



2025-2026 Post-65 Retiree Health Plan Options

Supplemental Medical \$1,000 Deductible Plan with primary coverage Pharmacy Plan		
\$1,000 PPO		
		In Network
		OON
ER Copay		\$150
Deductible *		\$150
Single		
Family		\$1,000
		\$2,000
Coinsurance		20%
		50%
OOP Maximum		
Single		\$4,000
		\$8,000
Family		\$8,000
		\$16,000
Pharmacy Retail		\$10/20% + \$15/30% + \$20
Pharmacy Mail		\$0/20%/30% + \$15
Pharmacy Specialty Rx		\$10/20% + \$15/30% + \$20

Medicare Supplemental Type Plan Includes Medical Only		
		Plan Design
		No Network
OV Copay:		n/a
ER Surcharge		n/a
Urgent Care:		n/a
Deductible:		
Single:		n/a
		n/a
Two-party:		n/a
		n/a
Coinsurance:	Medicare Eligible	Non-Medicare Eligible
	0%	20%
OOP Maximum:	Medicare Eligible	Non-Medicare Eligible
Single:	\$0	\$2,000
Two-Party:	\$0	\$4,000
Pharmacy:		No Benefit

Preventative Procedures Covered at 100% In-network

Out of Pocket maximum includes deductibles and Medical and Pharmacy copays. Pharmacy counts towards in-network only.

* Deductible:

If you have family coverage, any combination of covered family members can help meet the maximum family deductible, up to each person's individual amount.

* Services not covered by Medicare may be covered under this plan subject to the Medical Schedule of Benefits.

*Post-65 Retirees choosing to enroll in this plan will not be allowed to change to other SCSD#1 health plans with prescription coverages.

*Retirees choosing this plan must find a Medicare Part D supplement for prescription coverage.

Stand-Alone Dental & Vision Plans

		Dental
*Deductible:		
Single		\$50
Two-Party		\$100
Diagnostic/Preventive		100% (Ded waived)
Basic Services		80%
Major Services		80%
Orthodontic		80%
Annual Benefit Maximum		\$2,000 per person
Lifetime Ortho Maximum		\$1,500 per person

Medical enrollment is not required to maintain Dental and/or Vision coverages.

		Vision
Eye Exam (1 per year)		100%
Lenses (1 set per year)		100% to \$350 Max
** or	Frames (1 pair per year)	100% to \$200 Max
	Elective Contacts (1x year)	100% to \$350 Max

One set of frames and lenses for glasses **OR one order of elective contact lenses allowed

*Deductible: If you have two-party coverage, any combination of covered members can help meet the maximum two-party deductible, up to each person's individual amount.

Flexible Spending Account (FSA)	
Plan Year 9/2023 - 8/2024	
Max Contribution	\$ 3,050

Health Savings Account	
Calendar Year 2023	
Max Contribution	\$ 3,850
	\$ 7,750
Catch-up (55+)	\$ 1,000
Calendar Year 2024	
Max Contribution	\$ 4,150
	\$ 8,300
Catch-up (55+)	\$ 1,000

nt (HSA)
23
Individual Family
24
Individual Family

Health Savings Account (HSA)		
Calendar Year 2023		
Max Contribution	\$ 3,850	Individual
	\$ 7,750	Family
Catch-up (55+)	\$ 1,000	
Calendar Year 2024		
Max Contribution	\$ 4,150	Individual
	\$ 8,300	Family
Catch-up (55+)	\$ 1,000	

Sweetwater County School District # 1 - Health Insurance Plan Options - Plan Year 9/2017 to 8/2018

Employee Information

Current Health Plan Grandfathered Plan			Option C Health Plan (Keeps Grandfathered Status)			Option D Health Plan			Option E Health Plan			Option F Health Plan			Option G Health Plan		
Current Design			Plan C			Plan D			Plan E			Plan F			Plan G		
In-Network			In Network			In Network			In Network			In Network			In Network		
OON			OON			OON			OON			OON			OON		
OV Copay	n/a	n/a	OV Copay	n/a	n/a	OV Copay	n/a	n/a	OV Copay	n/a	n/a	OV Copay	n/a	n/a	OV Copay	n/a	n/a
ER Surcharge	\$45	\$45	ER Surcharge	\$45	\$45	ER Surcharge	\$100	\$100	ER Surcharge	\$45	\$45	ER Surcharge	\$100	\$100	ER Surcharge	\$100	\$100
Urgent Care	20%	40%	Urgent Care	20%	40%	Urgent Care	20%	40%	Urgent Care	20%	40%	Urgent Care	20%	40%	Urgent Care	20%	50%
Deductible *			Deductible *			Deductible *			Deductible *			Deductible *			Deductible *		
Single	\$400 Combined w/Dental		Single	\$545 Combined w/Dental		Single	\$700	\$1,400	Single	\$700	\$1,400	Single	\$1,000	\$2,000	Single	\$1,200	\$2,400
Family	\$800 Combined w/Dental		Family	\$1,089 Combined w/Dental		Family	\$1,400	\$2,800	Family	\$1,400	\$2,800	Family	\$2,000	\$4,000	Family	\$2,400	\$4,800
Coinurance	20%	40%	Coinurance	20%	40%	Coinurance	20%	40%	Coinurance	20%	40%	Coinurance	20%	40%	Coinurance	20%	50%
OOP Maximum			OOP Maximum			OOP Maximum			OOP Maximum			OOP Maximum			OOP Maximum		
Single	\$2,000	\$2,000	Single	\$2,724	\$2,724	Single	\$2,500	\$5,000	Single	\$2,500	\$5,000	Single	\$4,000	\$8,000	Single	\$5,000	\$10,000
Family	\$4,000	\$4,000	Family	\$5,447	\$5,447	Family	\$5,000	\$10,000	Family	\$5,000	\$10,000	Family	\$8,000	\$16,000	Family	\$10,000	\$20,000
Pharmacy	\$0/20%/30%+\$15		Pharmacy	\$0/20%/30% + \$15		Pharmacy	\$0/20%/30% + \$15		Pharmacy	\$5/20%/30% + \$15		Pharmacy	\$10/20%/30% + \$15		Pharmacy	\$10/20%/30% + \$15	
			% Reduction-A/P65/O65	-1.83% (Medical Only)		% Reduction-A/P65/O65	-4.73% (Medical Only)		% Reduction-A/P65/O65	-9.04% (Medical and Rx)		% Reduction-A/P65/O65	-12.77% (Medical and Rx)		% Reduction-A/P65/O65	-16.29% (Medical and Rx)	
			% Reduction-A/P65			% Reduction-A/P65	-4.42% (Medical Only)		% Reduction-A/P65	-7.62% (Medical and Rx)		% Reduction-A/P65	-10.66% (Medical and Rx)		% Reduction-A/P65	-13.98% (Medical and Rx)	
Flexible Spending Account			Flexible Spending Account			Flexible Spending Account			Flexible Spending Account			Flexible Spending Account			Flexible Spending Account		
Max Contribution: \$	2,600		Max Contribution: \$	2,600		Max Contribution: \$	2,600		Max Contribution: \$	2,600		Max Contribution: \$	2,600		Max Contribution: \$	2,600	
Preventative Care:			Preventative Care:			Preventative Procedures Covered at 100%.			Preventative Procedures Covered at 100%.			Preventative Procedures Covered at 100%.			Preventative Procedures Covered at 100%.		
Maximum benefit per plan year is \$500.			Maximum benefit per plan year is \$500.			The \$500 maximum benefit limit			The \$500 maximum benefit limit			The \$500 maximum benefit limit			The \$500 maximum benefit limit		
After maximum is satisfied, amount paid by plan is generally 80%.			After maximum is satisfied, amount paid by plan is generally 80%.			does not apply.			does not apply.			does not apply.			does not apply.		
Combined Medical and Dental Deductible			Combined Medical and Dental Deductible			Optional Dental:			Optional Dental:			Optional Dental:			Optional Dental:		
Single deductible limit for family, etc.			Single deductible limit for family, etc.			Deductible - \$50/Individual, \$100/Family			Deductible - \$50/Individual, \$100/Family			Deductible - \$50/Individual, \$100/Family			Deductible - \$50/Individual, \$100/Family		
Medical, Dental, and Vision all included in a single premium			Medical, Dental, and Vision all included in a single premium			Separate Election			Separate Election			Separate Election			Separate Election		
Out of Pocket maximum does not include deductibles or Medical copays.			Out of Pocket maximum does not include deductibles or Medical copays.			Optional Vision:			Optional Vision:			Optional Vision:			Optional Vision:		
						No Change from Current Plan			No Change from Current Plan			No Change from Current Plan			No Change from Current Plan		
						Separate Election			Separate Election			Separate Election			Separate Election		
						Out of Pocket maximum does not include deductibles or Medical copays.			Out of Pocket maximum does not include deductibles or Medical copays.			Out of Pocket maximum includes deductibles and Medical and Pharmacy copays.			Out of Pocket maximum includes deductibles and Medical and Pharmacy copays.		

*Deductible:

If you have family coverage, any combination of covered family members can help meet the maximum family deductible, up to each person's individual amount.