Inpatient Hospital \$0 after deductible Deductible + \$500/d 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	December 51, 2025		
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  FACILITY VISITS  Referrals Not Required Not Required Primary Care \$30 copay \$30 copay \$30 copay  Specialist Visits \$60 copay \$60 copay  Telemedicine – Teladoc \$0 \$0 \$0  Imaging or Procedure through KISX Card Urgent Care \$100 copay \$100 copay  Emergency Room \$300 after deductible \$300 after deductible Inpatient Hospital \$0 after deductible Deductible + \$500/d  Outpatient Surgery \$0 after deductible Deductible + \$500/d  Outpatient Lab/Pathology \$60 copay \$60 copay  X-Ray Services \$60 copay \$60 copay  X-Ray Services \$60 copay \$60 copay  PRESCRIPTIONS - SmithRX  Tier 1 - Generic \$15 copay \$20 copay  Tier 2 - Preferred Brand \$50 copay \$40 copay  Tier 3 - Non-Preferred Brand \$50 copay \$70 copay  Tier 4 - Specialty** Covered at 100%/\$0 copay  Mail Order 2x retail 2x retail  OUT-OF-NETWORK - Refer to Summary of Benefits and Coverage	IN-NETWORK BENEFITS – Meritai	n using the Aetna Network	
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  FACILITY VISITS  Referrals Not Required Not Required  Primary Care \$30 copay \$30 copay  Specialist Visits \$60 copay \$60 copay  Telemedicine – Teladoc \$0 \$0 \$0  Imaging or Procedure through KISX card  Urgent Care \$100 copay \$100 copay  Emergency Room \$300 after deductible \$300 after deductible inpatient Hospital \$0 after deductible \$300 after deductible \$500 after deductible \$5	DEDUCTIBLE		
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  FACILITY VISITS  Referrals  Not Required Primary Care \$30 copay \$30 copay  Specialist Visits \$60 copay \$60 copay  Telemedicine – Teladoc \$0 \$0  Imaging or Procedure through KISx Card  Urgent Care \$100 copay \$100 copay  Emergency Room \$300 after deductible \$300 after deductibl inpatient Hospital \$0 after deductible Deductible +\$500/d  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  T/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 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	Individual / Family	\$2,500 / \$5,000	\$4,000 / \$8,000
Maximum Out-of-Pocket Includes: Deductible, Coinsurance & Copayments (including prescription copays)  PREVENTIVE CARE  Annual Well Check, Immunizations, and Other Related Services  FACILITY VISITS  Referrals  Not Required  Primary Care  \$30 copay \$50 copay \$50 copay  Specialist Visits \$60 copay \$60 copay  Telemedicine – Teladoc \$0 \$0 Imaging or Procedure through KISx Card  Urgent Care  \$100 copay \$300 after deductible \$300 after deductible Inpatient Hospital \$0 after deductible Deductible + \$500/d Outpatient Surgery \$0 after deductible  OUTPATIENT DIAGNOSTIC SERVICES  Outpatient Lab/Pathology \$60 copay \$60 copay  \$70 copay  PRESCRIPTIONS – SmithRx  Tier 1 – Generic \$15 copay \$20 copay  Tier 2 – Preferred Brand \$55 copay \$70 copay  Tier 3 – Non-Preferred Brand \$50 copay  Covered at 100%/\$0 copay  Mail Order  OUT-OF-NETWORK – Refer to Summary of Benefits and Coverage  WEEKLY COST FOR MEDICAL & PRESCRIPTION COVERAGE	MAXIMUM OUT-OF-POCKET		
(including prescription copays)  PREVENTIVE CARE  Annual Well Check, Immunizations, and Other Related Services  FACILITY VISITS  Referrals  Not Required  No	Individual / Family	\$7,900 / \$15,800	\$7,900 / \$15,800
Annual Well Check, Immunizations, and Other Related Services  FACILITY VISITS  Referrals  Not Required  Not Required  Not Required  Not Required  Primary Care  \$30 copay  \$50 copay  \$50 copay  \$60 copay  Telemedicine – Teladoc  \$0 \$0  Imaging or Procedure through KISX Card  Urgent Care  \$100 copay  Emergency Room  \$300 after deductible  \$300 after deductible  Deductible + \$500/d  Outpatient Hospital  Outpatient Surgery  \$0 after deductible  \$500 after deductible  Deductible + \$500/d  Outpatient Lab/Pathology  \$60 copay  \$70 copay  \$80 copay  \$8			ce & Copayments
and Other Related Services  FACILITY VISITS  Referrals  Referrals  Not Required  Primary Care  \$30 copay \$30 copay \$50 copay  Specialist Visits \$60 copay \$60 copay  Telemedicine – Teladoc  Imaging or Procedure through KISX Card  Urgent Care  \$100 copay \$100 copay  Emergency Room \$300 after deductible \$300 after deductible Inpatient Hospital  Outpatient Surgery \$0 after deductible \$500 after deductible \$500 after deductible  OUTPATIENT DIAGNOSTIC SERVICES  Outpatient Lab/Pathology \$60 copay \$80 copay \$	PREVENTIVE CARE		
Referrals Not Required Primary Care \$30 copay \$30 copay \$30 copay \$50 copay \$50 copay \$50 copay \$60 copay		\$0	
Primary Care \$30 copay \$30 copay  Specialist Visits \$60 copay \$60 copay  Telemedicine – Teladoc \$0 \$0 \$0  Imaging or Procedure through KISX Card  Urgent Care \$100 copay \$100 copay  Emergency Room \$300 after deductible \$300 after deductible Inpatient Hospital \$0 after deductible Deductible + \$500/d Outpatient Surgery \$0 after deductible \$500 after deductib  OUTPATIENT DIAGNOSTIC SERVICES  Outpatient Lab/Pathology \$60 copay \$60 copay  X-Ray Services \$60 copay \$60 copay  TC/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  Mail Order \$2x retail \$2x retail  OUT-OF-NETWORK – Refer to Summary of Benefits and Coverage	FACILITY VISITS		
Specialist Visits \$60 copay \$60 copay Telemedicine – Teladoc \$0 \$0 Imaging or Procedure through KISx Card Urgent Care \$100 copay \$100 copay Emergency Room \$300 after deductible \$300 after deductible Inpatient Hospital \$0 after deductible Deductible + \$500/d 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	Referrals	Not Required	Not Required
Telemedicine – Teladoc \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	Primary Care	\$30 copay	\$30 copay
Imaging or Procedure through KISX Card \$0 \$0  Urgent Care \$100 copay \$100 copay  Emergency Room \$300 after deductible \$300 after deductibl Inpatient Hospital \$0 after deductible Deductible \$500 after deductible OUTPATIENT DIAGNOSTIC SERVICES  Outpatient Lab/Pathology \$60 copay \$60 copay \$60 copay \$60 copay \$7. Ray Services \$60 copay \$200 copay \$200 copay \$7. Rescriptions — SmithRx  Tier 1 – Generic \$15 copay \$20 copay \$40 copay \$100 cop	Specialist Visits	\$60 copay	\$60 copay
Urgent Care \$100 copay \$100 copay  Emergency Room \$300 after deductible \$300 after deductible Inpatient Hospital \$0 after deductible Deductible + \$500/d Outpatient Surgery \$0 after deductible \$500 after deductib 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 Covered at 100%/\$0 copay Covered at 100%/\$0 copay  Covered at 100%/\$0 copay	Telemedicine – Teladoc	\$0	\$0
Emergency Room \$300 after deductible \$300 after deductible Inpatient Hospital \$0 after deductible Deductible + \$500/d Outpatient Surgery \$0 after deductible \$500 after deductible OUTPATIENT DIAGNOSTIC SERVICES  Outpatient Lab/Pathology \$60 copay \$60 copay \$60 copay \$60 copay \$70 copay \$200 copay \$100 copay		\$0	\$0
Inpatient Hospital \$0 after deductible Deductible + \$500/d 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 Mail Order \$2x retail \$2x retail OUT-OF-NETWORK – Refer to Summary of Benefits and Coverage	Urgent Care	\$100 copay	\$100 copay
Outpatient Surgery \$0 after deductible \$500 after deductible OUTPATIENT DIAGNOSTIC SERVICES  Outpatient Lab/Pathology \$60 copay \$60 copay \$60 copay \$200 c	Emergency Room	\$300 after deductible	\$300 after deductible
OUTPATIENT DIAGNOSTIC SERVICES  Outpatient Lab/Pathology \$60 copay \$60 copay \$20 copay \$60 copay \$200 copay \$2	Inpatient Hospital	\$0 after deductible	Deductible + \$500/day
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	Outpatient Surgery	\$0 after deductible	\$500 after deductible
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	OUTPATIENT DIAGNOSTIC SERVI	CES	
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	Outpatient Lab/Pathology	\$60 copay	\$60 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	X-Ray Services	\$60 copay	\$60 copay
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 co Mail Order 2x retail 2x retail OUT-OF-NETWORK – Refer to Summary of Benefits and Coverage WEEKLY COST FOR MEDICAL & PRESCRIPTION COVERAGE	CT/PET Scan, MRI	\$200 copay	\$200 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 co Mail Order 2x retail 2x retail OUT-OF-NETWORK – Refer to Summary of Benefits and Coverage WEEKLY COST FOR MEDICAL & PRESCRIPTION COVERAGE	PRESCRIPTIONS – SmithRx		
Tier 3 – Non-Preferred Brand \$50 copay \$70 copay  Tier 4 – Specialty** Covered at 100%/\$0 copay Covered at 100%/\$0 co  Mail Order 2x retail 2x retail  OUT-OF-NETWORK – Refer to Summary of Benefits and Coverage  WEEKLY COST FOR MEDICAL & PRESCRIPTION COVERAGE	Tier 1 – Generic	\$15 copay	\$20 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	Tier 2 – Preferred Brand	\$35 copay	\$40 copay
Mail Order 2x retail 2x retail  OUT-OF-NETWORK – Refer to Summary of Benefits and Coverage  WEEKLY COST FOR MEDICAL & PRESCRIPTION COVERAGE	Tier 3 – Non-Preferred Brand	\$50 copay	\$70 copay
OUT-OF-NETWORK – Refer to Summary of Benefits and Coverage WEEKLY COST FOR MEDICAL & PRESCRIPTION COVERAGE	Tier 4 – Specialty**	Covered at 100%/\$0 copay	Covered at 100%/\$0 copay
WEEKLY COST FOR MEDICAL & PRESCRIPTION COVERAGE	Mail Order	2x retail	2x retail
	OUT-OF-NETWORK – Refer to Sur	mmary of Benefits and Covera	ge
Employee Only \$109.21	WEEKLY COST FOR MEDICAL & P	RESCRIPTION COVERAGE	
\$50.05	Employee Only	\$108.21	\$56.65
Employee + Spouse \$349.14 \$230.18	Employee + Spouse	\$349.14	\$230.18
Employee + Child(ren) \$271.98 \$159.23	Employee + Child(ren)	\$271.98	\$159.23
Employee + Family \$467.27 \$314.92	Employee + Family	\$467.27	\$314.92

<sup>\*\*</sup>May require a small manufacturer's copay.