# 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<br>All Other Coverage Levels: $3,400 | Employee Only: $2,500<br>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** | $4,000 | $8,000 | $2,500 | $5,000 |
| **OOP Limit Family** | $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 & Substa | $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 |

Revised Sept. 25, 2025

# 2026 Surest and Consumer Choice Medical Plan Comparion

| Plan Design | Surest Plan | | Consumer Choice | |
|---|---|---|---|---|
| | 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 | $10 to $65 | $185 | 10% after the deductible is met | 30% after the deductible is met |
| Physical Therapy | $5 to $45 | $135 | 10% after the deductible is met | 30% after the deductible is met |
| Speech Therapy | $10 to $65 | $185 | 10% after the deductible is met | 30% after the deductible is met |
| **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 |

Revised Sept. 25, 2025

# 2026 Surest and Consumer Choice Medical Plan Comparion

| 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 | Not Covered |
| Preferred Brand | $125 | Not Covered | 20% | $60 Min $300 Max | |
| Non-Preferred Brand | $175 | Not Covered | 20% | $100 Min $500 Max | |
| **Specialty Mail Order Pharmacy Up to 30 Days Supply** | | | **Before Deductible** | **After Deductible** | |
| Generic | $50 | Not Covered | 20% | $10 Min $75 Max | 50% after the deductible is met. Member must file a claim. |
| Preferred Brand | $100 | Not Covered | 20% | $25 Min $150 Max | |
| Non-Preferred Brand | $150 | Not Covered | 20% | $40 Min $250 Max | |
| **Specialty Mail Order Pharmacy Up to 90 Days Supply** | | | **Before Deductible** | **After Deductible** | |
| Generic | $125 | Not Covered | 20% | $20 Min $150 Max | 50% after the deductible is met. Member must file a claim. |
| Preferred Brand | $250 | Not Covered | 20% | $60 Min $300 Max | |
| Non-Preferred Brand | $375 | Not Covered | 20% | $100 Min $500 Max | |

Revised Sept. 25, 2025