

Patterson JUSD EPO Plans Effective 10/01/2026 - 09/30/2027					
MEMBER RESPONSIBILITY					
Annual Limits and Co-Insurance	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5
Calendar Year Deductible (Individual)	\$0	\$250	\$500	\$1,000	\$3,000
Calendar Year Deductible (Family)	\$0	\$500	\$1,000	\$2,000	\$6,000
Calendar Year Out-of-Pocket Maximum (Individual OOPM)	\$1,000	\$1,500	\$2,500	\$3,500	\$6,500
Calendar Year Out-of-Pocket Maximum (Family OOPM)	\$2,000	\$3,000	\$5,000	\$7,000	\$13,000
Coinsurance	No Charge	10% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible
Office Visits	MEMBER RESPONSIBILITY				
Preventive Care/Immunizations	No Charge	No Charge	No Charge	No Charge	No Charge
Doctor Visits (Primary Care)	\$0	\$10	\$20	\$25	30% After Deductible
Doctor Visits (Specialists)	\$0	\$20	\$40	\$50	30% After Deductible
Urgent Care	\$0	\$10	\$20	\$25	30% After Deductible
Chiropractic	\$0	\$10	\$20	\$25	30% After Deductible
Physical Therapy	\$0	10% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible
Prescriptions Drugs	MEMBER RESPONSIBILITY				
Tier 1	\$5 Copay	\$10 Copay	\$15 Copay	\$20 Copay	30% After Deductible
Tier 2	\$10 Copay	\$20 Copay	\$25 Copay	\$30 Copay	30% After Deductible
Tier 3	\$25 Copay	\$30 Copay	\$40 Copay	\$50 Copay	30% After Deductible
Tier 4	\$50 Copay	\$60 Copay	\$65 Copay	\$70 Copay	30% After Deductible
Mail Order - Tier 1/Tier 2	\$10/\$20 After Mail-In Reimbursement	\$20/\$40 After Mail-In Reimbursement	\$30/\$50 After Mail-In Reimbursement	\$40/\$60 After Mail-In Reimbursement	30% After Deductible

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Ambulance-Ground/Air	\$150 Copay	10% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible
Durable Medical Equipment	\$50 Copay	10% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible
Laboratory and Radiology	MEMBER RESPONSIBILITY				
Outpatient Diagnostic Tests and or Imaging	Quest/Free Standing Clinic \$0 Copay. Hospital Facility \$50 Lab Copay/ \$250 Imaging Copay	10% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible
Radiation Therapy Chemotherapy	\$0 Copay	10% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible
Substance Abuse and Mental Health	MEMBER RESPONSIBILITY				
Telephonic Medical Services	No Charge	No Charge	No Charge	No Charge	No Charge
Mental Health In & Out Patient	\$0 Copay	10% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible
Substance Abuse In & Out Patient	\$0 Copay	10% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible
Hospital	MEMBER RESPONSIBILITY				
Outpatient Surgery	\$250 Copay	10% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible
Hospital Inpatient	\$500 Admit Copay Then \$250 Per Day Up Two Days	10% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible
Emergency Room	\$250 Copay	10% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible
Home Health Care	\$100 Copay Per Visit (Limited to 100 Calendar Days Per Year)	10% After Deductible (Limited to 100 Calendar Days Per Year)	20% After Deductible (Limited to 100 Calendar Days Per Year)	20% After Deductible (Limited to 100 Calendar Days Per Year)	30% After Deductible (Limited to 100 Calendar Days Per Year)
2026-2027 Rates	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5
Employee Only	\$ 1,390.00	\$ 1,294.00	\$ 1,192.00	\$ 910.00	\$ 730.00
Employee + 1	\$ 2,391.00	\$ 2,226.00	\$ 2,050.00	\$ 1,566.00	\$ 1,254.00
Employee + 2 or more	\$ 3,016.00	\$ 2,808.00	\$ 2,585.00	\$ 1,974.00	\$ 1,583.00