



PLAN COMPARISON:

Summary of Benefits & Coverage



Rates effective as of January 1, 2025

PPO in-network and out-of-network benefits

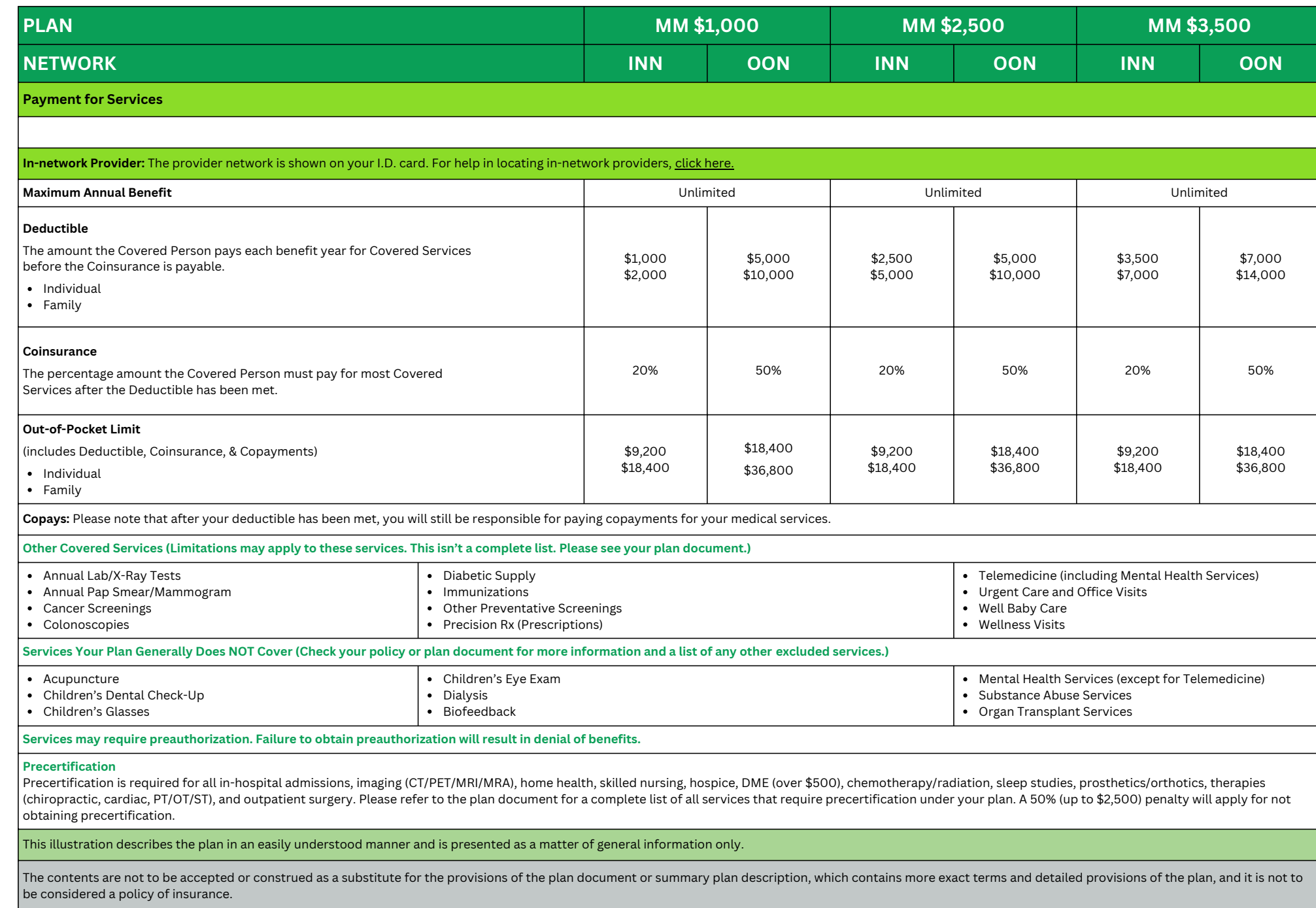
MM \$1,000 Deductible

MM \$2,500 Deductible

MM \$3,500 Deductible

PHCS PPO, Cigna PPO, or Anthem PPO

Rates effective as of January 1, 2025



Plan Comparison: Summary of Benefits & Coverage

Rates effective as of January 1, 2025



PLAN	MM \$1,000		MM \$2,500		MM \$3,500	
NETWORK	INN	OON	INN	OON	INN	OON
Covered Services - Illness or Injury						
Physician Office Services - Primary Care Physician - Specialist Office Visit - Urgent Care Visit - Spinal Manipulation Chiropractic	\$25 Copay \$40 Copay \$60 Copay \$30 Copay	OON Deductible & Coinsurance	\$25 Copay \$40 Copay \$60 Copay \$30 Copay	OON Deductible & Coinsurance	\$25 Copay \$40 Copay \$60 Copay \$30 Copay	OON Deductible & Coinsurance
Telemedicine - Virtual Primary Care - Urgent Care - Mental Health	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
Emergency Services (Precertification Required) - Emergency Room Care - Emergency Medical Transportation - Ground/Air Ambulance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Testing - Diagnostic Testing Labs (Quest Diagnostics/LabCorp) - X-Rays (Precertification Required) - Advanced Imaging (Precertification Required)	\$25 Copay \$100 Copay 20% After Deductible	OON Deductible & Coinsurance	\$25 Copay \$100 Copay 20% After Deductible	OON Deductible & Coinsurance	\$25 Copay \$100 Copay 20% After Deductible	OON Deductible & Coinsurance
Outpatient Facility Services (Precertification Required) - Infusions/Injections - Surgical Services - Outpatient Chemotherapy and Radiotherapy - Dialysis	20% After Deductible	OON Deductible & Coinsurance OON Deductible & Coinsurance Not Covered Not Covered	20% After Deductible	OON Deductible & Coinsurance OON Deductible & Coinsurance Not Covered Not Covered	20% After Deductible	OON Deductible & Coinsurance OON Deductible & Coinsurance Not Covered Not Covered
Inpatient Services (Precertification Required) - Inpatient Hospital Care Facility - Inpatient Hospital Surgical Services (All Fees) - Intensive Care Unit	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance

Plan Comparison: Summary of Benefits & Coverage

Rates effective as of January 1, 2025



PLAN	MM \$1,000		MM \$2,500		MM \$3,500	
NETWORK	INN	OON	INN	OON	INN	OON
Preventive Services - Click here for a complete list.						
Preventive Care/Screening/Immunization - Annual Adult Physical - Adult Immunizations: Flu Vaccine, Pneumonia Vaccine, Tetanus/Diphtheria - Mammogram - Gynecological Services - Routine Colonoscopy - Well Child Care/Newborn Care	\$0 Copay \$0 Deductible	OON Deductible & Coinsurance	\$0 Copay \$0 Deductible	OON Deductible & Coinsurance	\$0 Copay \$0 Deductible	OON Deductible & Coinsurance
Mental Health, Behavioral Health, and/or Substance Use Disorder Services						
- Inpatient Care Mental Health Facility 30 days per benefit year maximum - Outpatient Mental Healthcare Services	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Other Covered Services - Illness or Injury						
Therapy 35 days per benefit year maximum combined - Physical & Occupational Therapies - Speech Therapy - Cardiac Rehabilitation Therapy	\$40 Copay	OON Deductible & Coinsurance	\$40 Copay	OON Deductible & Coinsurance	\$40 Copay	OON Deductible & Coinsurance
Pregnancy/Maternity - Prenatal/Postnatal Office Visit - Room and Board (limited to semi-private room rate)	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Home Health Care 60-visit limit per benefit year	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Hospice Care 30 days per benefit year Residential/Facility	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Inpatient Skilled Nursing Facility 30-day visit limit per benefit year	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Durable Medical Equipment (DME) Limited to 12-month rental or purchase price, whichever is less	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Organ Transplant	20% After Deductible	Not Covered	20% After Deductible	Not Covered	20% After Deductible	Not Covered

Plan Comparison: Summary of Benefits & Coverage

Rates effective as of January 1, 2025



PLAN		MM \$1,000		MM \$2,500		MM \$3,500	
NETWORK		INN	OON	INN	OON	INN	OON
Prescription Drugs							
Retail Pharmacy Copayments 30-day supply at retail pharmacies Mail order required for maintenance medication after initial 30-day supply	Preventive Medicine Generic or Brand Name	\$0 Copay	OON Deductible & Coinsurance	\$0 Copay	OON Deductible & Coinsurance	\$0 Copay	OON Deductible & Coinsurance
	Generic Urgently Needed Care Rx	\$10 Copay	OON Deductible & Coinsurance	\$10 Copay	OON Deductible & Coinsurance	\$10 Copay	OON Deductible & Coinsurance
	Generic Maintenance Rx	\$10 Copay	OON Deductible & Coinsurance	\$10 Copay	OON Deductible & Coinsurance	\$10 Copay	OON Deductible & Coinsurance
	Preferred Brand Name Drugs Urgently Needed Care Rx	\$90 Copay	OON Deductible & Coinsurance	\$90 Copay	OON Deductible & Coinsurance	\$90 Copay	OON Deductible & Coinsurance
	Non-Preferred Brand Name Drugs Urgently Needed Care Rx	\$110 Copay	OON Deductible & Coinsurance	\$110 Copay	OON Deductible & Coinsurance	\$110 Copay	OON Deductible & Coinsurance
	Non-Preferred Brand Name Drugs Maintenance Rx	\$110 Copay	OON Deductible & Coinsurance	\$110 Copay	OON Deductible & Coinsurance	\$110 Copay	OON Deductible & Coinsurance
	Specialty Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available
Mail Order or Retail Pharmacy Copayments 90-day supply	Preventive Medicine Generic or Brand Name	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay		\$0 Copay
	Generic	\$20 Copay	OON Deductible & Coinsurance	\$20 Copay	OON Deductible & Coinsurance	\$20 Copay	OON Deductible & Coinsurance
	Preferred Brand Name Drugs	\$180 Copay	OON Deductible & Coinsurance	\$180 Copay	OON Deductible & Coinsurance	\$180 Copay	OON Deductible & Coinsurance
	Non-Preferred Brand Name Drugs	\$220 Copay	OON Deductible & Coinsurance	\$220 Copay	OON Deductible & Coinsurance	\$220 Copay	OON Deductible & Coinsurance
	Specialty Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available
RX Benefit Highlights							
RX Company		ProAct					
Phone		1-877-635-9545					
Website		https://secure.proactrx.com/					
Pharmacy Advantage Formulary		Pharmacy Advantage Formulary					
Telehealth and Mail Order Formulary		Telehealth and Mail Order Formulary					
Pharmacy Exclusions		Pharmacy Exclusions					

Plan Comparison: Summary of Benefits & Coverage



PREMIUMS BY AGE BAND									
PLAN	MM \$1,000			MM \$2,500			MM \$3,500		
NETWORK	PHCS	CIGNA	ANTHEM	PHCS	CIGNA	ANTHEM	PHCS	CIGNA	ANTHEM
AGES 18-29									
Employee	\$794.78	\$854.78	\$874.78	\$689.25	\$749.25	\$769.25	\$622.11	\$682.11	\$702.11
Employee + Spouse	\$1,407.81	\$1,487.81	\$1,507.81	\$1,203.11	\$1,283.11	\$1,303.11	\$1,072.86	\$1,152.86	\$1,172.86
Employee + Child(ren)	\$1,295.61	\$1,375.61	\$1,395.61	\$1,109.46	\$1,189.46	\$1,209.46	\$991.03	\$1,071.03	\$1,091.03
Family	\$2,028.45	\$2,128.45	\$2,148.45	\$1,724.53	\$1,824.53	\$1,844.53	\$1,531.17	\$1,631.17	\$1,651.17
AGES 30-44									
Employee	\$820.64	\$880.64	\$900.64	\$710.89	\$770.89	\$790.89	\$666.07	\$726.07	\$746.07
Employee + Spouse	\$1,457.99	\$1,537.99	\$1,557.99	\$1,245.09	\$1,325.09	\$1,345.09	\$1,189.00	\$1,269.00	\$1,289.00
Employee + Child(ren)	\$1,341.23	\$1,421.23	\$1,441.23	\$1,171.06	\$1,251.06	\$1,271.06	\$1,089.00	\$1,169.00	\$1,189.00
Family	\$2,102.93	\$2,202.93	\$2,222.93	\$1,786.86	\$1,886.86	\$1,906.86	\$1,627.00	\$1,727.00	\$1,747.00
AGES 45-54									
Employee	\$857.89	\$917.89	\$937.89	\$742.88	\$802.88	\$822.88	\$694.00	\$754.00	\$774.00
Employee + Spouse	\$1,525.42	\$1,605.42	\$1,625.42	\$1,302.31	\$1,382.31	\$1,402.31	\$1,211.00	\$1,291.00	\$1,311.00
Employee + Child(ren)	\$1,403.03	\$1,483.03	\$1,503.03	\$1,224.64	\$1,304.64	\$1,324.64	\$1,119.00	\$1,199.00	\$1,219.00
Family	\$2,200.63	\$2,300.63	\$2,320.63	\$1,869.41	\$1,969.41	\$1,989.41	\$1,689.00	\$1,789.00	\$1,809.00
AGES 55-64									
Employee	\$950.20	\$1,010.20	\$1,030.20	\$819.31	\$879.31	\$899.31	\$739.00	\$799.00	\$819.00
Employee + Spouse	\$1,709.34	\$1,789.34	\$1,809.34	\$1,455.41	\$1,535.41	\$1,555.41	\$1,289.00	\$1,369.00	\$1,389.00
Employee + Child(ren)	\$1,569.76	\$1,649.76	\$1,669.76	\$1,338.88	\$1,418.88	\$1,438.88	\$1,191.00	\$1,271.00	\$1,291.00
Family	\$2,476.05	\$2,576.05	\$2,596.05	\$2,099.09	\$2,199.09	\$2,219.09	\$1,824.00	\$1,924.00	\$1,944.00