2026 Surest and Consumer Choice Medical Plan Comparion

Plan Design	Surest Plan		Consumer Choice	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$0		Employee Only: $1,700 All Other Coverage Levels: $3,400	Employee Only: $2,500 All Other Coverage Levels: $5,000
Coinsurance (Plan Paid)	100%		After you meet your deductible, you pay 10% for medical and 20% for prescriptions	After you meet your deductible, you pay 30% for medical and 50% for prescriptions
OOP Limit Individual - includes medical and prescription copays	$4,000	$8,000	$2,500	$5,000
OOP Limit Family - includes medical and prescription copays	$8,000	$16,000	$5,000	$10,000
Office Visit	$20 to $75	$220	10% after the deductible is met	30% after the deductible is met
Virtual Care/Telehealth Services				
Virtual Health (Primary and Urgent)	$0	Not Covered	10% after the deductible is met	30% after the deductible is met
Virtual Health (Mental Health & Substanc	$20 to $40	Not Covered	10% after the deductible is met	30% after the deductible is met
Virtual Health (Specialty)	$0 to $75	Not Covered	10% after the deductible is met	30% after the deductible is met
Preventive Care	$0	$115	$0	30% after deductible is met for mammograms, pap smears, and maternity screening
Diagnostic Test (e.g. X-ray, Lab, Ultrasound)	$0	$0	10% after the deductible is met	30% after the deductible is met
Complex Imaging (MRI, CT, etc.)	$100 to $600	Up to $1,800	10% after the deductible is met	30% after the deductible is met
Emergency Room	$350	$350	10% after the deductible is met	10% after the in-network deductible is met
Observation Stay	$350	$350	10% after the deductible is met	10% after the in-network deductible is met
Ambulance	$150	$150	10% after the deductible is met	10% after the in-network deductible is met
Urgent Care	$35	$105	10% after the deductible is met	10% after the in-network deductible is met

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	In-Network	Out-of-Network	In-Network	Out-of-Network
Procedures (Office, Outpatient and Inpatient)	$15 to $2,500	Up to $7,000	10% after the deductible is met	30% after the deductible is met
Procedures (Inpatient and some Outpatient)	$200 to $2,500	Up to $7,000	10% after the deductible is met	30% after the deductible is met
Other Outpatient Hospital Services	$75 to $525	$1,575	10% after the deductible is met	30% after the deductible is met
Other Inpatient Stay (inc. admission from ER)	$1,600	$4,800	10% after the deductible is met	30% after the deductible is met
Mental Health & Substance Use Disorder				
In an office setting	$20	$115	10% after the deductible is met	30% after the deductible is met
Intensive Outpatient Treatment Program	$40	$120	10% after the deductible is met	30% after the deductible is met
Partial Hospitalization Program	$75	$225	10% after the deductible is met	30% after the deductible is met
In an outpatient setting	$75	$225	10% after the deductible is met	30% after the deductible is met
In an inpatient setting	$1,200	$3,600	10% after the deductible is met	30% after the deductible is met
Maternity				
Routine Prenatal and Postnatal Care	$0	$115	$0	30% after the deductible is met
Delivery	$350 to $1,600	$4,800	10% after the deductible is met	30% after the deductible is met
Home Health Care	$35	$105	10% after the deductible is met	30% after the deductible is met
Rehabilitative Therapies	$5 to $85	Up to $220	10% after the deductible is met	30% after the deductible is met
Acupuncture	Not Covered	Not Covered	Not Covered	Not Covered
Chiropractic – 25 visit maximum	$20	Not Covered	10% after the deductible is met	Not Covered
Occupational Therapy (OT)*	$10 to $65	$185	10% after the deductible is met	30% after the deductible is met
Physical Therapy (PT)*	$5 to $45	$135	10% after the deductible is met	30% after the deductible is met
Speech Therapy (ST)*	$10 to $65	$185	10% after the deductible is met	30% after the deductible is met
* 180 visits per calendar year (OT, PT, ST, and Cardiac and Pulmonary Rehab combined)				
Skilled Nursing Facility	$1,200	$3,600	10% after the deductible is met	30% after the deductible is met
Durable Medical Equipment	$0 to $500	Up to $1,000	10% after the deductible is met	30% after the deductible is met
Hearing Aids Per Ear Every 36 months	$400 copay	Not Covered	10% after the deductible is met	Not Covered

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Plan Design	Surest Plan		Consumer Choice	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospice				
Home Hospice Visit	$35	$105	10% after the deductible is met	30% after the deductible is met
Inpatient Hospice Care	$1,600	$4,800	10% after the deductible is met	30% after the deductible is met
Advanced Tests	$10 to $800	Up to $2,400	10% after the deductible is met	30% after the deductible is met
Chemotherapy	$10 to $550	Up to $1,650	10% after the deductible is met	30% after the deductible is met
Medical Infusions	$20 to $2,000	Up to $6,000	10% after the deductible is met	30% after the deductible is met

Plan Design	Surest Plan		Consumer Choice		
	In-Network	Out-of-Network	In-Network		Out-of-Network
Preventive Pharmacy Up to 90 Days Supply	$0	Not Covered	$0		Not Covered
Retail Pharmacy Up to 30 Days Supply			**Before Deductible**	**After Deductible**	
Generic	$10	Not Covered	20%	$10 Min $75 Max	50% after the deductible is met. Member must file a claim.
Preferred Brand	$50	Not Covered	20%	$25 Min $150 Max	
Non-Preferred Brand	$75	Not Covered	20%	$40 Min $250 Max	
Retail and Mail Order Pharmacy Up to 90 Days Supply			**Before Deductible**	**After Deductible**	
Generic	$25	Not Covered	20%	$20 Min $150 Max	Retail only - 50% after the deductible is met. Member must file a claim.
Preferred Brand	$125	Not Covered	20%	$60 Min $300 Max	
Non-Preferred Brand	$175	Not Covered	20%	$100 Min $500 Max	
Specialty Pharmacy - Accredo Only Up to 30 Days Supply			**Before Deductible**	**After Deductible**	
Generic	$50	Not Covered	20%	$10 Min $75 Max	Not Covered
Preferred Brand	$100	Not Covered	20%	$25 Min $150 Max	
Non-Preferred Brand	$150	Not Covered	20%	$40 Min $250 Max	
Specialty Pharmacy - Accredo Only Up to 90 Days Supply			**Before Deductible**	**After Deductible**	
Generic	$125	Not Covered	20%	$20 Min $150 Max	Not Covered
Preferred Brand	$250	Not Covered	20%	$60 Min $300 Max	
Non-Preferred Brand	$375	Not Covered	20%	$100 Min $500 Max	

Revised Oct. 10, 2025