SEPTEMBER 1, 2025 - AUGUST 31, 2026		
BCBS BLUE CARE NETWORK HMO	**Plan Choice #9 (BCN HMO) Compatible with FSA account**	**Plan Choice #10 (BCN HMO HSA) Compatible with HSA Account**
Plan Design	**In-Network**	**In-Network**
Deductible (Single/Family)	**$2,000/$4,000**	**$3,000 (need to meet before anything covered/$6,000 (2 or more members need to meet family deductible before anything is covered.**
Office Visit / Urgent Care	**$30 copay**	**80% after deductible**
Emergency Room	**$300 copay (waived if injury or if admitted)**	**80% after deductible**
Preventive Care	**100% (not subject to deductible)**	**100% (not subject to deductible)**
Coinsurance	**80% after deductible**	**80% after deductible**
Coinsurance Maximum (Single/Family) Not Including Deductible	**$1,500 / $3,000**	**N/A**
Prescription Drugs	**$15 Generic** **$50 Brand** **50% ($70 min/$100 max) Non Preferred Brand** **(Mail Order x 2)**	**$15 Generic after ded.** **$50 Brand after ded.** **50% ($70 min/$100 max) Non Preferred Brand after ded.** **(Mail Order x 2)**
Out-of-Pocket Maximum **In-Network includes applicable deductibles, coinsurance and copays. Out-of-Network excludes copays**	**$6,350 per member/$12,700 for 2 or more members per calendar year**	**$4,000 per member/$8,000 for 2 or more members per calendar year**
	YEARLY COST	**YEARLY COST**
Single	**$1,676.42**	**$225.95**
2-Person	**$3,506.18**	**$472.54**
Family	**$4,570.46**	**$616.24**
	PER PAY DEDUCTION **BEGINNING 9-10-25** **(OVER 20 PAYS)**	**PER PAY DEDUCTION** **BEGINNING 9-10-25** **(OVER 20 PAYS)**
Single	**$83.83**	**$11.30**
2-Person	**$175.31**	**$23.63**
Family	**$228.53**	**$30.82**