# HEALTH PLAN BENEFITS AT-A-GLANCE 2026

St. Jude Children's Research Hospital

| PLAN PROVISION | | IN-NETWORK | | OUT-OF-NETWORK | |
|---|---|---|---|---|---|
| | | Select PPO | Choice PPO | Select PPO | Choice PPO |
| **Calendar Year Deductible** | | Per Person: $300<br>Max Per Family: $900 | Per Person: $450<br>Max Per Family: $1,350 | Per Person: $550<br>Max Per Family: $1,650 | Per Person: $850<br>Max Per Family: $2,550 |
| **Calendar Year Out-Of-Pocket Maximum*** | **Medical** | Per Person: $2,000<br>Max Per Family: $4,000 | Per Person: $3,000<br>Max Per Family: $5,000 | Per Person: $3,000<br>Max Per Family: $5,000 | Per Person: $4,000<br>Max Per Family: $6,000 |
| | **Prescription Drug** | Per Person: $2,000<br>Max Per Family: $4,000 | Per Person: $3,000<br>Max Per Family: $5,000 | No Coverage | |
| **Physician Office Visit** | | $15 Co-Pay | $15 Co-Pay | 30% after deductible | 40% after deductible |
| **Coinsurance** *(most services)* | | 10% after deductible | 20% after deductible | 30% after deductible | 40% after deductible |
| **Preventive Care**<br>**Onsite† Clinic** | | No Co-Pay<br>No Co-Pay | No Co-Pay<br>No Co-Pay | 30% after deductible<br>30% after deductible | 40% after deductible<br>40% after deductible |
| **Specialist Office Visit**<br>**Onsite† Clinic Visit** | | $25 Co-Pay<br>$10 Co-Pay | $25 Co-Pay<br>$10 Co-Pay | 30% after deductible<br>30% after deductible | 40% after deductible<br>40% after deductible |
| **Urgent Care Center** | | $35 Co-Pay | $35 Co-Pay | 30% after deductible | 40% after deductible |
| **Emergency Room Visit** | | $100 Co-Pay | | | |
| **Prescription Drugs**<br>*31-Day Supply* | | $5 Generic Drugs<br>$30 for drugs on the preferred Drug List (formulary)<br>$60 for drugs not on the preferred Drug List<br>$75 for specialty drugs | | No Coverage | |
| **Prescription Drugs**<br>90-Day Supply | | $10 Generic Drugs<br>$60 for drugs on the preferred Drug List (Formulary)<br>$120 for drugs not on the preferred Drug List<br>$150 for specialty drugs | | No Coverage | |
| **Over The Counter Tobacco Cessation Products**<br>*0–31-Day Supply* | | No Co-Pay (fully paid by St. Jude) | | No Coverage | |
| **Teladoc Health Teleheath**<br>**Onsite† Clinic** | | $15 Co-Pay<br>$10 Co-Pay | $15 Co-Pay<br>$10 Co-Pay | No Coverage | |

*The out-of pocket max limits continue to be separate for medical and prescription drug expenses in 2026.
†St. Jude Living Well Health & Wellness Center

| 2026 HEALTH BENEFITS | YOUR BI-WEEKLY[1] PREMIUM | | MONTHLY COBRA RATES[3] |
|---|---|---|---|
| **Medical – Select PPO[2]** | **Full-Time** | **Part-Time** | **–** |
| **Employee Only** | $0 | $38 | $1,081 |
| **Employee + Spouse** | $64 | $128 | $2,590 |
| **Employee + Child(ren)** | $39 | $78 | $2,060 |
| **Employee + Spouse + Child(ren)** | $90 | $180 | $3,447 |
| **Medical – Choice PPO[2]** | **Full-Time** | **Part-Time** | **–** |
| **Employee Only** | $0 | $19 | $614 |
| **Employee + Spouse** | $32 | $64 | $1,475 |
| **Employee + Child(ren)** | $19.50 | $39 | $1,167 |
| **Employee + Spouse + Child(ren)** | $45 | $90 | $1,964 |
| **Dental** | **Full-Time** | **Part-Time** | **–** |
| **Employee Only** | $0 | 4.50 | $33 |
| **Family** | $4.50 | $9 | $99 |
| **VISION** | **FULL-TIME** | **PART-TIME** | **–** |
| **Employee Only** | $0 | $0 | $7.65 |
| **Family** | $4.88 | $4.88 | $17.61 |

[1]In the months with three (3) pay period end dates, health premiums will not impact the paycheck for the last pay period of the month.
[2]Tobacco users pay a $50/month surcharge for medical premiums for each coverage level.
[3]This is the full cost of coverage if you or one of your dependents loses coverage under the plan and becomes eligible for COBRA.

Your premiums may be adjusted depending upon your effective date. In these situations, the Payroll team will contact you directly with more details.