Plan Year: June 1, 2024 – May 31, 2025	Option 1	Option 2	Option 3
IN-NETWORK BENEFITS – Meritain			
ANNUAL DEDUCTIBLE			
Individual / Family	$0	$0	$0
*If enrolled as a family, the individual deductible does not apply, and one member can satisfy the full deductible			
MAXIMUM OUT-OF-POCKET			
Individual / Family	$7,150 / $14,300	$7,150 / $14,300	$7,150 / $14,300
PREVENTIVE CARE			
Annual Well Check, Immunizations, and Other Related Services		$0	
VISITS			
Primary Care	$5 copay	$10 copay	$20 copay
Specialist	$30 copay	$40 copay	$60 copay
Urgent Care	$87 copay	$87 copay	$140 copay
Emergency Room	$125 copay	$125 copay	$200 copay
Inpatient Hospital	$100/day	$150/day	$500/day
Outpatient Surgery	$50 copay	$150 copay	$500 copay
Telemedicine - Teladoc	$0	$0	$0
Therapy	$0	$0	$0
OUTPATIENT DIAGNOSTIC SERVICES			
X-Ray and Lab Services	$30 copay	$40 copay	$60 copay
CT/PET Scan, MRI	$60 copay	$120 copay	$200 copay
PRESCRIPTIONS – Prime Therapeutics			
Tier 1 – Generic	$10 copay	$10 copay	$10 copay
Tier 2 – Preferred Brand	$20 copay	$40 copay	$40 copay
Tier 3 – Non-Preferred Brand	$35 copay	$70 copay	$200 copay
Mail order	2x retail	2x retail	2x retail
Mental Health Medications*	$0	$0	$0
OUT-OF-NETWORK - Refer to Summary of Benefits and Coverage			
MEDICAL BI-WEEKLY PAYROLL DEDUCTIONS			
Employee Only	$74.49	$51.59	$22.60
Employee + Spouse	$527.65	$478.52	$414.10
Employee + Child(ren)	$349.35	$310.64	$260.26
Employee + Family	$760.54	$687.03	$604.82

**Certain medications to manage mental health conditions are available at no cost. For a full list, visit www.plbenefits.org/medical.*