OneHealth
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Benefit Summary	5,000 Classic	7,350 Value	3,500 HSA	5,000 HSA
Benefits	In-Network	In-Network	In-Network	In-Network
Deductible Individual / Family	$5,000 / $10,000	$7,350 / $14,700	$3,500 / $7,000	$5,000 / $10,000
Coinsurance Plan Pays /Member Pays	80% / 20%	100%	80% / 20%	80% / 20%
Out-of-Pocket Maximum Individual / Family	$7,350 / $14,700	$7,350/$14,700	$6,550/$13,100	$7,350 / $14,700
Routine Preventive Services (Non Diagnostic)	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived
Lifetime Maximum	No Maximum	No Maximum	No Maximum	No Maximum
Co-Pay				
Primary Care Co-Pay	$45	$50	20% after deductible	20% after deductible
Specialist Co-Pay	$90	$100	20% after deductible	20% after deductible
Chiropractice Care Co-Pay Limited to 20 visits per benefit period	$20	$20	20% after deductible	20% after deductible
Urgent Care	$90	$100	20% after deductible	20% after deductible
Embedded No Cost Services				
Telemedicine	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Virtual Primary Care	Included	Included	Included	Included
Advocacy Services	Included	Included	Included	Included
Facility & Professional Services (Patient Responsibility)				
Inpatient Hospital (patient responsibility)	20% after deductible	0% after deductible	20% after deductible	20% after deductible
Out Patient Services **Surgical Services** (Procedure & Anesthesia)	20% after deductible	0% after deductible	20% after deductible	20% after deductible
Emergency Room	20% after deductible	0% after deductible	20% after deductible	20% after deductible
Laboratory & Diagnostic Services (Patient Responsibility)				
Free Standing Lab & Diagnostic Services (Lab & x-ray)	0% after deductible	0% after deductible	0% after deductible	0% after deductible
Complex Diagnositc Services (CT, MRI, Ultra Sound, PET, Nuclear Med.)	20% after deductible	0% after deductible	20% after deductible	20% after deductible
Professional Fees	20% after deductible	0% after deductible	20% after deductible	20% after deductible
Prescription Drug Benefit – **Non participating pharmacies are not covered**				
Prescription Drug	In-Network	In-Network	In-Network	In-Network
Deductible	None	None	None	None
Speciality			Specialty See plan document for more information	
Retail (30 Day Supply)	$15/65/$100	$15/65/$100	$15/$65/$100	$15/$65/$100
Generic	Retail: $15 co-pay	Retail: $15 co-pay	Retail: $15 co-pay	Retail: $15 co-pay
Preferred Brand	Retail: $65 co-pay	Retail: $65 co-pay	Retail: $65 co-pay	Retail: $65 co-pay
Non-Preferred Brand	Retail: $100 co-pay	Retail: $100 co-pay	Retail: $100 co-pay	Retail: $100 co-pay
Mail Order (31-90 Day Supply)	$45/$90/$150	$45/$90/$150	$45/$90/$150	$30/$130/$200
Generic	Mail Order: $45 co-pay	Mail Order: $45 co-pay	Mail Order: $45 co-pay	Mail Order: $30 co-pay
Preferred Brand	Mail Order: $90 co-pay	Mail Order: $90 co-pay	Mail Order: $90 co-pay	Mail Order: $130 co-pay
Non-Preferred Brand	Mail Order: $150 co-pay	Mail Order: $150 co-pay	Mail Order: $150 co-pay	Mail Order: $200 co-pay
Non-Network Services (Patient Responsibility)				
Coinsurance Plan Pays/Member Pays	60% / 40%	50% / 50%	60% / 40%	60% / 40%
Deductible Individual/Family	$7,000 / $14,000	$14,700 / $29,400	$7,000 / $14,000	$10,000 / $20,000
Out of Pocket Maximum Individual/Family	$14,700 / $29,400	$14,700 / $29,400	$13,100 / $26,200	$14,700 / $29,400

NOTE: Precerticiation is required for all in-hospital admissions, chemotherapy, diagnostic testing and outpatient surgery. Penalty may apply for not obtaining precertification.

This comparison describes the plan in an easy understood manner and presented as a matter of general information.
The contents are not to be accepted as a substitute for the provision of the plan.

OneHealth
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Benefit Summary	1,000 Classic	1,500 Classic	2,500 Classic	3,500 Classic
Benefits	In-Network	In-Network	In-Network	In-Network
Deductible Individual / Family	$1,000 / $2000	$1,500 / $3,000	$2,500 / $5,000	$3,500 / $7,000
Coinsurance Plan Pays /Member Pays	80% / 20%	80% / 20%	80% / 20%	80% / 20%
Out-of-Pocket Maximum Individual / Family	$5,000 / $10,000	$7,350 / $14,700	$7,350 / $14,700	$7,350 / $14,700
Routine Preventive Services (Non Diagnostic)	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived
Lifetime Maximum	No Maximum	No Maximum	No Maximum	No Maximum
Co-Pay				
Primary Care Co-Pay	$20	$30	$30	$45
Specialist Co-Pay	$40	$60	$60	$90
Chiropractice Care Co-Pay Limited to 20 visits per benefit period	$20	$20	$20	$20
Urgent Care	$40	$80	$80	$90
Embedded No Cost Services				
Telemedicine	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Virtual Primary Care	Included	Included	Included	Included
Advocacy Services	Included	Included	Included	Included
Facility & Professional Services (Patient Responsibility)				
Inpatient Hospital (patient responsibility)	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Out Patient Services **Surgical Services** (Procedure & Anesthesia)	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Emergency Room	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Laboratory & Diagnostic Services (Patient Responsibility)				
Free Standing Lab & Diagnostic Services (Lab & x-ray)	0% after deductible	0% after deductible	0% after deductible	0% after deductible
Complex Diagnositc Services (CT, MRI, Ultra Sound, PET, Nuclear Med.)	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Professional Fees	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Prescription Drug Benefit – **Non participating pharmacies are not covered**				
Prescription Drug	In-Network	In-Network	In-Network	In-Network
Deductible	None	None	None	None
Speciality	Specialty See plan document for more information			ty See plan document for more infor
Retail (30 Day Supply)	$15/$45/$85	$15/$45/$85	$15/$45/$85	$15/$65/$100
Generic	Retail: $15 co-pay	Retail: $15 co-pay	Retail: $15 co-pay	Retail: $15 co-pay
Preferred Brand	Retail: $45 co-pay	Retail: $45 co-pay	Retail: $45 co-pay	Retail: $65 co-pay
Non-Preferred Brand	Retail: $85 co-pay	Retail: $85 co-pay	Retail: $85 co-pay	Retail: $100 co-pay
Mail Order (31-90 Day Supply)	$45/$90/$150	$45/$90/$150	$45/$90/$150	$45/$90/$150
Generic	Mail Order: $45 co-pay	Mail Order: $45 co-pay	Mail Order: $45 co-pay	Mail Order: $45 co-pay
Preferred Brand	Mail Order: $90 co-pay	Mail Order: $90 co-pay	Mail Order: $90 co-pay	Mail Order: $90 co-pay
Non-Preferred Brand	Mail Order: $150 co-pay	Mail Order: $150 co-pay	Mail Order: $150 co-pay	Mail Order: $150 co-pay
Non-Network Services (Patient Responsibility)				
Coinsurance Plan Pays/Member Pays	60% / 40%	60% / 40%	60% / 40%	60% / 40%
Deductible Individual/Family	$2,000 / $4,000	$3,000 / $6,000	$5,000 / $10,000	$7,000 / $14,000
Out of Pocket Maximum Individual/Family	$10,000 / $20,000	$14,700 / $29,400	$14,700 / $29,400	$14,700 / $29,400

NOTE: Precerticiation is required for all in-hospital admissions, chemotherapy, diagnostic testing and outpatient surgery. Penalty may apply for not obtaining precertification.

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