2026 HOPE GAS BI-WEEKLY PREMIUMS

HSA ESSENTIAL	EMPLOYEE BI-WEEKLY PREMIUM	ANNUAL DEDUCTIBLE	OUT-OF-POCKET MAXIMUM (IN NETWORK)	OUT-OF-POCKET MAXIMUM (OUT OF NETWORK)	TYPE OF SERVICE	AFTER DEDUCTIBLE PARTICIPANT PAYS (IN NETWORK)	AFTER DEDUCTIBLE PARTICIPANT PAYS (OUT OF NETWORK)
EMPLOYEE ONLY	$19.18	$5,000	$6,900	$13,800	**Office Visits**	0%	50%
EMPLOYEE + SPOUSE	$65.13	$5000/$10,000	$6900/$13,800	$13,800/$27,600	**Urgent Care/ER**	0%	50%
EMPLOYEE + CHILDREN	$77.34	$5000/$10,000	$6900/$13,800	$13,800/$27,600	**Inpatient Hosp.**	0%	50%
EMPLOYEE + FAMILY	$104.59	$5000/$10,000	$6900/$13,800	$13,800/$27,600	**Prescriptions**	20%	20%

HSA PREMIUM	EMPLOYEE BI-WEEKLY PREMIUM	ANNUAL DEDUCTIBLE	OUT-OF-POCKET MAXIMUM (IN NETWORK)	OUT-OF-POCKET MAXIMUM (OUT OF NETWORK)	TYPE OF SERVICE	AFTER DEDUCTIBLE PARTICIPANT PAYS (IN NETWORK)	AFTER DEDUCTIBLE PARTICIPANT PAYS (OUT OF NETWORK)
EMPLOYEE ONLY	$21.92	$3,200	$3,200	$9,000	**Office Visits**	0%	50%
EMPLOYEE + SPOUSE	$73.79	$6,400	$6,400	$18,000	**Urgent Care/ER**	0%	50%
EMPLOYEE + CHILDREN	$87.51	$6,400	$6,400	$18,000	**Inpatient Hosp.**	0%	50%
EMPLOYEE + FAMILY	$118.39	$6,400	$6,400	$18,000	**Prescriptions**	0%	0%

PPO ESSENTIAL	EMPLOYEE BI-WEEKLY PREMIUM	ANNUAL DEDUCTIBLE	OUT-OF-POCKET MAXIMUM (IN NETWORK)	OUT-OF-POCKET MAXIMUM (OUT OF NETWORK)	TYPE OF SERVICE	AFTER DEDUCTIBLE PARTICIPANT PAYS (IN NETWORK)	AFTER DEDUCTIBLE PARTICIPANT PAYS (OUT OF NETWORK)
EMPLOYEE ONLY	$26.65	$1,500	$5,000	$10,000	**Office Visits**	20%	50%
EMPLOYEE + SPOUSE	$64.31	$1500/$3000	$5000/$10,000	$10,000/$20,000	**Urgent Care/ER**	20%	50%
EMPLOYEE + CHILDREN	$80.05	$1500/$3000	$5000/$10,000	$10,000/$20,000	**Inpatient Hosp.**	20%	50%
EMPLOYEE + FAMILY	$114.66	$1500/$3000	$5000/$10,000	$10,000/$20,000	**Prescriptions**	20%	20%

PPO PREMIUM	EMPLOYEE BI-WEEKLY PREMIUM	ANNUAL DEDUCTIBLE	OUT-OF-POCKET MAXIMUM (IN NETWORK)	OUT-OF-POCKET MAXIMUM (OUT OF NETWORK)	TYPE OF SERVICE	PARTICIPANT PAYS (IN NETWORK)	PARTICIPANT PAYS (OUT OF NETWORK)
EMPLOYEE ONLY	$62.77	$750	$3,000	$6,000	**Office Visits**	20%	50%
EMPLOYEE + SPOUSE	$131.78	$750/$1500	$3000/$6000	$6000/$12,000	**Urgent Care/ER**	20%	50%
EMPLOYEE + CHILDREN	$160.74	$750/$1500	$3000/$6000	$6000/$12,000	**Inpatient Hosp.**	20%	50%
EMPLOYEE + FAMILY	$225.99	$750/$1500	$3000/$6000	$6000/$12,000	**Prescriptions**	20%	20%

PEAK HEALTH	EMPLOYEE BI-WEEKLY PREMIUM	ANNUAL DEDUCTIBLE (Enhanced Network)	ANNUAL DEDUCTIBLE (Standard Network)	ANNUAL DEDUCTIBLE (Out of Network)	OUT-OF-POCKET MAXIMUM (In Network)	OUT-OF-POCKET MAXIMUM (Out of Network)
EMPLOYEE ONLY	$62.77	$0	$3,000	$6,000	$4,000	$8,000
EMPLOYEE + SPOUSE	$131.78	$0/$0	$3000/$6000	$6000/$12,000	$4000/$8000	$8000/$16,000
EMPLOYEE + CHILDREN	$160.74	$0/$0	$3000/$6000	$6000/$12,000	$4000/$8000	$8000/$16,000
EMPLOYEE + FAMILY	$225.99	$0/$0	$3000/$6000	$6000/$12,000	$4000/$8000	$8000/$16,000

TYPE OF SERVICE	PARTICIPANT PAYS (Enhanced Network)	PARTICIPANT PAYS (Standard Network)	PARTICIPANT PAYS (Out of Network)
Office Visits (Primary)	$10 copay	$30 copay (deductible waived)	No Benefits
Office Visits (Specialist)	$75 copay	$150 copay (deductible waived)	No Benefits
Urgent Care	$100 copay	$150 copay (deductible waived)	No Benefits
In Patient Hosp.	$0	$500 copay (subject to deductible)	No Benefits
Emergency Room	$500 copay, then 20% (copay waived if admitted)	$500 copay, then 20% (copay waived if admitted) No deductible required	$500 copay, then 20% (copay waived if admitted) No deductible required
Prescriptions	Generic $15 copay Formulary $45 copay Non-Formulary $90 copay Specialty $350 copay	Generic $15 copay Formulary $45 copay Non-Formulary $90 copay Specialty $350 copay	Generic $15 copay Formulary $45 copay Non-Formulary $90 copay Specialty $350 copay

DENTAL	EMPLOYEE BI-WEEKLY PREMIUM	ANNUAL DEDUCTIBLE (In Network)	ANNUAL DEDUCTIBLE (Out of Network)	ANNUAL MAXIMUM BENEFIT
EMPLOYEE ONLY	$5.00	$25	$75	$1,750
EMPLOYEE + SPOUSE	$10.00	$25/$75	$75/$225	$1,750
EMPLOYEE + CHILDREN	$12.00	$25/$75	$75/$225	$1,750
EMPLOYEE + FAMILY	$18.00	$25/$75	$75/$225	$1,750

VISION	EMPLOYEE BI-WEEKLY PREMIUM	EYE EXAM (In Network)	EYE EXAM (Out of Network)
EMPLOYEE ONLY	$2.00	$0	Up to $45
EMPLOYEE + SPOUSE	$4.00	$0	Up to $45 Per Person
EMPLOYEE + CHILDREN	$4.00	$0	Up to $45 Per Person
EMPLOYEE + FAMILY	$5.00	$0	Up to $45 Per Person