

**Plan Year: January 1 –
December 31, 2026**

PLAN A

PLAN B

IN-NETWORK – Meritain, using the Aetna network

DEDUCTIBLE

Individual / Family	\$0 / \$0	\$2,500 / \$5,000
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COINSURANCE

0%	20%
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REFERALLS

Not required	Not required
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MAXIMUM OUT-OF-POCKET

Individual / Family	\$5,000 / \$10,000	\$5,000 / \$10,000
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PREVENTIVE CARE

Preventive Care – Annual Well Check, Immunizations, and Other Related Services	\$0	\$0
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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 Valenz	\$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	\$155.00	\$78.00
Employee + Spouse	\$358.00	\$179.00
Employee + Child(ren)	\$298.00	\$149.00
Employee + Family	\$465.00	\$233.00

**May require a small manufacturer's copay.