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*
*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%
MAXIMUM OUT-OF-POCKET		
Individual / Family	$5,000 / $15,000	$7,000 / $14,000
PREVENTIVE CARE		
Preventive Care – Annual Well Check, Immunizations, and Other Related Services	$0	
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)		