

**2025 EGTS MONTHLY PREMIUMS**

<b>HDHP PLAN</b> Includes HSA company contribution \$500 Individual, \$1000 Family	<b>VEBA CONTRIBUTION</b>	<b>EMPLOYEE MONTHLY PREMIUM</b>	<b>TOTAL</b>	<b>ANNUAL DEDUCTIBLE</b>	<b>OUT-OF-POCKET MAXIMUM (IN NETWORK)</b>	<b>OUT-OF-POCKET MAXIMUM (OUT OF NETWORK)</b>	<b>TYPE OF SERVICE</b>	<b>PARTICIPANT PAYS (IN NETWORK)</b>	<b>PARTICIPANT PAYS (OUT OF NETWORK)</b>
EMPLOYEE ONLY	\$8.81	\$102.06	\$110.87	\$1,600	\$3,500	\$6,000	Preventative Care (Includes routine physicals, well-child, well-woman care, immunizations, vaccinations, mammograms, colonoscopies)	0%	40% after deductible
EMPLOYEE + CHILDREN	\$28.36	\$219.30	\$247.66	\$1600 Individual \$3200 Family	\$3500 Individual \$6850 Family	\$6000 Individual \$12,000 Family	Office Visits/Specialist visits	20% after deductible	40% after deductible
EMPLOYEE + SPOUSE	\$35.77	\$238.14	\$273.91	\$1600 Individual \$3200 Family	\$3500 Individual \$6850 Family	\$6000 Individual \$12,000 Family	Ambulance (Ground)	20% after deductible	40% after deductible
EMPLOYEE + FAMILY	\$52.96	\$378.46	\$431.42	\$1600 Individual \$3200 Family	\$3500 Individual \$6850 Family	\$6000 Individual \$12,000 Family	Inpatient or Outpatient Services	20% after deductible	40% after deductible
DOMESTIC PARTNER	\$0.00	\$652.14	\$652.14	\$1,600	\$3,500	\$6,000	Prescriptions	Generic 20% Formulary 30% Nonformulary 40%	Generic 20% Formulary 30% Nonformulary 40%

<b>COPAY PLAN</b>	<b>VEBA CONTRIBUTION</b>	<b>EMPLOYEE MONTHLY PREMIUM</b>	<b>TOTAL</b>	<b>ANNUAL DEDUCTIBLE</b>	<b>OUT-OF-POCKET MAXIMUM (IN NETWORK)</b>	<b>OUT-OF-POCKET MAXIMUM (OUT OF NETWORK)</b>	<b>TYPE OF SERVICE</b>	<b>PARTICIPANT COPAY (IN NETWORK)</b>	<b>PARTICIPANT COPAY (OUT OF NETWORK)</b>
EMPLOYEE ONLY	\$18.52	\$103.52	\$122.04	NONE	\$3,500	\$7,000	Preventative Care (Includes routine physicals, well-child, well-woman care, immunizations, vaccinations, mammograms, colonoscopies)	\$0 copay	\$60 copay
EMPLOYEE + CHILDREN	\$50.82	\$221.80	\$272.62	NONE	\$3500 Individual \$6850 Family	\$7000 Individual \$13,700 Family	Primary Care Office Visits (includes walk-in clinics, chiropractor and labs/x-rays in office)	\$30 copay	\$60 copay
EMPLOYEE + SPOUSE	\$62.94	\$238.58	\$301.52	NONE	\$3500 Individual \$6850 Family	\$7000 Individual \$13,700 Family	Specialist Office Visits (includes labs and x-rays in office)	\$60 copay	\$120 copay
EMPLOYEE + FAMILY	\$90.18	\$384.70	\$474.88	NONE	\$3500 Individual \$6850 Family	\$7000 Individual \$13,700 Family	Advanced Imaging (CT scan, PET scan, MRI including facility and physician charges)	\$300 copay	\$600 copay
DOMESTIC PARTNER	\$0.00	\$731.54	\$731.54	NONE	\$3,500	\$7,000	Ambulance (Ground)	\$300 copay	\$600 copay

<b>DENTAL Option 1 (with Ortho)</b>	<b>VEBA CONTRIBUTION</b>	<b>EMPLOYEE MONTHLY PREMIUM</b>	<b>TOTAL</b>	<b>ANNUAL DEDUCTIBLE</b>	<b>MAXIMUM BENEFIT</b>
EMPLOYEE ONLY	\$0.00	\$22.38	\$22.38	\$50	\$2,000
EMPLOYEE + CHILDREN	\$0.00	\$51.48	\$51.48	\$50 Per Person	\$2000 Per Person
EMPLOYEE + SPOUSE	\$0.00	\$44.78	\$44.78	\$50 Per Person	\$2000 Per Person
EMPLOYEE + FAMILY	\$0.00	\$72.40	\$72.40	\$50 Per Person	\$2000 Per Person
DOMESTIC PARTNER	\$0.00	\$44.80	\$44.80	\$50	\$2,000

Outpatient (includes physician, lab and x-ray charges)	\$800 copay	\$1600 copay
Inpatient (includes physician, lab, x-ray and advanced imaging charges)	\$1800 copay Generic \$15 copay Formulary \$75 copay NonFormulary \$150 copay	\$3600 copay Generic \$30 copay Formulary \$150 copay NonFormulary \$300 copay
Prescriptions		

<b>DENTAL Option 2 (without Ortho)</b>	<b>VEBA CONTRIBUTION</b>	<b>EMPLOYEE MONTHLY PREMIUM</b>	<b>TOTAL</b>	<b>ANNUAL DEDUCTIBLE</b>	<b>MAXIMUM BENEFIT</b>
EMPLOYEE ONLY	\$0.00	\$13.60	\$13.60	\$50	\$1,000
EMPLOYEE + CHILDREN	\$0.00	\$31.24	\$31.24	\$50 Per Person	\$1000 Per Person
EMPLOYEE + SPOUSE	\$0.00	\$27.20	\$27.20	\$50 Per Person	\$1000 Per Person
EMPLOYEE + FAMILY	\$0.00	\$44.32	\$44.32	\$50 Per Person	\$1000 Per Person
DOMESTIC PARTNER	\$0.00	\$33.64	\$33.64	\$50	\$1,000

<b>VISION (New Frames every 24 Months)</b>	<b>VEBA CONTRIBUTION</b>	<b>EMPLOYEE MONTHLY PREMIUM</b>	<b>TOTAL</b>	<b>EYE EXAM CO-PAY</b>
EMPLOYEE ONLY	\$0.00	\$3.36	\$3.36	\$10
EMPLOYEE + CHILDREN	\$0.00	\$7.74	\$7.74	\$10 Per Person
EMPLOYEE + SPOUSE	\$0.00	\$6.70	\$6.70	\$10 Per Person
EMPLOYEE + FAMILY	\$0.00	\$10.92	\$10.92	\$10 Per Person
DOMESTIC PARTNER	\$0.00	\$6.72	\$6.72	\$10

<b>VISION BUY UP (New Frames every 12 Months)</b>	<b>VEBA CONTRIBUTION</b>	<b>EMPLOYEE MONTHLY PREMIUM</b>	<b>TOTAL</b>	<b>EYE EXAM CO-PAY</b>
EMPLOYEE ONLY	\$0.00	\$3.70	\$3.70	\$10
EMPLOYEE + CHILDREN	\$0.00	\$8.52	\$8.52	\$10 Per Person
EMPLOYEE + SPOUSE	\$0.00	\$7.38	\$7.38	\$10 Per Person
EMPLOYEE + FAMILY	\$0.00	\$12.02	\$12.02	\$10 Per Person
DOMESTIC PARTNER	\$0.00	\$7.40	\$7.40	\$10