

| Medical – BCBSTX                                                           | HSA<br>In-Network<br>(You Pay)               | PPO Core<br>In-Network<br>(You Pay) | PPO Select<br>In-Network<br>(You Pay) |
|----------------------------------------------------------------------------|----------------------------------------------|-------------------------------------|---------------------------------------|
| Calendar Year Deductible<br>- Individual<br>- Family                       | \$1,750<br>\$3,500                           | \$400<br>\$800                      | \$0<br>\$0                            |
| Coinsurance                                                                | 10%                                          | 10%                                 | 0%                                    |
| Out-of-Pocket Maximum<br>(Deductible included)<br>- Individual<br>- Family | \$4,000<br>\$8,000                           | \$1,500<br>\$3,000                  | \$1,500<br>\$3,000                    |
| Lifetime Maximum Benefit                                                   | Unlimited                                    | Unlimited                           | Unlimited                             |
| Preventive Care                                                            | No charge                                    | No charge                           | No charge                             |
| Office Visit<br>- Primary<br>- Specialist                                  | 10% after deductible<br>10% after deductible | \$20 copay<br>\$35 copay            | \$20 copay<br>\$30 copay              |
| Telemedicine (Virtual Visits)                                              | No charge                                    | No charge                           | No charge                             |
| Inpatient Hospital Services                                                | 10% after deductible                         | 10% after deductible                | \$400 per admission                   |
| Outpatient Hospital / Facility                                             | 10% after deductible                         | 10% after deductible                | \$250 per visit                       |
| Inpatient Physician & Surgeon                                              | 10% after deductible                         | 10% after deductible                | No charge                             |
| Emergency Room<br>(Waived if admitted)                                     | 10% after deductible                         | \$150 copay                         | \$150 copay                           |
| Urgent Care<br>(Waived if admitted)                                        | 10% after deductible                         | \$35 copay                          | \$30 copay                            |
| Emergency Ambulance                                                        | 10% after deductible                         | 10% after deductible                | No charge                             |
| Mental Health / Substance Abuse<br>- Inpatient<br>- Outpatient             | 10% after deductible<br>10% after deductible | 10% after deductible<br>\$35 copay  | \$400 per admission<br>\$30 copay     |
| Chiropractic Care (25 days max)                                            | 10% after deductible                         | \$25 copay                          | \$20 copay                            |
| Outpatient Rehab (180 days max)                                            | 10% after deductible                         | \$25 copay                          | \$20 copay                            |
| Durable Medical Equipment                                                  | 10% after deductible                         | 10% after deductible                | No charge                             |
| Home Health / Skilled Nursing<br>(60 days max each)                        | 10% after deductible                         | 10% after deductible                | No charge                             |
| Hearing Aids<br>(1 pair/36 mos.; \$3,000 max per pair)                     | 10% after deductible                         | 10% after deductible                | No charge                             |

| Prescription Drugs-Express Scripts | HSA<br>In-Network<br>(You Pay) | PPO Core<br>In-Network<br>(You Pay) | PPO Select<br>In-Network<br>(You Pay) |
|------------------------------------|--------------------------------|-------------------------------------|---------------------------------------|
| Annual Rx Deductible               | Combined with<br>Medical       | \$0                                 | \$0                                   |
| <b>RETAIL – 30-DAY SUPPLY</b>      |                                |                                     |                                       |
| Generic                            | \$10 after deductible          | \$10 copay                          | \$5 copay                             |
| Brand                              | \$25 after deductible          | \$25 copay                          | \$20 copay                            |
| Non-Preferred Brand                | \$50 after deductible          | \$50 copay                          | \$35 copay                            |
| <b>MAIL ORDER – 90-DAY SUPPLY</b>  |                                |                                     |                                       |
| Generic                            | \$15 after deductible          | \$15 copay                          | \$10 copay                            |
| Brand                              | \$50 after deductible          | \$50 copay                          | \$40 copay                            |
| Non-Preferred Brand                | \$100 after deductible         | \$100 copay                         | \$70 copay                            |

## OPEN ENROLLMENT

**October 19 – October 30, 2026**

Elections due to the Pantex Benefits Department by  
12 p.m. CT on Friday, October 30, 2026

## How to Make Changes During Open Enrollment

Access opens on Monday, October 19 on the internal Pantex Benefits Plans webpage. Forms will be available online or can be requested from the Benefits office. All enrollment changes must be turned in by Friday, October 30 at 12 p.m. CST. Please call the Benefits team if you have any questions.

## What's New for 2027

- New medical carrier: BlueCross BlueShield of TX
- New Dental carrier: Sun Life
- HSA deductible increases to \$1,750 individual / \$3,500 family. All other plan deductibles are unchanged.
- HSA contribution limits rise to \$4,500 / \$9,000.
- Review your rates carefully; they have changed for 2027.

## Health Savings Account (HSA) – HSA Bank

### 2027 IRS Annual Contribution Maximums:

|                    |          |
|--------------------|----------|
| Individual         | \$4,500  |
| Family             | \$9,000  |
| Catch-Up (age 55+) | +\$1,000 |

## How Your Deductible Works

- HSA plan: Aggregate deductible. If you cover dependents, the full family deductible must be met before the plan pays coinsurance for anyone.
- PPO Core: Embedded deductible. Each person meets his or her own deductible; no one member pays more than the individual amount.
- PPO Select: no deductible.

## Employee Assistance Program – Aetna

Confidential support for you and your household, available 24/7 at [www.resourcesforliving.com](http://www.resourcesforliving.com) (Username: PANTEX / Password: EAP) or 1-866-611-2826.

*Specialty medications: PXD partners with Express Scripts with the SaveOnSP program. Enrolled members pay \$0 for select specialty drugs, filled through Accredo by mail. Declining participation means paying the increased copay. SaveOnSP: 1-800-683-1074.*

| Dental – Sun Life                                                                                   | Basic In-Network (You Pay) | Buy-Up In-Network (You Pay) | Enhanced In-Network (You Pay) |
|-----------------------------------------------------------------------------------------------------|----------------------------|-----------------------------|-------------------------------|
| Annual Deductible (per person)<br>Applies to Basic & Major                                          | \$50                       | \$50                        | \$50                          |
| Annual Benefit Maximum                                                                              | \$1,500 allowance          | \$2,000 allowance           | \$2,000 allowance             |
| Lifetime Maximum                                                                                    | None                       | None                        | None                          |
| Preventive & Diagnostic (exams, cleanings, X-rays, fluoride to age 19, space maintainers to age 14) | 0% (no deductible)         | 0% (no deductible)          | 0% (no deductible)            |
| Sealants                                                                                            | 20% after deductible       | 20% after deductible        | 10% after deductible          |
| Basic Services (fillings, extractions, oral surgery, periodontics, endodontics)                     | 20% after deductible       | 20% after deductible        | 10% after deductible          |
| Major Services (crowns, bridges, dentures, implants)                                                | 50% after deductible       | 50% after deductible        | 20% after deductible          |
| Orthodontia – Child(ren)                                                                            | Not covered                | 50% (no deductible)         | 50% (no deductible)           |
| Orthodontia Lifetime Maximum                                                                        | N/A                        | \$1,500                     | \$1,500                       |

| Vision – VSP                                                             | Basic In-Network (You Pay)                | Alternative In-Network (You Pay)          |
|--------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------|
| Exam (once each calendar year)                                           | No charge                                 | No charge                                 |
| Lenses – Single, Bifocal, Trifocal, Lenticular (once each calendar year) | No charge                                 | No charge                                 |
| Tints/Light-Reactive Lenses                                              | Not covered                               | No charge                                 |
| Standard Progressive                                                     | \$0 to \$55 copay                         | \$0 to \$55 copay                         |
| Premium Progressive                                                      | \$95 to \$105 copay                       | \$95 to \$105 copay                       |
| Custom Progressive                                                       | \$150 to \$175 copay                      | \$150 to \$175 copay                      |
| Other Lens Enhancements                                                  | Save 30% on average                       | Save 30% on average                       |
| Frames (every other calendar year)                                       | \$150 Allowance                           | \$150 Allowance                           |
| Frame Cost Over Allowance                                                | 20% off overage or \$80 at Costco Optical | 20% off overage or \$80 at Costco Optical |
| Contacts – Medically Necessary                                           | No charge                                 | No charge                                 |
| Contacts – Elective (incl. exam)                                         | \$130 Allowance                           | \$175 Allowance                           |
| Contact Lens Fitting & Evaluation                                        | Up to \$60 copay                          | Up to \$60 copay                          |
| Laser Vision Correction                                                  | 15% off regular price                     | 15% off regular price                     |

## Contact Information

### Medical – BCBSTX

Pantex Dedicated Line: 1-800-618-5449  
[www.bcbstx.com](http://www.bcbstx.com)

### Prescription – Express Scripts

1-877-765-6543  
[www.express-scripts.com](http://www.express-scripts.com)

### Dental – Sun Life

1-833-305-5994  
[www.sunlife.com](http://www.sunlife.com)

### HSA – HSA Bank

1-855-731-5220  
<https://enterprise.hsabank.com>

### Vision – VSP

1-800-877-7195  
[www.vsp.com](http://www.vsp.com)

### EAP – Aetna Resources For Living

1-866-611-2826  
[www.resourcesforliving.com](http://www.resourcesforliving.com)

### Questions about your benefits?

Pantex Benefit Plans Office  
1-806-573-1100  
Mon–Thu, 7 a.m.–3:30 p.m. CT  
[benefitspantex@pantex.doe.gov](mailto:benefitspantex@pantex.doe.gov)