**$3,244.09**	**$38,929.08**	**$3,701.49**	**$44,417.88**	**$3,203.60**	**$38,443.20**	**$2,901.59**	**$34,819.08**
$ Change from Current			**$457.40**	**$5,488.80**	**($40.49)**	**($485.88)**	**($342.50)**	**($4,110.00)**
% Change from Current			**14.10%**		**-1.25%**		**-10.56%**	

BCBSM PPO Plan Disclaimers

1) Employee headcounts obtained from July 2025 census.
2) The Embedded Coinsurance Maximum excludes the deductible, office visit copay, prescription drug copays and private duty nursing coinsurance.
3) Final premium cost subject to change based on employee enrollment.
4) Dependent (Child) Cap - Health Care Reform regulations require a child rate cap of no more than three children under the age of 21, on a family contract. For example, a family with five children under the age of 21 would only be charged for the three oldest children. All dependents 21 and older will be rated.
5) The benefits shown in this section are not an insurance contract. The information provided is for illustrative purposes only. Please refer to the contract for the exact description and details.
6) United Healthcare Core Essential Plans are Only Available to Groups in Wayne, Oakland and Macomb Counties

*BCBSM Virtual Care Visit - Copay applies to Members 18 years of age or older, by a BCBSM Selected Vendor. Virtual Primary Care Visits by a non-BCBSM selected vendor are not covered
*BCN Medical Online Visits are covered 100% when received by a BCN Participating Provider or BCN Designated Online Vendor. Not all services virtually care considered an online visit but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.
**HAP Telehealth Visit is covered 100% when there contracted telehealth services provider is used

H.S.A. Plans
Aggregate - The Total Deductible or Out of Pocket Limit does not contain an individual limit. An individual is covered when the family deductible or out of pocket limit is met
Embedded - The plan contains and individual limit (stop) within the family total. The embeded stop occurs when an individuals deductible or out of pocket limit has been satisfied, but the family deductible or our of pocket limit hasn't

Benefit Improvements	Benefit Reductions

Dental Policy # 4554 *Renewal Date:* 11/1/2025		Current Delta Dental			Renewal Delta Dental			MetLife[2] *(Increase INN Max $500 if Sold w/ Vision)*	
Plan Provisions:		**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**	**In-Network**	**Out-of-Network**
Network / UCR		Delta USA		Non-Par Fee	Delta USA		Non-Par Fee	MetLife PDP Plus	90th
Single Deductible		$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible		$150	$150	$150	$150	$150	$150	$150	$150
Deductible Waived for Preventative			Yes			Yes		Yes	
Calendar Year Max Per Person			$1,500			$1,500		$1,500	
Pediatric Dental EHB (Small Group Only)			Included in Rates			Included in Rates		Included in Rates	
Maximum Rollover / Preventative Advantage			Not Included / Included			Not Included / Included		Not Included / Not Included	
Type I - Preventative Services:									
Cleanings (Oral Prophylaxis)		100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings		2x	2x	2x	2x	2x	2x	2x	2x
Exams / Flouride Treatments		100%	100%	100%	100%	100%	100%	100%	100%
X-Rays		100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:									
Fillings		80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery / Anesthesia		80%	80%	80%	80%	80%	80%	80%	80%
Periodontics / Endodontics		80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:									
Crowns / Onlays		50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures / Implants		50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontics:									
Orthodontics		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Orthodontic Lifetime Max			N/A			N/A		N/A	
Orthodontic Age Limit			N/A			N/A		N/A	
Plan Administration:									
Participation Requirement		Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees			Contributory-50% of EE's w/ Min. 10	
Dependent Age		To End of Year Age 26			To End of Year Age 26			To End of Month Age 26	
Hourly Requirement		30 or More Hours Per Week			30 or More Hours Per Week			30 Hours	
Headcounts / Rates:									
Single	**31**		**$52.21**			**$53.99**		**$43.58**	
EE & Spouse	**3**		**$96.07**			**$99.34**		**$80.19**	
EE & Child	**0**		**$96.07**			**$99.34**		**$80.19**	
EE & Children	**0**		**$160.99**			**$166.46**		**$134.37**	
Family	**5**		**$160.99**			**$166.46**		**$134.37**	
Total Enrolled	**39**								
Rate Guarantee Duration:					12 Months - Expires 11/01/2026			12 Months - Expires 11/01/2026	
Monthly / Annual Premium		$2,711.67		$32,540.04	$2,804.01		$33,648.12	$2,263.40	$27,160.80
$ Change from Current					**$92.34**		**$1,108.08**	($448.27)	($5,379.24)
% Change from Current						**3.41%**			-16.53%

Dental Policy # 4554 *Renewal Date:* 11/1/2025	Current Delta Dental			Renewal Delta Dental			UNUM	
Plan Provisions:	**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**	**In-Network**	**Out-of-Network**
Network / UCR	Delta USA		Non-Par Fee	Delta USA		Non-Par Fee	DenteMax	90th
Single Deductible	$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible	$150	$150	$150	$150	$150	$150	$150	$150
Deductible Waived for Preventative		Yes			Yes		Yes	
Calendar Year Max Per Person		$1,500			$1,500		$1,500	
Pediatric Dental EHB (Small Group Only)		Included in Rates			Included in Rates		Included in Rates	
Maximum Rollover / Preventative Advantage		Not Included / Included			Not Included / Included		Included / Not Included	
Type I - Preventative Services:								
Cleanings (Oral Prophylaxis)	100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings	2x	2x	2x	2x	2x	2x	2x	2x
Exams / Flouride Treatments	100%	100%	100%	100%	100%	100%	100%	100%
X-Rays	100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:								
Fillings	80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery / Anesthesia	80%	80%	80%	80%	80%	80%	80%	80%
Periodontics / Endodontics	80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:								
Crowns / Onlays	50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures / Implants	50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontics:								
Orthodontics	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Orthodontic Lifetime Max		N/A			N/A		N/A	
Orthodontic Age Limit		N/A			N/A		N/A	
Plan Administration:								
Participation Requirement	Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees			Minimum 10 Enrolled	
Dependent Age	To End of Year Age 26			To End of Year Age 26			To End of Year Age 26	
Hourly Requirement	30 or More Hours Per Week			30 or More Hours Per Week			30 Hours	
Headcounts / Rates:								
Single 31		**$52.21**			**$53.99**		**$46.37**	
EE & Spouse 3		**$96.07**			**$99.34**		**$91.37**	
EE & Child 0		**$96.07**			**$99.34**		**$121.93**	
EE & Children 0		**$160.99**			**$166.46**		**$121.93**	
Family 5		**$160.99**			**$166.46**		**$180.94**	
Total Enrolled 39								
Rate Guarantee Duration:				12 Months - Expires 11/01/2026			12 Months - Expires 11/01/2026	
Monthly / Annual Premium	$2,711.67		$32,540.04	$2,804.01		$33,648.12	$2,616.28	$31,395.36
$ Change from Current				**$92.34**		**$1,108.08**	($95.39)	($1,144.68)
% Change from Current					**3.41%**			-3.52%

		Current Delta Dental			Renewal Delta Dental			Guardian *(Package Sale - All Quoted Lines)*	
Dental Policy # **4554**									
Renewal Date:	***11/1/2025***								
Plan Provisions:		**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**	**In-Network**	**Out-of-Network**
Network / UCR		Delta USA		Non-Par Fee	Delta USA		Non-Par Fee	DentalGuard Preferred	90th
Single Deductible		$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible		$150	$150	$150	$150	$150	$150	$150	$150
Deductible Waived for Preventative			Yes			Yes		Yes	
Calendar Year Max Per Person			$1,500			$1,500		$1,500	
Pediatric Dental EHB (Small Group Only)			Included in Rates			Included in Rates		Included in Rates	
Maximum Rollover / Preventative Advantage			Not Included / Included			Not Included / Included		**Included / Included**	
Type I - Preventative Services:									
Cleanings (Oral Prophylaxis)		100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings		2x	2x	2x	2x	2x	2x	2x	2x
Exams / Flouride Treatments		100%	100%	100%	100%	100%	100%	100%	100%
X-Rays		100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:									
Fillings		80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery / Anesthesia		80%	80%	80%	80%	80%	80%	80%	80%
Periodontics / Endodontics		80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:									
Crowns / Onlays		50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures / Implants		50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontics:									
Orthodontics		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Orthodontic Lifetime Max			N/A			N/A		N/A	
Orthodontic Age Limit			N/A			N/A		N/A	
Plan Administration:									
Participation Requirement		Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees			Contributory-100% of EE's Enrolled	
Dependent Age		To End of Year Age 26			To End of Year Age 26			To End of Month Age 26	
Hourly Requirement		30 or More Hours Per Week			30 or More Hours Per Week			30 Hours	
Headcounts / Rates:									
Single	**31**		**$52.21**			**$53.99**		**$51.69**	
EE & Spouse	**3**		**$96.07**			**$99.34**		**$95.11**	
EE & Child	**0**		**$96.07**			**$99.34**		**$95.11**	
EE & Children	**0**		**$160.99**			**$166.46**		**$159.38**	
Family	**5**		**$160.99**			**$166.46**		**$159.38**	
Total Enrolled	**39**								
Rate Guarantee Duration:					12 Months - Expires 11/01/2026			12 Months - Expires 11/01/2026	
Monthly / Annual Premium		$2,711.67		$32,540.04	$2,804.01		$33,648.12	$2,684.62	$32,215.44
$ Change from Current					**$92.34**		**$1,108.08**	($27.05)	($324.60)
% Change from Current					**3.41%**			-1.00%	

Dental Policy # 4554 *Renewal Date:* 11/1/2025		Current Delta Dental			Renewal Delta Dental			UNUM - Option #1	
Plan Provisions:		**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**	**In-Network**	**Out-of-Network**
Network / UCR		Delta USA		Non-Par Fee	Delta USA		Non-Par Fee	DenteMax	**90th**
Single Deductible		$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible		$150	$150	$150	$150	$150	$150	$150	$150
Deductible Waived for Preventative			Yes			Yes		Yes	
Calendar Year Max Per Person			$1,500			$1,500		$1,500	
Pediatric Dental EHB (Small Group Only)			Included in Rates			Included in Rates		Included in Rates	
Maximum Rollover / Preventative Advantage			Not Included / Included			Not Included / Included		**Included / Not Included**	
Type I - Preventative Services:									
Cleanings (Oral Prophylaxis)		100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings		2x	2x	2x	2x	2x	2x	2x	2x
Exams / Flouride Treatments		100%	100%	100%	100%	100%	100%	100%	100%
X-Rays		100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:									
Fillings		80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery / Anesthesia		80%	80%	80%	80%	80%	80%	80%	80%
Periodontics / Endodontics		80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:									
Crowns / Onlays		50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures / Implants		50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontics:									
Orthodontics		N/A	N/A	N/A	N/A	N/A	N/A	**50%**	**50%**
Orthodontic Lifetime Max			N/A			N/A		**$1,000**	
Orthodontic Age Limit			N/A			N/A		**Through Age 18 and Under**	
Plan Administration:									
Participation Requirement		Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees			Minimum 10 Enrolled	
Dependent Age		To End of Year Age 26			To End of Year Age 26			To End of Year Age 26	
Hourly Requirement		30 or More Hours Per Week			30 or More Hours Per Week			30 Hours	
Headcounts / Rates:									
Single	**31**		**$52.21**			**$53.99**		**$46.37**	
EE & Spouse	**3**		**$96.07**			**$99.34**		**$91.37**	
EE & Child	**0**		**$96.07**			**$99.34**		**$127.85**	
EE & Children	**0**		**$160.99**			**$166.46**		**$127.85**	
Family	**5**		**$160.99**			**$166.46**		**$187.95**	
Total Enrolled	**39**								
Rate Guarantee Duration:					12 Months - Expires 11/01/2026			12 Months - Expires 11/01/2026	
Monthly / Annual Premium		$2,711.67		$32,540.04	$2,804.01		$33,648.12	$2,651.33	$31,815.96
$ Change from Current					**$92.34**		**$1,108.08**	($60.34)	($724.08)
% Change from Current						**3.41%**			**-2.23%**

Dental Policy # 4554 *Renewal Date:* 11/1/2025		Current Delta Dental			Renewal Delta Dental			MetLife[2] - Option #1 *(Increase INN Max $500 if Sold w/ Vision)*	
Plan Provisions:		**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**	**In-Network**	**Out-of-Network**
Network / UCR		Delta USA		Non-Par Fee	Delta USA		Non-Par Fee	MetLife PDP Plus	90th
Single Deductible		$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible		$150	$150	$150	$150	$150	$150	$150	$150
Deductible Waived for Preventative			Yes			Yes		Yes	
Calendar Year Max Per Person			$1,500			$1,500		$1,500	
Pediatric Dental EHB (Small Group Only)			Included in Rates			Included in Rates		Included in Rates	
Maximum Rollover / Preventative Advantage			Not Included / Included			Not Included / Included		Not Included / Not Included	
Type I - Preventative Services:									
Cleanings (Oral Prophylaxis)		100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings		2x	2x	2x	2x	2x	2x	2x	2x
Exams / Flouride Treatments		100%	100%	100%	100%	100%	100%	100%	100%
X-Rays		100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:									
Fillings		80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery / Anesthesia		80%	80%	80%	80%	80%	80%	80%	80%
Periodontics / Endodontics		80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:									
Crowns / Onlays		50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures / Implants		50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontics:									
Orthodontics		N/A	N/A	N/A	N/A	N/A	N/A	50%	50%
Orthodontic Lifetime Max			N/A			N/A		$1,000	
Orthodontic Age Limit			N/A			N/A		Through Age 18 and Under	
Plan Administration:									
Participation Requirement		Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees			Contributory-50% of EE's w/ Min. 10	
Dependent Age		To End of Year Age 26			To End of Year Age 26			To End of Month Age 26	
Hourly Requirement		30 or More Hours Per Week			30 or More Hours Per Week			30 Hours	
Headcounts / Rates:									
Single	**31**		**$52.21**			**$53.99**		**$44.27**	
EE & Spouse	**3**		**$96.07**			**$99.34**		**$81.46**	
EE & Child	**0**		**$96.07**			**$99.34**		**$81.46**	
EE & Children	**0**		**$160.99**			**$166.46**		**$136.51**	
Family	**5**		**$160.99**			**$166.46**		**$136.51**	
Total Enrolled	**39**								
Rate Guarantee Duration:						12 Months - Expires 11/01/2026		12 Months - Expires 11/01/2026	
Monthly / Annual Premium		$2,711.67		$32,540.04	$2,804.01		$33,648.12	$2,299.30	$27,591.60
$ Change from Current					**$92.34**		**$1,108.08**	($412.37)	($4,948.44)
% Change from Current						**3.41%**			-15.21%

Dental Plan Disclaimers

1) Employee headcounts obtained from July 2025 census.
2) Rates are contingent on a packaged sale.
3) Final premium cost subject to change based on employee enrollment (age banded rates only).
4) Some carriers offer multi-product discounts, if you move a line of coverage it may increase cost to other lines if this discount is in place.
5) If the pediatric essential health benefits are not included in the dental plan, the medical plan premium may increase. No one currently enrolled under age 19.
6) **Mutual of Omaha**: Late Entrant Waiting Period for Type B, C and Ortho is 12 Months.
7) **MMA/MetLife**: Late Entrant Waiting Period for Type B is 6 months (fillings)/12 months (other services), C and Ortho is 24 Months.
8) **Principal**: Late Entrant Waiting Period for Type B is 6 months (fillings)/12 months (other services), C and Ortho is 24 Months.
9) The benefits shown in this section are not an insurance contract. The information provided is for illustrative purposes only. Please refer to the contract for the exact description and details.

Vision Policy # 007005509-0000 & 00125981-0001 *Renewal Date:* 11/1/2025	Current Plan Blue Vision		Renewal Plan Blue Vision		UNUM		MetLife	
Plan Co-Payments:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Examinations	$5	Up to $34	$5	Up to $34	**$10**	**Up to $40**	$5	**Up to $45**
Materials	$10		$10		$10		$10	
Frequency (# of Months):	***Once Every:***		***Once Every:***		***Once Every:***		***Once Every:***	
Examinations	24		24		**12**		24	
Lenses / Contact Lenses	24		24		**12**		24	
Frames	24		24		24		24	
Plan Allowances:	***Up to:***		***Up to:***		***Up to:***		***Up to:***	
Single Vision Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$30**	Paid-in-Full[4]	**$30**
Bifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$50**	Paid-in-Full[4]	**$50**
Trifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$70**	Paid-in-Full[4]	**$65**
Lenticular Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$50**	Paid-in-Full[4]	**$100**
Frames	$130	$38.25	$130	$38.25	$130	**$91**	$130	**$70**
Medically Necessary Contacts	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210
Elective Contacts	$130	$100	$130	$100	$130	**$130**	$130	**$105**
Plan Provisions:								
Network	**VSP Choice**		**VSP Choice**		**EyeMed Insight**		**VSP Choice + MetLife Vision PPO**	
Contact Lenses in Lieu of Frames	No		No		**Yes**		**Yes**	
Dependent Age	To End of Year Age 26		To End of Year Age 26		To End of Year Age 26		To End of Year Age 26	
Participation Requirement	Sold with BCBSM Medical		Sold with BCBSM Medical		90% of Eligible Employees		35% of EE's with Min. 10 Enrolled	
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Headcounts / Rates:								
Single 33	**Age Banded**		**Age Banded**		**$4.88**		**$6.38**	
EE & Spouse 0	**Age Banded**		**Age Banded**		**$9.76**		**$12.80**	
EE & Child 1	**Age Banded**		**Age Banded**		**$10.68**		**$10.83**	
EE & Children 1	**Age Banded**		**Age Banded**		**$10.68**		**$10.83**	
Family 4	**Age Banded**		**Age Banded**		**$16.78**		**$17.87**	
Total Enrolled 39								
Rate Guarantee Duration			12 Months - Expires 11/01/2026		48 Months - Expires 11/01/2029		24 Months - Expires 11/01/2027	
Monthly / Annual Premium	$166.56	$1,998.72	$167.28	$2,007.36	$249.52	$2,994.24	$303.68	$3,644.16
$ Change from Current			**$0.72**	**$8.64**	**$82.96**	**$995.52**	**$137.12**	**$1,645.44**
% Change from Current			**0.43%**		**49.81%**		**82.32%**	

Vision Policy # 007005509-0000 & 00125981-0001 *Renewal Date:* 11/1/2025	Current Plan Blue Vision		Renewal Plan Blue Vision		Delta Vision		Guardian *(Package Sale - All Quoted Lines)*	
Plan Co-Payments:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Examinations	$5	Up to $34	$5	Up to $34	**$10**	**Up to $45**	**$10**	**Up to $39**
Materials	$10		$10		**$25**		$10	
Frequency (# of Months):	***Once Every:***		***Once Every:***		***Once Every:***		***Once Every:***	
Examinations	24		24		**12**		**12**	
Lenses / Contact Lenses	24		24		**12**		**12**	
Frames	24		24		24		**12**	
Plan Allowances:	***Up to:***		***Up to:***		***Up to:***		***Up to:***	
Single Vision Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$30**	Paid-in-Full[4]	**$23**
Bifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$50**	Paid-in-Full[4]	**$37**
Trifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$65**	Paid-in-Full[4]	**$49**
Lenticular Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$100**	Paid-in-Full[4]	**$64**
Frames	$130	$38.25	$130	$38.25	$130	**$70**	$130	**$46**
Medically Necessary Contacts	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210
Elective Contacts	$130	$100	$130	$100	$130	**$105**	$130	$100
Plan Provisions:								
Network	**VSP Choice**		**VSP Choice**		**VSP Choice**		**VSP Choice C**	
Contact Lenses in Lieu of Frames	No		No		**Yes**		**Yes**	
Dependent Age	To End of Year Age 26		To End of Year Age 26		To End of Year Age 26		End of Year Age 26	
Participation Requirement	Sold with BCBSM Medical		Sold with BCBSM Medical		Min. 2 Enrolled - Sold w/ Delta Dental		Contrib/Non Contrib/Voluntary	
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Headcounts / Rates:								
Single 33	**Age Banded**		**Age Banded**		**$6.23**		**$8.39**	
EE & Spouse 0	**Age Banded**		**Age Banded**		**$12.47**		**$15.88**	
EE & Child 1	**Age Banded**		**Age Banded**		**$13.34**		**$16.18**	
EE & Children 1	**Age Banded**		**Age Banded**		**$13.34**		**$16.18**	
Family 4	**Age Banded**		**Age Banded**		**$21.33**		**$25.62**	
Total Enrolled 39								
Rate Guarantee Duration			12 Months - Expires 11/01/2026		12 Months - Expires 11/01/2026		24 Months - Expires 11/01/2027	
Monthly / Annual Premium	**$166.56**	**$1,998.72**	**$167.28**	**$2,007.36**	**$317.59**	**$3,811.08**	**$411.71**	**$4,940.52**
$ Change from Current			**$0.72**	**$8.64**	**$151.03**	**$1,812.36**	**$245.15**	**$2,941.80**
% Change from Current			**0.43%**		**90.68%**		**147.18%**	

Vision Policy # 007005509-0000 & 00125981-0001 *Renewal Date:* 11/1/2025	Current Plan Blue Vision		Renewal Plan Blue Vision		UNUM - Option #1		MetLife - Option #1	
Plan Co-Payments:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Examinations	$5	Up to $34	$5	Up to $34	**$10**	**Up to $40**	$5	**Up to $45**
Materials	$10		$10		$10		$10	
Frequency (# of Months):	***Once Every:***		***Once Every:***		***Once Every:***		***Once Every:***	
Examinations	24		24		**12**		24	
Lenses / Contact Lenses	24		24		**12**		24	
Frames	24		24		24		24	
Plan Allowances:	***Up to:***		***Up to:***		***Up to:***		***Up to:***	
Single Vision Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$30**	Paid-in-Full[4]	**$30**
Bifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$50**	Paid-in-Full[4]	**$50**
Trifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$70**	Paid-in-Full[4]	**$65**
Lenticular Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$50**	Paid-in-Full[4]	**$100**
Frames	$130	$38.25	$130	$38.25	**$150**	**$105**	**$150**	**$70**
Medically Necessary Contacts	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210
Elective Contacts	$130	$100	$130	$100	**$150**	**$150**	**$150**	**$105**
Plan Provisions:								
Network	**VSP Choice**		**VSP Choice**		**EyeMed Insight**		**VSP Choice + MetLife Vision PPO**	
Contact Lenses in Lieu of Frames	No		No		**Yes**		**Yes**	
Dependent Age	To End of Year Age 26		To End of Year Age 26		To End of Year Age 26		To End of Year Age 26	
Participation Requirement	Sold with BCBSM Medical		Sold with BCBSM Medical		90% of Eligible Employees		35% of EE's with Min. 10 Enrolled	
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Headcounts / Rates:								
Single 33	**Age Banded**		**Age Banded**		**$5.29**		**$6.64**	
EE & Spouse 0	**Age Banded**		**Age Banded**		**$10.58**		**$13.31**	
EE & Child 1	**Age Banded**		**Age Banded**		**$11.53**		**$11.27**	
EE & Children 1	**Age Banded**		**Age Banded**		**$11.53**		**$11.27**	
Family 4	**Age Banded**		**Age Banded**		**$18.13**		**$18.57**	
Total Enrolled 39								
Rate Guarantee Duration			12 Months - Expires 11/01/2026		48 Months - Expires 11/01/2029		24 Months - Expires 11/01/2027	
Monthly / Annual Premium	$166.56	$1,998.72	$167.28	$2,007.36	**$270.15**	**$3,241.80**	**$315.94**	**$3,791.28**
$ Change from Current			**$0.72**	**$8.64**	**$103.59**	**$1,243.08**	**$149.38**	**$1,792.56**
% Change from Current			**0.43%**		**62.19%**		**89.69%**	

Vision Policy # 007005509-0000 & 00125981-0001 *Renewal Date:* 11/1/2025	Current Plan Blue Vision		Renewal Plan Blue Vision		Delta Vision - Option #1		Guardian - Option #1 *(Package Sale - All Quoted Lines)*	
Plan Co-Payments:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Examinations	$5	Up to $34	$5	Up to $34	$10	Up to $45	$10	Up to $39
Materials	$10		$10		$25		$10	
Frequency (# of Months):	***Once Every:***		***Once Every:***		***Once Every:***		***Once Every:***	
Examinations	24		24		12		12	
Lenses / Contact Lenses	24		24		12		12	
Frames	24		24		24		12	
Plan Allowances:	***Up to:***		***Up to:***		***Up to:***		***Up to:***	
Single Vision Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	$30	Paid-in-Full[4]	$23
Bifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	$50	Paid-in-Full[4]	$37
Trifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	$65	Paid-in-Full[4]	$49
Lenticular Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	$100	Paid-in-Full[4]	$64
Frames	$130	$38.25	$130	$38.25	$150	$70	$150	$46
Medically Necessary Contacts	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210
Elective Contacts	$130	$100	$130	$100	$150	$105	$150	$100
Plan Provisions:								
Network	VSP Choice		VSP Choice		VSP Choice		VSP Choice C	
Contact Lenses in Lieu of Frames	No		No		Yes		Yes	
Dependent Age	To End of Year Age 26		To End of Year Age 26		To End of Year Age 26		End of Year Age 26	
Participation Requirement	Sold with BCBSM Medical		Sold with BCBSM Medical		Min. 2 Enrolled - Sold w/ Delta Dental		Contrib/Non Contrib/Voluntary	
Hourly Requirement	30 Hours		30 Hours		__ Hours		30 Hours	
Headcounts / Rates:								
Single 33	Age Banded		Age Banded		$6.55		$9.01	
EE & Spouse 0	Age Banded		Age Banded		$13.09		$17.06	
EE & Child 1	Age Banded		Age Banded		$14.01		$17.38	
EE & Children 1	Age Banded		Age Banded		$14.01		$17.38	
Family 4	Age Banded		Age Banded		$22.38		$27.52	
Total Enrolled 39								
Rate Guarantee Duration			12 Months - Expires 11/01/2026		12 Months - Expires 11/01/2026		24 Months - Expires 11/01/2027	
Monthly / Annual Premium	$166.56	$1,998.72	$167.28	$2,007.36	$333.69	$4,004.28	$442.17	$5,306.04
$ Change from Current			$0.72	$8.64	$167.13	$2,005.56	$275.61	$3,307.32
% Change from Current			0.43%		100.34%		165.47%	

Vision Plan Disclaimers

1) Employee headcounts obtained from July 2025 census.
2) Rates are contingent on a packaged sale.
3) Final premium cost subject to change based on employee enrollment (age banded rates only).
4) Applicable copayments apply.
5) Some carriers offer multi-product discounts, if you move a line of coverage it may increase cost to other lines if this discount is in place.
6) The benefits shown in this section are not an insurance contract. The information provided is for illustrative purposes only. Please refer to the contract for the exact description and details.

Benefit Improvements

Benefit Reductions