

Plan Year:
January 1 – December 31, 2026

PLAN A

PLAN B

IN-NETWORK – Meritain, using the Aetna network

DEDUCTIBLE

Individual / Family	\$0	\$2,000 / \$4,000*
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*if you are enrolled with a family member, each person is capped at the individual deductible

MAXIMUM OUT-OF-POCKET

Individual / Family	\$7,350 / \$14,700	\$7,350 / \$14,700
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PREVENTIVE CARE

Annual Well Check, Immunizations, and Other Related Services	\$0
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FACILITY VISITS

Primary Care	\$15 copay	\$20 copay
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Specialist Visits	\$30 copay	\$40 copay
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Telemedicine – Teladoc	\$0	\$0
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Imaging or Procedure through KISx Card	\$0	\$0
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Inpatient Hospital	\$400/day	You pay 20% after deductible
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Outpatient Surgery	\$400 copay	You pay 20% after deductible
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Emergency Room	\$500 copay <i>waived if admitted</i>	\$500 copay <i>waived if admitted</i>
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Urgent Care	\$100 copay	\$100 copay
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OUTPATIENT DIAGNOSTIC SERVICES

X-Ray Services	\$60 copay	\$60 copay
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CT/PET Scan, MRI	\$400 copay	\$400 copay
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PRESCRIPTIONS

Tier 1 – Generic*	\$15 copay
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Tier 2 – Preferred Brand	\$35 copay
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Tier 3 – Non-Preferred Brand	\$50 copay
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Tier 4 – Specialty**	Covered at 100%/\$0 copay
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OUT-OF-NETWORK – Refer to Summary of Benefits and Coverage

BI-WEEKLY COST FOR MEDICAL & PRESCRIPTION COVERAGE

Employee Only	\$65.88	\$42.76
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Employee + Spouse	\$215.67	\$155.54
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Employee + Child(ren)	\$144.48	\$100.02
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Employee + Family	\$400.31	\$303.12
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*Select mental health generic medications are \$0.

**May require a small manufacturer's copay.