# 2025 EGTS MONTHLY PREMIUMS

| HDHP PLAN<br>Includes HSA company contribution<br>$500 Individual, $1000 Family | VEBA CONTRIBUTION | EMPLOYEE MONTHLY PREMIUM | TOTAL | ANNUAL DEDUCTIBLE | OUT-OF-POCKET MAXIMUM (IN NETWORK) | OUT-OF-POCKET MAXIMUM (OUT OF NETWORK) |
|---|---|---|---|---|---|---|
| EMPLOYEE ONLY | $8.81 | $102.06 | $110.87 | $1,650 | $3,500 | $6,000 |
| EMPLOYEE + CHILDREN | $28.36 | $219.30 | $247.66 | $3,300 | $6,850 | $12,000 |
| EMPLOYEE + SPOUSE | $35.77 | $238.14 | $273.91 | $3,300 | $6,850 | $12,000 |
| EMPLOYEE + FAMILY | $52.96 | $378.46 | $431.42 | $3,300 | $6,850 | $12,000 |
| DOMESTIC PARTNER | $0.00 | $652.14 | $652.14 | $3,300 | $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 MONTHLY PREMIUM | TOTAL | ANNUAL DEDUCTIBLE | OUT-OF-POCKET MAXIMUM (IN NETWORK) | OUT-OF-POCKET MAXIMUM (OUT OF NETWORK) |
|---|---|---|---|---|---|---|
| EMPLOYEE ONLY | $18.52 | $103.52 | $122.04 | NONE | $3,500 | $7,000 |
| EMPLOYEE + CHILDREN | $50.82 | $221.80 | $272.62 | NONE | $3500 Individual<br>$6850 Family | $7000 Individual<br>$13,700 Family |
| EMPLOYEE + SPOUSE | $62.94 | $238.58 | $301.52 | NONE | $3500 Individual<br>$6850 Family | $7000 Individual<br>$13,700 Family |
| EMPLOYEE + FAMILY | $90.18 | $384.70 | $474.88 | 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 MONTHLY PREMIUM | TOTAL | ANNUAL DEDUCTIBLE | MAXIMUM BENEFIT |
|---|---|---|---|---|---|
| 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 |

| DENTAL<br>Option 2 (without Ortho) | VEBA CONTRIBUTION | EMPLOYEE MONTHLY PREMIUM | TOTAL | ANNUAL DEDUCTIBLE | MAXIMUM BENEFIT |
|---|---|---|---|---|---|
| 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 |

| VISION<br>(New Frames every 24 Months) | VEBA CONTRIBUTION | EMPLOYEE MONTHLY PREMIUM | TOTAL | EYE EXAM CO-PAY |
|---|---|---|---|---|
| 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 |

| VISION BUY UP<br>(New Frames every 12 Months) | VEBA CONTRIBUTION | EMPLOYEE MONTHLY PREMIUM | TOTAL | EYE EXAM CO-PAY |
|---|---|---|---|---|
| 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 |