Plan Year: July 1, 2025 – June 30, 2026	BASE PLAN	PREMIUM PLAN
IN-NETWORK		
ANNUAL DEDUCTIBLE – Plan Year (July 1 – June 30)		
Individual / Family	$1,000 / $2,000	Not applicable
ANNUAL MAXIMUM OUT-OF-POCKET – Plan Year (July 1 – June 30)		
Individual / Family	$3,500 / $7,000	$5,000 / $10,000
PRIMARY CARE PHYSICIAN SELECTION REQUIRED		
	No	No
REFERRAL REQUIRED FOR SPECIALIST VISIT		
	No	No
PREVENTIVE CARE		
Annual Well Check, Immunizations, and Other Related Services	$0	$0
FACILITY VISITS		
Telemedicine (Horizon CareOnline)	$15 copay	$15 copay
Primary Care	$20 copay	$15 copay
Specialist Visits	$40 copay	$25 copay
Inpatient Hospital	20% after deductible	$200 copay
Outpatient Surgery	20% after deductible	$50 copay
Emergency Room	$100 copay, then 20% (deductible does not apply)	$50 copay
Urgent Care	$40 copay	$25 copay
OUTPATIENT DIAGNOSTIC SERVICES		
X-Ray Services	Freestanding: $0 Hospital: 20% after deductible	$0
CT/PET Scan, MRI	20% after deductible	$0
PRESCRIPTIONS – SmithRx		
Tier 1 – Generic	$15 copay	$15 copay
Tier 2 – Preferred Brand	$35 copay	$35 copay
Tier 3 – Nonpreferred Brand	$50 copay	$50 copay
Mail Order – 90-day supply	2x retail	2x retail
OUT-OF-NETWORK - Refer to Summary of Benefits and Coverage at www.cpcbenefits.org/legal		

Be sure to verify if your current providers are in-network by searching for your specific plan at www.horizonblue.com.