

## 2026-27 Medical Benefit Plan Comparisons and Costs

Benefit	B1 EPO COPAY (\$\$\$)		B2 HIGH DEDUCTIBLE (\$)		B3 EPO SPIRA CARE(\$\$)	
	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Network	BlueSelect Plus	No Coverage	BlueSelect Plus	N/A	BlueSelect Plus	No Coverage
Emergency Care Treated as In-Network	Yes	Yes	Yes	Yes	Yes	Yes
Access to Meritas Primary Care Providers	Yes - No Office Visit Copay	No Coverage	Deductible/Coinsurance	Deductible/Coinsurance	Yes- No Cost for Office Visit	No Coverage
Access to SPIRA Care Facilities	N/A	No Coverage	Yes	N/A	Yes	No Coverage
Deductible (individual/family) *Calendar Year	N/A	No Coverage	*\$2,100/ \$4,200 (Aggregate)	*\$4,200/ \$8,400 (Aggregate)	*\$1,700/ \$3,400 (Embedded)	No Coverage
Coinsurance	N/A	No Coverage	20% After Deductible	50% After Deductible	N/A	No Coverage
Out of Pocket Maximum (individual/family) *Calendar Year	*\$6,500 / \$13,000	No Coverage	*\$4,500 / \$9,000	*\$25,000 / \$50,000	*\$1,700/ \$3,400	No Coverage
PCP Office Visit (Non Meritas/SPIRA)/ Specialist Office Visit	\$40/\$80 Copay	No Coverage	Deductible/Coinsurance	Deductible/Coinsurance	Deductible	No Coverage
Urgent Care Office Visit	\$80 Copay	No Coverage	Deductible/Coinsurance	Deductible/Coinsurance	Deductible	No Coverage
BlueKC Virtual Care Office Visit/Behavioral Health Visit	\$10 Copay/ \$40 Copay	No Coverage	Deductible/Coinsurance	No Coverage	No Member Cost Share/\$40 Copay	No Coverage
Mental Health Office Visit/Therapy	\$0/\$0 Copay	No Coverage	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/No Member Cost Share	No Coverage
Other Radiology (MRI, CT, PET, MRA)-Non SPIRA Locations	\$300 Copay	No Coverage	Deductible/Coinsurance	Deductible/Coinsurance	Deductible	No Coverage
Hospital Inpatient/ Outpatient Surgery	\$750 Copay per Admit	No Coverage	Deductible/Coinsurance	Deductible/Coinsurance	Deductible	No Coverage
Emergency Room	\$300 Copay	\$300 Copay	Deductible/Coinsurance	Deductible/Coinsurance	Deductible	Deductible
Chiropractic Care Office Visit/Spinal Manipulation	\$40 Copay/Covered at 100%	No Coverage	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Covered at 100%	No Coverage
Routine Eye Exam	\$10 Copay	No Coverage	Covered at 100%/Deductible Waived	Deductible/Coinsurance	Covered at 100%/Deductible Waived	No Coverage
Speech, Hearing, Physical & Occupational Therapy	No Member Cost Share	No Coverage	Deductible/Coinsurance	Deductible/Coinsurance	No Member Cost Share	No Coverage

Benefit	B1 EPO COPAY (\$\$\$)		B2 HIGH DEDUCTIBLE (\$)		B3 EPO SPIRA CARE(\$\$)	
	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Rx Generic (Up to 34 Day Supply)	\$15 Copay	No Coverage	\$15 Copay After Deductible	50% of Submitted Costs After Deductible then Applicable Copay	\$10 Copay	No Coverage
Rx Preferred (Up to 34 Day Supply)	\$55 Copay	No Coverage	\$55 Copay After Deductible	50% of Submitted Costs After Deductible then Applicable Copay	\$55 Copay	No Coverage
Rx Non-Preferred (Up to 34 Day Supply)	\$80 Copay	No Coverage	\$80 Copay After Deductible	50% of Submitted Costs After Deductible then Applicable Copay	\$65 Copay	No Coverage
Rx Mail Order (35-102 Day Supply)	\$45 generic / \$165 preferred brand/\$240 non-preferred brand	No Coverage	\$45 generic/\$165 preferred brand/\$240 non-preferred brand	50% of Submitted Costs After Deductible then Applicable Copay	\$30 generic / \$165 preferred brand /\$195 non-preferred brand	No Coverage

Pharmacy Network: Premium Formulary

B1 EPO Copay (\$\$\$)	Total EE Monthly Plan Cost; Total Monthly <i>Retiree</i> Cost	Employee Monthly Contribution Paid By District	Employee Monthly Cost*		Retiree Over Age 65 Monthly Cost	Cobra Monthly Cost
Employee	\$1,035.26	\$951.00	\$84.26		\$1,138.80	\$1,055.98
Employee + Spouse	\$2,162.04	\$951.00	\$1,211.04		\$2,378.26	\$2,205.28
Employee + Child(ren)	\$1,881.18	\$951.00	\$930.18		\$2,069.30	\$1,918.80
Family	\$2,478.70	\$951.00	\$1,527.70		\$2,726.58	\$2,528.28
Family Split Premium**	\$2,478.70	\$1,902.00	\$288.36		n/a	n/a

B2 High Deductible (\$)	Total EE Monthly Plan Cost; Total Monthly <i>Retiree</i> Cost	Employee Monthly Contribution Paid By District	Employee Monthly Cost*	Employee Monthly HSA Contribution Paid By District ( <i>Retiree Not Eligible</i> )	Retiree Over Age 65 Monthly Cost	Cobra Monthly Cost
Employee	\$875.86	\$951.00	\$0.00	\$75.14	\$963.46	\$893.38
Employee + Spouse	\$1,829.16	\$951.00	\$953.30	\$75.14	\$2,012.08	\$1,865.74
Employee + Child(ren)	\$1,591.54	\$951.00	\$715.68	\$75.14	\$1,750.70	\$1,623.38
Family	\$2,097.06	\$951.00	\$1,221.20	\$75.14	\$2,306.78	\$2,139.00
Family Split Premium**	\$2,097.06	\$1,902.00	\$172.68	\$150.28	n/a	n/a

B3 EPO/SPIRA Care (\$\$)	Total EE Monthly Plan Cost; Total Monthly <i>Retiree</i> Cost	Employee Monthly Contribution Paid By District	Employee Monthly Cost*		Retiree Over Age 65 Monthly Cost	Cobra Monthly Cost
Employee	\$956.12	\$951.00	\$5.12		\$1,051.74	\$975.24
Employee + Spouse	\$1,996.78	\$951.00	\$1,045.78		\$2,196.47	\$2,036.72
Employee + Child(ren)	\$1,737.30	\$951.00	\$786.30		\$1,911.04	\$1,772.06
Family	\$2,289.22	\$951.00	\$1,338.22		\$2,518.14	\$2,335.00
Family Split Premium**	\$2,289.22	\$1,902.00	\$193.62		n/a	n/a

\*With Wellness Credit (Complete Biometric Screening, HRA and Total Points)

\*\*Both employee & spouse work for NKC Schools electing Family Tier