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*
*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
PREVENTIVE CARE		
Annual Well Check, Immunizations, and Other Related Services	$0	
FACILITY VISITS		
Primary Care	$15 copay	$20 copay
Specialist Visits	$30 copay	$40 copay
Telemedicine – Teladoc	$0	$0
Imaging or Procedure through Valenz	$0	$0
Inpatient Hospital	$400/day	You pay 20% after deductible
Outpatient Surgery	$400 copay	You pay 20% after deductible
Emergency Room	$500 copay *waived if admitted*	$500 copay *waived if admitted*
Urgent Care	$100 copay	$100 copay
OUTPATIENT DIAGNOSTIC SERVICES		
X-Ray Services	$60 copay	$60 copay
CT/PET Scan, MRI	$400 copay	$400 copay
PRESCRIPTIONS		
Tier 1 – Generic*	$15 copay	
Tier 2 – Preferred Brand	$35 copay	
Tier 3 – Non-Preferred Brand	$50 copay	
Tier 4 – Specialty**	Covered at 100%/$0 copay	
OUT-OF-NETWORK – Refer to Summary of Benefits and Coverage		

BI-WEEKLY COST FOR MEDICAL & PRESCRIPTION COVERAGE		
Employee Only	$65.88	$42.76
Employee + Spouse	$215.67	$155.54
Employee + Child(ren)	$144.48	$100.02
Employee + Family	$400.31	$303.12

*Select mental health generic medications are $0.
**May require a small manufacturer's copay.