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*
**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
PREVENTIVE CARE		
Annual Well Check, Immunizations, and Other Related Services	$0	
FACILITY VISITS		
Primary Care	$15 copay	$0 after deductible
Specialist Visits	$45 copay	$0 after deductible
Imaging or Procedure through Valenz	$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.