onehealth

Plan Comparison

Benefit Summary	0 Premier	1,000 Classic	1,500 Classic	3,000 Classic
Deductible Individual / Family	$0 / $0	$1,000 / $2,000	$1,500 / $3,000	$3,000 / $6,000
Out-of-Pocket Deductible Individual / Family	$500 / $1,000	$2,500 / $5,000	$3,000 / $6,000	$6,000 / $12,000
Co-Pay				
Primary Care Co-Pay	$25	$15	$35	$35
Specialist Co-Pay	$45	$40	$55	$55
Urgent Care	$45	$40	$55	$55
Emergency Room	$300	$300	$500	$500
Embedded No Cost Services				
Routine Preventive Services	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Telehealth Using Connected Care App (powered by OpynHealth)	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Preventative Prenatal Care	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Facility & Professional Services (Patient Responsibility)				
Inpatient Hospital	30% after deductible	20% after deductible	20% after deductible	20% after deductible
Outpatient Services Surgical Services (Procedures & Anesthesia)	30% after deductible	20% after deductible	20% after deductible	20% after deductible
Mental Health Care, Outpatient	$45 Copay 30% after deductible	$40 Copay 20% after deductible	$55 Copay 20% after deductible	$55 Copay 20% after deductible
Mental Health Care, Inpatient	30% after deductible	20% after deductible	20% after deductible	20% after deductible
Laboratory & Diagnostic Services (Patient Responsibility)				
Diagnostic Services (Lab & x-ray)	30% after deductible	20% after deductible	20% after deductible	20% after deductible
Complex Diagnostic Services (CT, MRI, PET)	30% after deductible	20% after deductible	20% after deductible	20% after deductible
Prescription Drug Benefit More information about prescription drug coverage is available from Connected Care Rx (Unified Labor Rx)				
Generic	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Preferred brand	$35 Copay	$35 Copay	$35 Copay	$35 Copay
Non-preferred brand	$75 Copay	$75 Copay	$75 Copay	$75 Copay
Specialty	$500 Copay	$500 Copay	$500 Copay	$500 Copay
Out-of-network prescriptions	Not covered	Not covered	Not covered	Not covered
Out-of-Pocket Limit				
In-Network Individual/Family	$1,250 / $2,500	$3,500 / $7,000	$3,000 / $6,000	$6,000 / $12,000
Out-of-Network Individual/Family	$3,750 / $7,500	$7,000 / $14,000	$6,000 / $12,000	$12,000 / $24,000

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

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This is a representation. Please refer to the SBCs for final plan terms.

onehealth

Plan Comparison

Benefit Summary	5,000 Classic	8,000 Value	3,400 HSA	6,000 HSA
Deductible Individual / Family	$5,000 / $10,000	$8,000 / $16,000	$3,400 / $6,800	$6,000 / $12,000
Out-of-Pocket Deductible Individual / Family	$10,000 / $20,000	$16,000 / $32,000	$4,000 / $8,000	$9,000 / $18,000
Co-Pay				
Primary Care Co-Pay	$40	$50	20% Coinsurance	30% Coinsurance
Specialist Co-Pay	$80	$120	20% Coinsurance	30% Coinsurance
Urgent Care	$60	$100	20% Coinsurance	30% Coinsurance
Emergency Room	30% after deductible	$500 Copay 30% after deductible	20% Coinsurance	30% Coinsurance
Embedded No Cost Services				
Routine Preventive Services	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Telehealth Using Connected Care App (powered by OpynHealth)	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Preventative Prenatal Care	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Facility & Professional Services (Patient Responsibility)				
Inpatient Hospital	30% after deductible	30% after deductible	20% after deductible	30% after deductible
Outpatient Services Surgical Services (Procedures & Anesthesia)	30% after deductible	30% after deductible	20% after deductible	30% after deductible
Mental Health Care, Outpatient	$80 Copay 30% after deductible	$120 Copay 30% after deductible	20% after deductible	30% after deductible
Mental Health Care, Inpatient	30% after deductible	30% after deductible	20% after deductible	30% after deductible
Laboratory & Diagnostic Services (Patient Responsibility)				
Diagnostic Services (Lab & x-ray)	30% after deductible	30% after deductible	20% after deductible	30% after deductible
Complex Diagnostic Services (CT, MRI, PET)	30% after deductible	30% after deductible	20% after deductible	30% after deductible
Prescription Drug Benefit More information about prescription drug coverage is available from Connected Care Rx (Unified Labor Rx)				
Generic	$0 Copay	$0 Copay	No charge after deductible	No charge after deductible
Preferred brand	$35 Copay	$35 Copay	25% Coinsurance after deductible	25% Coinsurance after deductible
Non-preferred brand	$75 Copay	$75 Copay	45% Coinsurance after deductible	45% Coinsurance after deductible
Specialty	$500 Copay	$500 Copay	$500 Copay	$500 Copay
Out-of-network prescriptions	Not covered	Not covered	Not covered	Not covered
Out-of-Pocket Limit				
In-Network Individual/Family	$8,700 / $17,400	$8,700 / $17,400	$6,800 / $13,300	$7,000 / $14,000
Out-of-Network Individual/Family	$17,400 / $34,800	$17,400 / $34,800	$8,000 / $16,000	$14,000 / $28,000

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