# Educators Health Alliance
# 2025-26 Benefit Summary for PPO Health Coverage - Alternate Networks Option 2

| Benefit Plan | Preferred | Non-Preferred |
|---|---|---|
| **Each Subscriber may choose 1 of 3 Network Options:** | | |
| **Individual Deductible** | | |
| **Blueprint Health Deductible (Paired with $2,500 HSA-Eligible Plan)** | $400 | $800 |
| **Premier Select BlueChoice Deductible (Paired with $2,500 HSA-Eligible Plan)** | $400 | $800 |
| **NEtwork Blue Deductible (Paired with $3,800 HSA-Eligible Plan)** | $1,900 | $3,800 |
| **Family Deductible Maximum** | 2x Individual | 2x Individual |
| **Blueprint Health Coinsurance** | 20% | 40% |
| **Premier Select BlueChoice Coinsurance** | 20% | 40% |
| **NEtwork Blue Coinsurance** | 20% | 40% |
| **Individual Out-of-Pocket Maximum by Deductible Option** | | |
| **Blueprint Health Out-of-Pocket Maximum** | $6,000 | $12,000 |
| **Premier Select BlueChoice Out-of-Pocket Maximum** | $6,000 | $12,000 |
| **NEtwork Blue Out-of-Pocket Maximum** | $6,500 | $13,000 |
| **Family Out-of-Pocket Maximum** | 2x Individual | 2x Individual |
| ***Combined Maximum includes Deductible, Coinsurance, and Copays for all services including Prescription Drugs*** | | |
| **Lifetime Maximum** | Unlimited | |
| **Office Visit Copay** | | |
| Primary Copay | $35 | Ded & Coins |
| Specialist Copay | $55 | Ded & Coins |
| **Inpatient Hospital** | Ded & Coins | |
| **Outpatient Hospital** | Ded & Coins | |
| **Emergency Services** | | |
| Urgent Care | $55 Copay, Ded & Coins | |
| Emergency Room | $85 Copay, Ded & Coins | |
| **Prescription Drugs** | | |
| Generic Copay | 25% Coins ($10 minimum, $40 maximum) | |
| Formulary Brand Copay | 25% Coins ($50 minimum, $100 maximum) | |
| Non-Formulary Brand Copay | 50% Coins ($75 minimum, $150 maximum) | |
| In Network Specialty Copay (30 Day Supply) | 25% Coins ($125 minimum, $250 maximum) | |
| Out of Network Specialty Copay (30 Day Supply) | N/C | |
| Formulary Diabetic Supplies | 20% | |
| Non-Formulary Diabetic Supplies | 30% | |
| Mail Order Maximum | 180 Days Supply | |
| Mail Order Copay | 1 Copay per 30 Days Supply with 5 Copay Maximum | |
| Preauthorization Programs Included | Gastroprotective NSAIDs and Proton Pump Inhibitors | |
| **Preventive Services** | Covered at 100% | Ded & Coins |
| **Mental Health and Substance Abuse** | | |
| Inpatient | Ded & Coins | |
| Outpatient | Ded & Coins | |
| Office Visit | Covered at 100% | Ded & Coins |

Please note: This Schedule of Benefits Summary is intended to provide you with a brief overview of your benefits. It is not a contract and should not be regarded as one. For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the master group contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.