The district pays: $566

Tipton R-VI School District
OSBA Choice Medical Plans (2025-2026)

PPO Plans

Coverage Level	500/1000 Choice PPO		1000/1500 Choice PPO		1500/2000 Choice PPO		2500/3000 Choice PPO	
Employee	$704.00		$665.00		$634.00		$610.00	
Employee + Spouse	$1,478.00		$1,397.00		$1,331.00		$1,281.00	
Employee + Child	$1,074.00		$1,014.00		$967.00		$930.00	
Employee + Child(ren)	$1,250.00		$1,180.00		$1,125.00		$1,083.00	
Employee + Family	$1,954.00		$1,845.00		$1,759.00		$1,693.00	
In-Network Services	**Blue Preferred Select/Blue Access**		**Blue Preferred Select/Blue Access**		**Blue Preferred Select/Blue Access**		**Blue Preferred Select/Blue Access**	
General Provisions	**Level 1 (BPS)**	**Level 2 (BA)**	**Level 1 (BPS)**	**Level 2 (BA)**	**Level 1 (BPS)**	**Level 2 (BA)**	**Level 1 (BPS)**	**Level 2 (BA)**
Deductible: Individual	$500	$1,000	$1,000	$1,500	$1,500	$2,000	$2,500	$3,000
Deductible: Family	$1,500	$3,000	$3,000	$4,500	$4,500	$6,000	$7,500	$9,000
Max out-of-pocket: Individual	$4,000	$5,000	$4,500	$5,500	$5,500	$6,500	$6,500	$7,500
Max out-of-pocket: Family	$8,000	$10,000	$9,000	$11,000	$11,000	$13,000	$13,000	$15,000
Copays & Coinsurance								
Primary Care Physician (PCP)	$25 Copay	$35 Copay	$25 Copay	$35 Copay	$25 Copay	$35 Copay	$25 Copay	$35 Copay
Specialists Physician	$50 Copay	$50 Copay	$60 Copay	$60 Copay	$60 Copay	$60 Copay	$60 Copay	$60 Copay
Virtual Primary Care Doctor Visits	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Live Health Online Doctor Visits	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay
Urgent Care Facility	$75 Copay	$75 Copay	$75 Copay	$75 Copay	$75 Copay	$75 Copay	$75 Copay	$75 Copay
Hospitalization: Emergency Room	$250 Copay	$250 Copay	$250 Copay	$250 Copay	$300 Copay	$300 Copay	$300 Copay	$300 Copay
Hospitalization: Inpatient	20% after Deductible	20% after Deductible	30% after Deductible	30% after Deductible	30% after Deductible	30% after Deductible	30% after Deductible	30% after Deductible
Hospitalization: Outpatient	20% after Deductible	20% after Deductible	30% after Deductible	30% after Deductible	30% after Deductible	30% after Deductible	30% after Deductible	30% after Deductible
Prescriptions Copays								
Prescription Drug Plan	$15/$45/$75/25% Max $200	$15/$45/$75/25% Max $200	$15/$45/$75/25% Max $200	$15/$45/$75/25% Max $200	$15/$45/$75/25% Max $200	$15/$45/$75/25% Max $200	$15/$45/$75/25% Max $200	$15/$45/$75/25% Max $200
Limited Preventative RX Plus	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Out-Of-Network Services	**Level 3 (Out of Network)**		**Level 3 (Out of Network)**		**Level 3 (Out of Network)**		**Level 3 (Out of Network)**	
Deductible: Individual	$4,000		$5,000		$6,000		$8,000	
Deductible: Family	$12,000		$15,000		$18,000		$24,000	
Maximum out-of-pocket: Individual	$10,000		$11,000		$13,000		$15,000	
Maximum out-of-pocket: Family	$20,000		$22,000		$26,000		$30,000	

The district pays: $566

Tipton R-VI School District
OSBA Choice Medical Plans (2025-2026)

HSA Plans

Coverage Level	3300/3300 Choice HSA		4000/4500 Choice HSA		4500/5500 Choice HSA		6000/6500 Choice HSA	
Employee	$595.00		$548.00		$529.00		$487.00	
Employee + Spouse	$1,250.00		$1,151.00		$1,111.00		$1,023.00	
Employee + Child	$907.00		$836.00		$807.00		$743.00	
Employee + Child(ren)	$1,056.00		$973.00		$939.00		$864.00	
Employee + Family	$1,651.00		$1,521.00		$1,468.00		$1,351.00	
In-Network Services	**Blue Preferred Select/Blue Access**		**Blue Preferred Select/Blue Access**		**Blue Preferred Select/Blue Access**		**Blue Preferred Select/Blue Access**	
General Provisions	**Level 1 (BPS)**	**Level 2 (BA)**	**Level 1 (BPS)**	**Level 2 (BA)**	**Level 1 (BPS)**	**Level 2 (BA)**	**Level 1 (BPS)**	**Level 2 (BA)**
Deductible: Individual	$3,300	$3,300	$4,000	$4,500	$4,500	$5,500	$6,000	$6,500
Deductible: Family	$6,600	$6,600	$8,000	$9,000	$9,000	$11,000	$12,000	$13,000
Max out-of-pocket: Individual	$4,300	$4,800	$5,500	$6,500	$6,000	$6,500	$6,900	$7,400
Max out-of-pocket: Family	$8,600	$9,600	$11,000	$13,000	$12,000	$13,000	$13,800	$14,800
Copays & Coinsurance								
Primary Care Physician (PCP)	$0 Copay after Deductible	$30 Copay after Deductible	$30 Copay after Deductible	$30 Copay after Deductible	$30 Copay after Deductible	$30 Copay after Deductible	$30 Copay after Deductible	$30 Copay after Deductible
Specialists Physician	$0 Copay after Deductible	$60 Copay after Deductible	$60 Copay after Deductible	$60 Copay after Deductible	$60 Copay after Deductible	$60 Copay after Deductible	$60 Copay after Deductible	$60 Copay after Deductible
Virtual Primary Care Doctor Visits	$0 Copay after Deductible	$0 Copay after Deductible	$0 Copay after Deductible	$0 Copay after Deductible	$0 Copay after Deductible	$0 Copay after Deductible	$0 Copay after Deductible	$0 Copay after Deductible
Live Health Online Doctor Visits	$0 Copay after Deductible	$10 Copay after Deductible	$10 Copay after Deductible	$10 Copay after Deductible	$10 Copay after Deductible	$10 Copay after Deductible	$10 Copay after Deductible	$10 Copay after Deductible
Urgent Care Facility	$0 Copay after Deductible	$75 Copay after Deductible	$75 Copay after Deductible	$75 Copay after Deductible	$75 Copay after Deductible	$75 Copay after Deductible	$75 Copay after Deductible	$75 Copay after Deductible
Hospitalization: Emergency Room	$0 Copay after Deductible	$300 Copay after Deductible	$300 Copay after Deductible	$300 Copay after Deductible	$300 Copay after Deductible	$300 Copay after Deductible	$300 Copay after Deductible	$300 Copay after Deductible
Hospitalization: Inpatient	0% after Deductible	0% after Deductible	20% after Deductible	20% after Deductible	20% after Deductible	20% after Deductible	0% after Deductible	20% after Deductible
Hospitalization: Outpatient	0% after Deductible	0% after Deductible	20% after Deductible	20% after Deductible	20% after Deductible	20% after Deductible	0% after Deductible	20% after Deductible
Prescriptions Copays								
Prescription Drug Plan	$15/$45/$75/25% Max $200 (after ded)	$15/$45/$75/25% Max $200 (after ded)	$15/$45/$75/25% Max $200 (after ded)	$15/$45/$75/25% Max $200 (after ded)	$15/$45/$75/25% Max $200 (after ded)	$15/$45/$75/25% Max $200 (after ded)	$15/$45/$75/25% Max $200 (after ded)	$15/$45/$75/25% Max $200 (after ded)
Limited Preventative RX Plus	0%	0%	0%	0%	0%	0%	0%	0%
Out-Of-Network Services	**Level 3 (Out of Network)**		**Level 3 (Out of Network)**		**Level 3 (Out of Network)**		**Level 3 (Out of Network)**	
Deductible: Individual	$8,000		$11,000		$13,000		$13,500	
Deductible: Family	$16,000		$22,000		$26,000		$27,000	
Maximum out-of-pocket: Individual	$12,250		$16,625		$17,250		$18,250	
Maximum out-of-pocket: Family	$25,000		$33,250		$35,000		$36,500	

*Red text indicates plan changes from prior plan year.

OSBA Dental Plans 2025-2026

Coverage Level	High Plan	Low Plan
Employee	$46.00	$28.00
Employee + Spouse	$92.00	$56.00
Employee + Child	$87.00	$53.00
Employee + Children	$116.00	$67.00
Employee + Family	$154.00	$91.00
General Provisions, Copays & Coinsurance	**In Network Services**	**In Network Services**
Annual Max Benefit	$2,000	$1,750
Deductible: Individual	$50	$50
Deductible: Family	$150	$150
Preventative Services	100%	100%
Minor Restorative	90%	80%
Oral Surgery, Endodontic, Periodontal, Prosthodontic	60% (Dental Implants Included)	50% (Dental Implants NOT Included)
Orthodontics	50% ($1,250 Lifetime max benefit)	No Coverage

OSBA Vision Plan

Coverage Level	Platinum Plan
Employee	$10.97
Employee + Spouse	$17.56
Employee + Children	$20.27
Employee + Family	$34.44
General Provisions, Copays & Coinsurance	**In Network Services**
Benefit Period	12 Months
Routine Eye Exam	$15 Copay
Eyeglass Frames	$180 Allowance
Eyeglass Lenses (Standard Plastic: single, bifocal, trifocal)	$15 Copay
*Progressive Lenses & Eyeglass Lens Upgrades	$0-68 Copay
Contacts (in place of glasses)	$180 Allowance