

Plan Year:
January 1 – December 31, 2026

PLAN 1
Copay Plan

PLAN 2
HDHP Plan

IN-NETWORK BENEFITS – Meritain using the Aetna Network

DEDUCTIBLE

Individual / Family	\$2,000 / \$4000*	\$3,300 / \$6,600*
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**If enrolled as a family, each family member is capped at the individual deductible, meaning no one person will pay more than the individual deductible amount*

MAXIMUM OUT-OF-POCKET

Individual / Family	\$4,000 / \$8,000	\$3,300 / \$6,600
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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	\$0 after deductible
Specialist Visits	\$45 copay	\$0 after deductible
Imaging or Procedure through KISx Card	\$0	\$0 after reimbursement
Urgent Care	\$100 copay	\$0 after deductible
Teladoc	\$25 copay	\$0 after deductible
Emergency Room	\$300 after deductible	\$0 after deductible
Inpatient Hospital	\$0 after deductible	\$0 after deductible
Outpatient Surgery	\$0 after deductible	\$0 after deductible

OUTPATIENT DIAGNOSTIC SERVICES

Outpatient Lab/Pathology	\$0 after deductible	\$0 after deductible
X-Ray Services	\$0 after deductible	\$0 after deductible
CT/PET Scan, MRI	\$0 after deductible	\$0 after deductible

PRESCRIPTIONS – SmithRx

Tier 1 – Generic	\$10 copay	\$0 after deductible
Tier 2 – Preferred Brand	\$35 copay	\$0 after deductible
Tier 3 – Non-Preferred Brand	\$75 copay	\$0 after deductible
Tier 4 – Specialty*	\$0 copay	\$0 after deductible
Mail Order	2x retail	\$0 after deductible

BI-WEEKLY COST FOR MEDICAL & PRESCRIPTION COVERAGE

Team Member Only	\$123.00	\$76.00
Team Member + Spouse	\$286.00	\$162.00
Team Member + Child(ren)	\$348.00	\$229.00
Team Member + Family	\$504.00	\$317.00

*May require a small manufacturer's copay.