Plan Year:
April 1, 2026 – March 31, 2027

IN-NETWORK	PPO PLAN		QHDHP PLAN	
	Choice 1 Provider	Choice 2 Provider	Choice 1 Provider	Choice 2 Provider
ANNUAL DEDUCTIBLE – Calendar Year				
Individual / Family	$3,000/$6,000	$6,000/$12,000	$3,500/$7,000	$7,000/$14,000
ANNUAL MAXIMUM OUT-OF-POCKET – Calendar Year				
Individual / Family	$8,550/$17,100		$7,500/$15,000	
COINSURANCE				
	0%	20% after ded.	0%	20% after ded.
PREVENTIVE CARE				
Annual Well Check, Immunizations, and Other Related Services	$0		$0	
FACILITY VISITS				
Telemedicine - VirtualCare	$5 copay (non-specialist)/ $40 copay (specialist)		$0 after ded.	
Primary Care	$20 copay	$40 copay	$0 after ded.	20% after ded.
Specialist Visits	$40 copay	$60 copay	$0 after ded.	20% after ded.
Inpatient Hospital	$0 after ded.	20% after ded.	$0 after ded.	20% after ded.
Outpatient Surgery	$0 after ded.	20% after ded.	$0 after ded.	20% after ded.
Emergency Room	$250 copay, waived if admitted		$250 copay after Choice 1 ded., waived if admitted	
Urgent Care	$75 copay		$75 copay after Choice 1 ded.	
OUTPATIENT DIAGNOSTIC SERVICES				
X-Ray Services	$0 after ded.	20% after ded.	$0 after ded.	20% after ded.
CT/PET Scan, MRI	$0 after ded.	20% after ded.	$0 after ded.	20% after ded.
PRESCRIPTIONS				
Generic Preferred	$4 copay		$7 copay after ded.	
Generic Nonpreferred	$15 copay		$25 copay after ded.	
Brand Preferred	$45 copay		$55 copay after ded.	
Brand Nonpreferred	$70 copay		$80 copay after ded.	
Mail Order – 90-day supply	2x retail		2x retail	
OUT-OF-NETWORK - Refer to Summary of Benefits and Coverage at www.hiltzbenefits.com/legal				
BI-WEEKLY COST FOR MEDICAL & PRESCRIPTION COVERAGE				
Employee Only	$34.00		$24.00	
Employee + Spouse	$353.00		$209.00	
Employee + Child(ren)	$257.00		$150.00	
Employee + Family	$572.00		$342.00	