

2026-2027 EMPLOYEE BENEFITS

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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 w/in Fam: \$3,400
Family	\$1,250	\$7,500	\$2,500	Family: \$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 w/in Fam: \$6,000
Family	\$10,000	\$18,750	\$15,000	Family: \$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	-	\$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](#).

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

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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.

¹Out-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	
	Per Paycheck	Monthly	Per Paycheck	Monthly	Per Paycheck	Monthly	Per Paycheck	Monthly
MEDICAL								
High PPO	\$126.45	\$252.89	\$252.89	\$505.78	\$219.22	\$438.43	\$330.71	\$661.41
Base EPO	\$76.93	\$153.85	\$153.87	\$307.73	\$130.39	\$260.77	\$183.82	\$367.63
HDHP with HSA	\$31.03	\$62.05	\$62.05	\$124.10	\$55.86	\$111.71	\$93.09	\$186.18
DENTAL								
Base DPPO	\$1.89	\$3.78	\$3.83	\$7.66	\$5.17	\$10.34	\$7.61	\$15.22
DPPO Buy-Up	\$7.24	\$14.48	\$14.68	\$29.35	\$19.85	\$39.69	\$29.24	\$58.48
VISION								
Blue View Vision	\$0.74	\$1.48	\$1.26	\$2.52	\$1.28	\$2.56	\$2.03	\$4.06