2025-26 Medical Benefit Plan Comparisons and Costs

Benefit	B1 EPO COPAY ($$$)		B2 HIGH DEDUCTIBLE ($)		B3 EPO SPIRA CARE ($$)	
	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Network	BlueSelect Plus	No Coverage	BlueSelect Plus	N/A	BlueSelect Plus	No Coverage
Emergency Care Treated as In-Network	Yes	Yes	Yes	Yes	Yes	Yes
Access to Meritas Primary Care Providers	Yes - No Office Visit Copay	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	Yes- No Cost for Office Visit	No Coverage
Access to SPIRA Care Facilities	N/A	No Coverage	Yes	N/A	Yes	No Coverage
Deductible (individual/family) *Calendar Year	N/A	No Coverage	*$2,100/ $4,200 (Aggregate)	*$4,200/ $8,400 (Aggregate)	*$1,700/ $3,400 (Embedded)	No Coverage
Coinsurance	N/A	No Coverage	20% After Deductible	50% After Deductible	N/A	No Coverage
Out of Pocket Maximum (individual/family) *Calendar Year	*$6,500 / $13,000	No Coverage	*$4,500 / $9,000	*$25,000 / $50,000	*$1,700/ $3,400	No Coverage
PCP Office Visit (Non Meritas/SPIRA)/ Specialist Office Visit	$40/$80 Copay	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	No Coverage
Urgent Care Office Visit	$80 Copay	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	No Coverage
BlueKC Virtual Care Office Visit/Behavioral Health Visit	$10 Copay/ $40 Copay	No Coverage	Deductible/ Coinsurance	No Coverage	No Member Cost Share/$40 Copay	No Coverage
Mental Health Office Visit/Therapy	$0/$0 Copay	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/No Member Cost Share	No Coverage
Other Radiology (MRI, CT, PET, MRA)-Non SPIRA Locations	$300 Copay	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	No Coverage
Hospital Inpatient/ Outpatient Surgery	$750 Copay per Admit	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	No Coverage
Emergency Room	$300 Copay	$300 Copay	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	Deductible
Chiropractic Care Office Visit/Spinal Manipulation	$40 Copay/Covered at 100%	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Covered at 100%	No Coverage
Routine Eye Exam	$10 Copay	No Coverage	Covered at 100%/Deductible Waived	Deductible/ Coinsurance	Covered at 100%/Deductible Waived	No Coverage
Speech, Hearing, Physical & Occupational Therapy	No Member Cost Share	No Coverage	Deductible/ Coinsurance	Deductible/ Coinsurance	No Member Cost Share	No Coverage

Any discrepancy between this document and the Plan Certificate, the Plan Certificate will prevail.

Benefit	B1 EPO COPAY ($$$)		B2 HIGH DEDUCTIBLE ($)		B3 EPO SPIRA CARE ($$)	
	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Rx Generic (Up to 34 Day Supply)	$15 Copay	No Coverage	$15 Copay After Deductible	50% of Submitted Costs After Deductible then Applicable Copay	$10 Copay	No Coverage
Rx Preferred (Up to 34 Day Supply)	$55 Copay	No Coverage	$55 Copay After Deductible	50% of Submitted Costs After Deductible then Applicable Copay	$55 Copay	No Coverage
Rx Non-Preferred (Up to 34 Day Supply)	$80 Copay	No Coverage	$80 Copay After Deductible	50% of Submitted Costs After Deductible then Applicable Copay	$65 Copay	No Coverage
Rx Mail Order (35-102 Day Supply)	$45 generic / $165 preferred brand/$240 non-preferred brand	No Coverage	$45 generic/$165 preferred brand/$240 non-preferred brand	50% of Submitted Costs After Deductible then Applicable Copay	$30 generic / $165 preferred brand /$195 non-preferred brand	No Coverage

Pharmacy Network: Premium Formulary

B1 EPO Copay ($$$)	Total EE Monthly Plan Cost; *Total Monthly Retiree Cost*	Employee Monthly Contribution Paid By District	Employee Monthly Cost*		*Retiree Over Age 65 Monthly Cost*	*Cobra Monthly Cost*
Employee	$990.68	$910.00	$80.68		$1,089.76	$1,010.49
Employee + Spouse	$2,068.94	$910.00	$1,158.94		$2,275.84	$2,110.32
Employee + Child(ren)	$1,800.16	$910.00	$890.16		$1,980.18	$1,836.16
Family	$2,371.96	$910.00	$1,461.96		$2,609.16	$2,419.40
Family Split Premium**	$2,371.96	$1,820.00	$275.98		n/a	n/a

B2 High Deductible ($)	Total EE Monthly Plan Cost; *Total Monthly Retiree Cost*	Employee Monthly Contribution Paid By District	Employee Monthly Cost*	Employee Monthly HSA Contribution Paid By District *(Retiree Not Eligible)*	*Retiree Over Age 65 Monthly Cost*	*Cobra Monthly Cost*
Employee	$838.14	$766.28	$0.00	$71.86	$921.96	$854.90
Employee + Spouse	$1,750.38	$766.28	$912.24	$71.86	$1,925.42	$1,785.39
Employee + Child(ren)	$1,523.00	$766.28	$684.86	$71.86	$1,675.30	$1,553.46
Family	$2,006.76	$766.28	$1,168.62	$71.86	$2,207.44	$2,046.90
Family Split Premium**	$2,006.76	$1,532.56	$237.10	$287.44	n/a	n/a

B3 EPO/SPIRA Care ($$)	Total EE Monthly Plan Cost; *Total Monthly Retiree Cost*	Employee Monthly Contribution Paid By District	Employee Monthly Cost*		*Retiree Over Age 65 Monthly Cost*	*Cobra Monthly Cost*
Employee	$914.94	$910.00	$4.94		$1,006.44	$933.24
Employee + Spouse	$1,910.78	$910.00	$1,000.78		$2,101.86	$1,949.00
Employee + Child(ren)	$1,662.48	$910.00	$752.48		$1,828.74	$1,695.73
Family	$2,190.64	$910.00	$1,280.64		$2,409.70	$2,234.45
Family Split Premium**	$2,190.64	$1,820.00	$185.32		n/a	n/a

**With Wellness Credit (Complete Biometric Screening, HRA and Total Points) **Both spouse work for NKC S*n

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