Plan Year: January 1, 2025 – December 31, 2025	PLAN A	PLAN B
IN-NETWORK BENEFITS – Meritain using the Aetna Network		
DEDUCTIBLE		
Individual / Family	$2,500 / $5,000	$4,000 / $8,000
MAXIMUM OUT-OF-POCKET		
Individual / Family	$7,900 / $15,800	$7,900 / $15,800
Maximum Out-of-Pocket Includes: Deductible, Coinsurance & Copayments (including prescription copays)		
PREVENTIVE CARE		
Annual Well Check, Immunizations, and Other Related Services	$0	
FACILITY VISITS		
Referrals	Not Required	Not Required
Primary Care	$30 copay	$30 copay
Specialist Visits	$60 copay	$60 copay
Telemedicine – Teladoc	$0	$0
Imaging or Procedure through KISx Card	$0	$0
Urgent Care	$100 copay	$100 copay
Emergency Room	$300 after deductible	$300 after deductible
Inpatient Hospital	$0 after deductible	Deductible + $500/day
Outpatient Surgery	$0 after deductible	$500 after deductible
OUTPATIENT DIAGNOSTIC SERVICES		
Outpatient Lab/Pathology	$60 copay	$60 copay
X-Ray Services	$60 copay	$60 copay
CT/PET Scan, MRI	$200 copay	$200 copay
PRESCRIPTIONS – SmithRx		
Tier 1 – Generic	$15 copay	$20 copay
Tier 2 – Preferred Brand	$35 copay	$40 copay
Tier 3 – Non-Preferred Brand	$50 copay	$70 copay
Tier 4 – Specialty**	Covered at 100%/$0 copay	Covered at 100%/$0 copay
Mail Order	2x retail	2x retail
OUT-OF-NETWORK – Refer to Summary of Benefits and Coverage		

WEEKLY COST FOR MEDICAL & PRESCRIPTION COVERAGE		
Employee Only	$108.21	$56.65
Employee + Spouse	$349.14	$230.18
Employee + Child(ren)	$271.98	$159.23
Employee + Family	$467.27	$314.92

**May require a small manufacturer's copay.