

**2025 HOPE GAS BI-WEEKLY PREMIUMS**

<b>HSA ESSENTIAL</b>	<b>EMPLOYEE BI-WEEKLY PREMIUM</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	\$17.44	\$5,000	\$6,900	\$13,800	Office Visits	0%	50%
EMPLOYEE + SPOUSE	\$59.21	\$5000/\$10,000	\$6900/\$13,800	\$13,800/\$27,600	Urgent Care/ER	0%	50%
EMPLOYEE + CHILDREN	\$70.31	\$5000/\$10,000	\$6900/\$13,800	\$13,800/\$27,600	Inpatient Hosp.	0%	50%
EMPLOYEE + FAMILY	\$95.09	\$5000/\$10,000	\$6900/\$13,800	\$13,800/\$27,600	Prescriptions	20%	20%

<b>HSA PREMIUM</b>	<b>EMPLOYEE BI-WEEKLY PREMIUM</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	\$19.92	\$3,200	\$3,200	\$9,000	Office Visits	0%	50%
EMPLOYEE + SPOUSE	\$67.08	\$3200/\$6400	\$3200/\$6400	\$9000/\$18,000	Urgent Care/ER	0%	50%
EMPLOYEE + CHILDREN	\$79.55	\$3200/\$6400	\$3200/\$6400	\$9000/\$18,000	Inpatient Hosp.	0%	50%
EMPLOYEE + FAMILY	\$107.63	\$3200/\$6400	\$3200/\$6400	\$9000/\$18,000	Prescriptions	0%	0%

<b>PPO ESSENTIAL</b>	<b>EMPLOYEE BI-WEEKLY PREMIUM</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	\$23.49	\$1,500	\$5,000	\$10,000	Office Visits	20%	50%
EMPLOYEE + SPOUSE	\$56.69	\$1500/\$3000	\$5000/\$10,000	\$10,000/\$20,000	Urgent Care/ER	20%	50%
EMPLOYEE + CHILDREN	\$70.56	\$1500/\$3000	\$5000/\$10,000	\$10,000/\$20,000	Inpatient Hosp.	20%	50%
EMPLOYEE + FAMILY	\$101.07	\$1500/\$3000	\$5000/\$10,000	\$10,000/\$20,000	Prescriptions	20%	20%

<b>PPO PREMIUM</b>	<b>EMPLOYEE BI-WEEKLY PREMIUM</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	\$53.65	\$750	\$3,000	\$6,000	Office Visits	20%	50%
EMPLOYEE + SPOUSE	\$112.64	\$750/\$1500	\$3000/\$6000	\$6000/\$12,000	Urgent Care/ER	20%	50%
EMPLOYEE + CHILDREN	\$137.39	\$750/\$1500	\$3000/\$6000	\$6000/\$12,000	Inpatient Hosp.	20%	50%
EMPLOYEE + FAMILY	\$193.16	\$750/\$1500	\$3000/\$6000	\$6000/\$12,000	Prescriptions	20%	20%

<b>PEAK HEALTH</b>	<b>EMPLOYEE BI-WEEKLY PREMIUM</b>	<b>ANNUAL DEDUCTIBLE (Enhanced Network)</b>	<b>ANNUAL DEDUCTIBLE (Standard Network)</b>	<b>ANNUAL DEDUCTIBLE (Out of Network)</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 (Enhanced Network)</b>	<b>PARTICIPANT PAYS (Standard Network)</b>	<b>PARTICIPANT PAYS (Out of Network)</b>
EMPLOYEE ONLY	\$53.65	\$0	\$3,000	\$6,000	\$4,000	\$8,000	Office Visits (Primary)	\$10 copay	\$30 copay (deductible waived)	No Benefits
EMPLOYEE + SPOUSE	\$112.64	\$0/\$0	\$3000/\$6000	\$6000/\$12,000	\$4000/\$8000	\$8000/\$16,000	Office Visits (Specialist)	\$75 copay	\$150 copay (deductible waived)	No Benefits
EMPLOYEE + CHILDREN	\$137.39	\$0/\$0	\$3000/\$6000	\$6000/\$12,000	\$4000/\$8000	\$8000/\$16,000	Urgent Care	\$100 copay	\$150 copay (deductible waived)	No Benefits
EMPLOYEE + FAMILY	\$193.16	\$0/\$0	\$3000/\$6000	\$6000/\$12,000	\$4000/\$8000	\$8000/\$16,000	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 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

<b>DENTAL</b>	<b>EMPLOYEE BI-WEEKLY PREMIUM</b>	<b>ANNUAL DEDUCTIBLE (In Network)</b>	<b>ANNUAL DEDUCTIBLE (Out of Network)</b>	<b>ANNUAL MAXIMUM BENEFIT</b>
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

<b>VISION</b>	<b>EMPLOYEE BI-WEEKLY PREMIUM</b>	<b>EYE EXAM (In Network)</b>	<b>EYE EXAM (Out of Network)</b>
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