

**Plan Year: January 1 –
December 31, 2026**

PPO PLAN

HSA PLAN

IN-NETWORK – Allied, using the Aetna network

DEDUCTIBLE

Individual / Family	\$1,250 / \$3,750	\$2,000 / \$4,000*
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*If enrolled as a family, the entire family deductible must be satisfied by one individual or collectively before benefits will be paid at the coinsurance rate

COINSURANCE – the amount covered by insurance after the deductible is met

	90%	95%
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MAXIMUM OUT-OF-POCKET

Individual / Family	\$5,000 / \$15,000	\$7,000 / \$9,200
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PREVENTIVE CARE

Preventive Care – Annual Well Check, Immunizations, and Other Related Services	\$0
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FACILITY VISITS

Telemedicine – Recuro Health	\$0	\$0
Primary Care	\$10 copay	\$0 after deductible
Specialist	\$25 copay	\$0 after deductible
Urgent Care	\$50 copay	\$0 after deductible
Emergency Room	\$175 copay	\$0 after deductible
Inpatient Hospital	90% after deductible	95% after deductible
Outpatient Surgery	90% after deductible	95% after deductible

OUTPATIENT DIAGNOSTIC SERVICES

X-Ray Services	90% after deductible	95% after deductible
CT/PET Scan, MRI	90% after deductible	95% after deductible

PRESCRIPTIONS – BeneCard

Expanded Preventive	\$5 copay for generic meds; \$25 copay for preferred meds	
Generic	\$10 copay	\$10 copay after deductible
Preferred Brand	\$35 copay	\$35 copay after deductible
Non-Preferred Brand	\$65 copay	\$65 copay after deductible
Mail Order: 90-day supply	2x retail	2x retail after deductible
Specialty	\$100 copay	\$100 copay after deductible

OUT-OF-NETWORK - Refer to Summary of Benefits and Coverage (SBC)