# 2026 EGTS BI-WEEKLY PREMIUMS

| HDHP PLAN<br>Includes HSA company contribution<br>$500 Individual, $1000 Family | VEBA CONTRIBUTION | EMPLOYEE BIWEEKLY PREMIUM | TOTAL | ANNUAL DEDUCTIBLE | OUT-OF-POCKET MAXIMUM (IN NETWORK) | OUT-OF-POCKET MAXIMUM (OUT OF NETWORK) |
|---|---|---|---|---|---|---|
| EMPLOYEE ONLY | $2.20 | $57.12 | $59.32 | $1,700 | $3,500 | $6,000 |
| EMPLOYEE + CHILDREN | $7.09 | $125.41 | $132.50 | $3,400 | $6,850 | $12,000 |
| EMPLOYEE + SPOUSE | $8.94 | $137.60 | $146.54 | $3,400 | $6,850 | $12,000 |
| EMPLOYEE + FAMILY | $13.24 | $217.57 | $230.81 | $3,400 | $6,850 | $12,000 |
| DOMESTIC PARTNER | $0.00 | $707.78 | $707.78 | $3,400 | $6,850 | $12,000 |

| TYPE OF SERVICE | PARTICIPANT PAYS (IN NETWORK) | PARTICIPANT PAYS (OUT OF NETWORK) |
|---|---|---|
| **Preventative Care** (Includes routine physicals, well-child, well-woman care, immunizations, vaccinations, mammograms, colonoscopies) | 0% | 40% after deductible |
| **Office Visits/Specialist visits** | 20% after deductible | 40% after deductible |
| **Ambulance** (Ground) | 20% after deductible | 40% after deductible |
| **Inpatient or Outpatient Services** | 20% after deductible | 40% after deductible |
| **Prescriptions** | Generic 20% after deductible<br>Formulary 30% after deductible<br>Nonformulary 40% after deductible | |

| COPAY PLAN | VEBA CONTRIBUTION | EMPLOYEE BIWEEKLY PREMIUM | TOTAL | ANNUAL DEDUCTIBLE | OUT-OF-POCKET MAXIMUM (IN NETWORK) | OUT-OF-POCKET MAXIMUM (OUT OF NETWORK) |
|---|---|---|---|---|---|---|
| EMPLOYEE ONLY | $4.63 | $60.60 | $65.23 | NONE | $3,500 | $7,000 |
| EMPLOYEE + CHILDREN | $12.70 | $133.15 | $145.85 | NONE | $3500 Individual<br>$6850 Family | $7000 Individual<br>$13,700 Family |
| EMPLOYEE + SPOUSE | $15.74 | $145.58 | $161.32 | NONE | $3500 Individual<br>$6850 Family | $7000 Individual<br>$13,700 Family |
| EMPLOYEE + FAMILY | $22.54 | $231.52 | $254.06 | NONE | $3500 Individual<br>$6850 Family | $7000 Individual<br>$13,700 Family |
| DOMESTIC PARTNER | $0.00 | $731.54 | $731.54 | NONE | $3,500 | $7,000 |

| TYPE OF SERVICE | PARTICIPANT COPAY (IN NETWORK) | PARTICIPANT COPAY (OUT OF NETWORK) |
|---|---|---|
| **Preventative Care** (Includes routine physicals, well-child, well-woman care, immunizations, vaccinations, mammograms, colonoscopies) | $0 copay | $60 copay |
| **Primary Care Office Visits** (includes walk-in clinics, chiropractor and labs/x-rays in office) | $30 copay | $60 copay |
| **Specialist Office Visits** (includes labs and x-rays in office) | $60 copay | $120 copay |
| **Advanced Imaging** (CT scan, PET scan, MRI including facility and physician charges) | $300 copay | $600 copay |
| **Ambulance** (Ground) | $300 copay | $600 copay |
| **Outpatient** (includes physician, lab and x-ray charges) | $800 copay | $1600 copay |
| **Inpatient** (includes physician, lab, x-ray and advanced imaging charges) | $1800 copay | $3600 copay |
| **Prescriptions** | Generic $15 copay<br>Formulary $75 copay<br>NonFormulary $150 copay | Generic $30 copay<br>Formulary $150 copay<br>NonFormulary $300 copay |

| DENTAL<br>Option 1 (with Ortho) | VEBA CONTRIBUTION | EMPLOYEE BIWEEKLY PREMIUM | TOTAL | DELTA DENTAL PPO ANNUAL DEDUCTIBLE | DELTA DENTAL PREMIER and OUT OF NETWORK ANNUAL DEDUCTIBLE | MAXIMUM BENEFIT |
|---|---|---|---|---|---|---|
| EMPLOYEE ONLY | $0.00 | $11.64 | $11.64 | $25 | $50 | $2,000 |
| EMPLOYEE + CHILDREN | $0.00 | $26.77 | $26.77 | $25 Individual<br>$75 Family | $50 Individual<br>$150 Family | $2000 Per Person |
| EMPLOYEE + SPOUSE | $0.00 | $23.28 | $23.28 | $25 Individual<br>$75 Family | $50 Individual<br>$150 Family | $2000 Per Person |
| EMPLOYEE + FAMILY | $0.00 | $37.65 | $37.65 | $25 Individual<br>$75 Family | $50 Individual<br>$150 Family | $2000 Per Person |
| DOMESTIC PARTNER | $0.00 | $23.28 | $23.28 | $25 Individual<br>$75 Family | $50 Individual<br>$150 Family | $2,000 |

| DENTAL<br>Option 2 (without Ortho) | VEBA CONTRIBUTION | EMPLOYEE BIWEEKLY PREMIUM | TOTAL | DELTA DENTAL PPO ANNUAL DEDUCTIBLE | DELTA DENTAL PREMIER and OUT OF NETWORK ANNUAL DEDUCTIBLE | MAXIMUM BENEFIT |
|---|---|---|---|---|---|---|
| EMPLOYEE ONLY | $0.00 | $7.07 | $7.07 | $25 | $50 | $1,000 |
| EMPLOYEE + CHILDREN | $0.00 | $16.24 | $16.24 | $25 Individual<br>$75 Family | $50 Individual<br>$150 Family | $1000 Per Person |
| EMPLOYEE + SPOUSE | $0.00 | $14.14 | $14.14 | $25 Individual<br>$75 Family | $50 Individual<br>$150 Family | $1000 Per Person |
| EMPLOYEE + FAMILY | $0.00 | $23.04 | $23.04 | $25 Individual<br>$75 Family | $50 Individual<br>$150 Family | $1000 Per Person |
| DOMESTIC PARTNER | $0.00 | $17.68 | $17.68 | $25 Individual<br>$75 Family | $50 Individual<br>$150 Family | $1,000 |

| VISION<br>New Frames every 24 Months<br>(up to $200) | VEBA CONTRIBUTION | EMPLOYEE BIWEEKLY PREMIUM | TOTAL | EYE EXAM CO-PAY | LENSES COPAY (IN-NETWORK) | CONTACT LENSES (IN-NETWORK) |
|---|---|---|---|---|---|---|
| EMPLOYEE ONLY | $0.00 | $1.73 | $1.73 | $10 | $25 | Up to $155 |
| EMPLOYEE + CHILDREN | $0.00 | $3.98 | $3.98 | $10 Per Person | $25 Per Person | Up to $155 per person |
| EMPLOYEE + SPOUSE | $0.00 | $3.45 | $3.45 | $10 Per Person | $25 Per Person | Up to $155 per person |
| EMPLOYEE + FAMILY | $0.00 | $5.62 | $5.62 | $10 Per Person | $25 Per Person | Up to $155 per person |
| DOMESTIC PARTNER | $0.00 | $3.46 | $3.46 | $10 | $25 | Up to $155 |

| VISION BUY UP<br>New Frames every 12 Months<br>(up to $250) | VEBA CONTRIBUTION | EMPLOYEE BIWEEKLY PREMIUM | TOTAL | EYE EXAM CO-PAY | LENSES COPAY (IN-NETWORK) | CONTACT LENSES (IN-NETWORK) |
|---|---|---|---|---|---|---|
| EMPLOYEE ONLY | $0.00 | $1.90 | $1.90 | $10 | $10 | Up to $200 |
| EMPLOYEE + CHILDREN | $0.00 | $4.39 | $4.39 | $10 Per Person | $10 Per Person | Up to $200 per person |
| EMPLOYEE + SPOUSE | $0.00 | $3.80 | $3.80 | $10 Per Person | $10 Per Person | Up to $200 per person |
| EMPLOYEE + FAMILY | $0.00 | $6.19 | $6.19 | $10 Per Person | $10 Per Person | Up to $200 per person |
| DOMESTIC PARTNER | $0.00 | $3.80 | $3.80 | $10 | $10 | Up to $200 |