

CHT 2025 Plan Grid Summary



	Plan 4 Blue Saver \$1900 (Ind) / \$3800 (Fam) 100/80		Plan 42 Premier Blue Copay 80/60 \$1000A	
Deductible	In network	Non-network	In-network	Non-network
Individual	\$1,900	\$3,800	\$1,000	\$2,000
Family maximum	\$3,800	\$7,600	\$3,000	\$6,000
Out of pocket				
Individual	\$4,100	\$8,200	\$4,750	\$9,500
Family	\$8,200	\$16,400	\$9,500	\$19,000
Coinsurance				
Plan pays	100%	80%	80%	60%
Subscriber pays	0%	20%	20%	40%
Office Visits				
Primary care physician	0% After Ded.	20% After Ded.	\$35	40% After Ded.
Specialist	0% After Ded.	20% After Ded.	\$50	40% After Ded.
Urgent care	0% After Ded.	20% After Ded.	\$50	40% After Ded.
Preventative care	No Charge	20%	No Charge	40% After Ded.
Physical, Speech & Occupational Therapy	0% After Ded.	20% After Ded.	\$35	40% After Ded.
Mental/Behavioral Health	0% After Ded.	20% After Ded.	\$35	40% After Ded.
If you have a test				
Diagnostic test (x-ray, blood work)	0% After Ded.	20% After Ded.	20% After Ded.	40% After Ded.
Imaging (CT/PET scans)	0% After Ded.	20% After Ded.	20% After Ded.	40% After Ded.
Hospitalizations				
Inpatient	0% After Ded.	20% After Ded.	20% After Ded.	40% After Ded.
Outpatient	0% After Ded.	20% After Ded.	20% After Ded.	40% After Ded.
Emergency room visits	0% After Ded.	0% After Ded.	\$350	\$350
Prescription coverage	In-network	Mail-order	In-network	Mail-order
Prescription deductible	Integrated in Deductible		\$250 per person	
Tier 1	0% After Ded.	0% After Ded.	\$15	\$45
Tier 2	20% After Ded.	20% After Ded.	\$40	\$120
Tier 3	N/A	N/A	\$70	\$210
Tier 4	N/A	N/A	10% w/ \$150 Max	10% w/ \$150 Max

Disclaimer: This is a generalization of the Chambers Health Trust (CHT) Schedule of Benefits and in no way details or authorizes benefit information and payments. Please refer to the Blue Cross Policy for Plan ID# 78U22ERC for exact terms and conditions, or call Blue Cross Customer Service, 800-495-2583.

CHT 2025 Plan Grid Summary



	Plan 49 Premier Blue Copay 80/60 \$2000		Plan 11 Blue Saver \$3000 80/60	
Deductible	In network	Non-network	In-network	Non-network
Individual	\$2,000	\$4,000	\$3,000	\$6,000
Family maximum	\$6,000	\$12,000	\$6,000	\$12,000
Out of pocket				
Individual	\$5,750	\$11,500	\$5,000	\$10,000
Family	\$11,500	\$23,000	\$10,000	\$20,000
Coinsurance				
Plan pays	80%	60%	80%	60%
Subscriber pays	20%	40%	20%	40%
Office Visits				
Primary care physician	\$40	40% After Ded.	20% After Ded.	40% After Ded.
Specialist	\$55	40% After Ded.	20% After Ded.	40% After Ded.
Urgent care	\$55	40% After Ded.	20% After Ded.	40% After Ded.
Preventative care	No Charge	40% After Ded.	No Charge	40%
Physical, Speech & Occupational Therapy	\$40	40% After Ded.	20% After Ded.	40% After Ded.
Mental/Behavioral Health	\$40	40% After Ded.	20% After Ded.	40% After Ded.
If you have a test				
Diagnostic test (x-ray, blood work)	20% After Ded.	40% After Ded	20% After Ded.	40% After Ded.
Imaging (CT/PET scans)	20% After Ded.	40% After Ded	20% After Ded.	40% After Ded.
Hospitalizations				
Inpatient	20% After Ded.	40% After Ded.	20% After Ded.	40% After Ded.
Outpatient	20% After Ded.	40% After Ded.	20% After Ded.	40% After Ded.
Emergency room visits	\$350.	\$350	20% After Ded.	20% After Ded.
Prescription coverage	In-network	Mail-order	In-network	Mail-order
Prescription deductible	None		Integrated in Deductible	
Tier 1	\$7	\$21	20% After Ded.	20% After Ded.
Tier 2	\$30	\$90	40% After Ded.	40% After Ded.
Tier 3	\$70	\$210	N/A	N/A
Tier 4	10% w/ \$150 Max	10% w/ \$150 Max	N/A	N/A

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