2025-2026 EMPLOYEE BENEFITS

Click the links below to view the sections.

UpwardHealth®

06/04/2025

MEDICAL

You can find an in-network provider here & search the OAP (Open Access Plus) network.

Plan name	High PPO		Base EPO	HDHP with H.S.A**
Provider	Cigna		Cigna	Cigna
Benefit	**In-Network**	**Out-Network**	**In-Network**	**In-Network**
PLAN YEAR DEDUCTIBLE				
Individual	$500	$3,000	$1,000	Employee $3,000 Individual in Fam $3,300
Family	$1,250	$7,500	$2,500	Family Max $6,000
Coinsurance	Plan Pays: 90% / Member Pays:10%	Plan Pays: 70% / Member Pays:30%	Plan Pays: 80% / Member Pays:20%	Plan Pays: 80% / Member Pays:20%
UCR	N/A	150% of Medicare	N/A	N/A
OUT-OF-POCKET MAX				
Individual	$4,000	$7,500	$6,000	Employee $6,000 Individual in Fam $6,000
Family	$10,000	$18,750	$15,000	Family Max $12,000
PHYSICIAN SERVICES				
Preventative	Covered 100%	30% after Deductible	Covered 100%	Covered 100%
Physician visit (in office & virtual visit*)	$10 copay	30% after Deductible	$30 copay	20% after Deductible
Specialist visit (in office & virtual visit*)	$25 copay	30% after Deductible	$60 copay	20% after Deductible
HealthJoy virtual visits*	$0		$0	$0
HOSPITAL MEDICAL SERVICES				
Inpatient Hospital	10% after Deductible	30% after Deductible	20% after Deductible	20% after Deductible
Outpatient Surgery	10% after Deductible	30% after Deductible	20% after Deductible	20% after Deductible
Urgent Care	$50 Copay	30% after Deductible	$75 Copay	20% after Deductible
Emergency	$200 Copay		$500 Copay	20% after Deductible
RETAIL PRESCRIPTION (30 DAY SUPPLY)				
Deductible (Individual / Family)	$100 / $200	Covered 50%	$100 / $200	Combined with medical
Generic / Preferred Brand / Non-Preferred Brand	$10 / $35 / $70	Covered 50%	$10 / $35 / $70	Deductible, then $15 / $35 / $75

*Virtual visits are available through MDLive via mycigna.com for the listed copay, or $0 copay for virtual visits with HealthJoy.
**For the HDHP, Upward Health will contribute $1,000 for Employee only and $2,000 Employee and Dependents to your H.S.A.
***For any plan with out of network benefits: All reimbursements are subject to the plans UCR or Medicare Rate %. We suggest locating an in-network doctor.
*****To learn more about how out-of-network benefits work, click here.

Find an in-network Dental provider here
& search the PDP Plus network

DENTAL

Benefit	Low Plan		High Plan	
	Metlife PDP Plus Network		Metlife PDP Plus Network	
	In-Network	Out-Network[1]	In-Network	Out-Network[1]
Calendar Year Annual Maximum Per Individual / Per Benefit Year	$1,800		$3,300	
Calendar Year Deductible Per Individual / Per Family	$50 / $150		$50 / $150	
Preventive* **Basic**** **Major Services*****	100%, Ded Waived 80%, After Ded 50%, After Ded		100%, Ded Waived 90%, After Ded 60%, After Ded	
Orthodontia (Adults & children to age 26) **Orthodontia Lifetime Max**. (per individual)	50% $1,500		50% $3,000	

This Summary is for informational purposes only. For specific benefit information, please refer to the applicable Insurance Contract.

[1]Out-of-network claims are subject to 90th $ of the submitted charges.

**Preventative services cover oral exams, cleanings, routine x-rays, fluoride application, sealants, space maintainers, non-routine x-rays, emergency care to relieve pain*

*** Basic Services cover fillings, oral surgery, extraction of impacted teeth, anesthetics, periodontics, root canal/endodontics, and brush biopsy.*

*** Major Services cover relines, rebases, adjustments, repairs of bridges, crowns, inlays & dentures, stainless steel/resin crowns, dentures, bridges*

Note: you will not receive a physical ID card. Dental ID cards are digital only.

Find an in-network Vision provider here

VISION

Benefit	Blue View Vision	
	Anthem	
	In-Network	Out-Network
Eye Exams*	$10 copay	Reimbursed up to $42
Lenses*	$20 Copay	Up to $40 Single Up to $60 Bifocal Up to $80 Trifocal
Frames Allowance*	Up to $150 allowance + 20% off remaining balance	Reimbursed up to $45
Contact Lenses (Allowance) • Elective Disposable • Elective Non-Disposable • Medically Necessary	• Up to $150 allowance + 15% off remaining balance • Up to $150 allowance • Covered in full	• Reimbursed Up to $105 • Reimbursed Up to $105 • Reimbursed Up to $210

This Summary is for informational purposes only. For specific benefit information, please refer to the plan information.
*Once every 12 months

YOUR BENEFIT COSTS

Upward Health continues to pay a portion of your healthcare coverage. The chart below displays the contributions you would make for your choice of medical, dental, and/or vision plans. Your total contribution is automatically made through payroll deductions once you have made your elections.

Payroll Deductions	Employee Only		Employee / Spouse		Employee / Child(ren)		Employee / Family	
MEDICAL Cigna	**Per Paycheck**	**Monthly**	**Per Paycheck**	**Monthly**	**Per Paycheck**	**Monthly**	**Per Paycheck**	**Monthly**
High PPO	$114.95	$229.90	$229.90	$459.80	$199.29	$398.57	$300.64	$601.28
Base EPO	$69.94	$139.87	$139.88	$279.75	$118.53	$237.06	$167.11	$334.21
HDHP with HSA	$28.21	$56.41	$56.41	$112.82	$50.78	$101.55	$84.63	$169.26
DENTAL MetLife	**Per Paycheck**	**Monthly**	**Per Paycheck**	**Monthly**	**Per Paycheck**	**Monthly**	**Per Paycheck**	**Monthly**
Low Plan	$1.72	$3.44	$3.48	$6.96	$4.70	$9.40	$6.92	$13.84
High Plan	$6.58	$13.16	$13.34	$26.68	$18.04	$36.08	$26.58	$53.16
VISION Anthem	**Per Paycheck**	**Monthly**	**Per Paycheck**	**Monthly**	**Per Paycheck**	**Monthly**	**Per Paycheck**	**Monthly**
Blue View Vision	$0.74	$1.48	$1.26	$2.52	$1.28	$2.56	$2.03	$4.06

Be sure to review the plan disclosures and plan documents within the company benefits website or ask your employer for copies.