Plan Year: January 1 – December 31, 2026	HSA PLAN	PPO PLAN
IN-NETWORK BENEFITS – Meritain using the Aetna Network		
DEDUCTIBLE		
Individual / Family	$3,400 / $6,800*	$1,000 / $3,000*
**If enrolled as a family, no one family member may contribute more than the individual deductible / out-of-pocket maximum*		
MAXIMUM OUT-OF-POCKET		
Individual / Family	$6,450 / $12,900*	$6,600 / $13,200
Maximum Out-of-Pocket Includes: Deductible & Copayments (including prescription copays)		
PREVENTIVE CARE		
Annual Well Check, Immunizations, and Other Related Services	$0	
FACILITY VISITS		
Telemedicine – Teladoc	You pay $0 after deductible	$10 copay
Primary Care	You pay $0 after deductible	$20 copay
Specialist Visits	You pay $0 after deductible	$40 copay
Inpatient Hospital	You pay $0 after deductible	You pay 20% after deductible
Outpatient Surgery	You pay $0 after deductible	You pay 20% after deductible
Emergency Room	You pay $0 after deductible	You pay 20% after deductible
Urgent Care	You pay $0 after deductible	You pay 20% after deductible
OUTPATIENT DIAGNOSTIC SERVICES		
X-Ray Services	You pay $0 after deductible	$40 copay
CT/PET Scan, MRI	You pay $0 after deductible	$80 copay
PRESCRIPTIONS		
Tier 1 – Generic	$20 copay after deductible	$20 copay
Tier 2 – Preferred Brand	$40 copay after deductible	$40 copay
Tier 3 – Non-Preferred Brand	$60 copay after deductible	$60 copay
Mail Order	2x retail	2x retail
Tier 4 – Specialty**	Covered at 100% after deductible	Covered at 100%/$0 Copay
OUT-OF-NETWORK - Refer to Summary of Benefits and Coverage found at www.chlbenefits.com/legal		
WEEKLY COST FOR MEDICAL & PRESCRIPTION COVERAGE		
Employee Only	$62.84	$90.00
Employee + Spouse	$142.24	$212.91
Employee + Child(ren)	$131.40	$195.36
Employee + Family	$151.45	$247.95

**May require a small manufacturer's copay.