Plan Year: January 1, 2025 – December 31, 2025	PLAN A	PLAN B
IN-NETWORK – Meritain, using the Aetna network		
DEDUCTIBLE		
Individual / Family	$0 / $0	$2,500 / $5,000
COINSURANCE		
	0%	20%
REFERALLS		
	Not required	Not required
MAXIMUM OUT-OF-POCKET		
Individual / Family	$5,000 / $10,000	$5,000 / $10,000
PREVENTIVE CARE		
Preventive Care – Annual Well Check, Immunizations, and Other Related Services	$0	$0
FACILITY VISITS		
Telemedicine – Teladoc	$0	$0
Primary Care	$20 copay	$20 copay
Specialist	$40 copay	$40 copay
Urgent Care	$80 copay	$80 copay
Emergency Room	$500 copay	You pay 20% after deductible
Inpatient Hospital	$650/day	You pay 20% after deductible
Outpatient Surgery	$500 copay	You pay 20% after deductible
Imaging or Procedure through KISx Card	$0	$0
OUTPATIENT DIAGNOSTIC SERVICES		
Lab Services	$0	$0
X-Ray Services	$120 copay	$150 copay
CT/PET Scan, MRI	$250 copay	$300 copay
PRESCRIPTIONS – SmithRx		
Tier 1 – Generic	$10 copay	$10 copay
Tier 2 – Preferred Brand	$50 copay	$50 copay
Tier 3 – Non-Preferred Brand	$150 copay	$150 copay
Mail Order	2x retail after deductible	2x retail after deductible
Tier 4 – Specialty*	$0	$0
OUT-OF-NETWORK - Refer to Summary of Benefits and Coverage		
BI-WEEKLY COST FOR MEDICAL & PRESCRIPTION COVERAGE		
Employee Only	$130.00	$65.00
Employee + Spouse	$300.00	$150.00
Employee + Child(ren)	$250.00	$125.00
Employee + Family	$390.00	$195.00

**May require a small manufacturer's copay.