

2026 Plan Summary Grid

| | | 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 through LIVINITI | | 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. For pharmacy benefits, call Liviniti Customer Service, 800-710-9341.

2026 Plan Summary Grid

| | 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 through LIVINITI | | In-network | Mail-order | In-network |
| 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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