PLAN COMPARISON:

Summary of Benefits & Coverage

Rates effective as of January 1, 2025

VL $250/$500 Deductible

VL $500/$1,000 Deductible

VL $750/$1,500 Deductible

VL $1,500/$3,000 Deductible

VL $1,500/$3,000 Deductible

Choose your National PPO network:

PLAN	VL $250	VL $500	VL $750	VL $1,000	VL $1,500
Deductible (The amount the Covered Person pays each benefit year for Covered Services before the Coinsurance is payable.) • Individual • Family	$250 $500	$500 $1,000	$750 $1,500	$1,000 $2,000	$1,500 $3,000
Out-of-Pocket Limit (includes Deductible, Coinsurance, & Copayments) • Individual • Family	$9,200 $18,400	$9,200 $18,400	$9,200 $18,400	$9,200 $18,400	$9,200 $18,400

Copays: Please note that after your deductible has been met, you will still be responsible for paying copayments for your medical services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

• Annual Lab/X-Ray Tests • Annual Pap Smear/Mammogram • Cancer Screenings • Colonoscopies	• Diabetic Supply • Immunizations • Other Preventative Screenings • Precision Rx (Prescriptions)	• Telemedicine (including Mental Health Services) • Urgent Care and Office Visits • Well Baby Care • Wellness Visits

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

• Acupuncture • Children's Dental Check-Up • Children's Glasses	• Children's Eye Exam • Dialysis • Biofeedback	• Mental Health Services (except for Telemedicine) • Substance Abuse Services • Organ Transplant Services

Services may require preauthorization. Failure to obtain preauthorization will result in denial of benefits.

Precertification
Precertification is required for all in-hospital admissions, imaging (CT/PET/MRI/MRA), home health, skilled nursing, hospice, DME (over $500), chemotherapy/radiation, sleep studies, prosthetics/orthotics, therapies (chiropractic, cardiac, PT/OT/ST), and outpatient surgery. Please refer to the plan document for a complete list of all services that require precertification under your plan. A 50% (up to $2,500) penalty will apply for not obtaining precertification.

Emergencies are covered but do require authorization/certification within 48 hours.

PLAN	VL $250	VL $500	VL $750	VL $1,000	VL $1,500
Covered Services - Illness or Injury					
Physician Office Services 10 visits per benefit year maximum is combined for PCP office visits, Specialist Office visits, and Urgent Care visits. 12 visits per benefit year maximum for Chiropractic Care. • Primary Care Physician • Specialist Office Visit • Urgent Care Visit • Spinal Manipulation Chiropractic	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible
Telemedicine • Virtual Primary Care • Urgent Care • Mental Health	$0 Copay $0 Deductible	$0 Copay $0 Deductible	$0 Copay $0 Deductible	$0 Copay $0 Deductible	$0 Copay $0 Deductible
Emergency Services • Emergency Room Care ◦ 2-visit limit per benefit year for accident-related visits ◦ 2-visit limit per benefit year for sickness-related visits • Emergency Medical Transportation ◦ Ground/Air Ambulance	$250 Copay After Deductible	$250 Copay After Deductible	$250 Copay After Deductible	$250 Copay After Deductible	$250 Copay After Deductible
Testing 3 per benefit year • Diagnostic Testing Labs (Quest Diagnostics/LabCorp) • X-Rays ◦ Precertification Required	$25 Copay $50 Copay	$25 Copay $50 Copay	$25 Copay $50 Copay	$25 Copay $50 Copay	$25 Copay $50 Copay
Outpatient Facility Services (Precertification Required) • Infusions/Injections ◦ 10-visit limit per benefit year; maximum combined with chemotherapy/radiation • Surgical Services ◦ 3 surgeries per benefit year; Elective Surgeries not covered • Outpatient Chemotherapy and Radiotherapy ◦ 10-visit limit per benefit year; maximum combined with infusion/injection drugs • Dialysis	$100 Copay After Deductible $250 Copay After Deductible $100 Copay After Deductible Not Covered	$100 Copay After Deductible $250 Copay After Deductible $100 Copay After Deductible Not Covered	$100 Copay After Deductible $250 Copay After Deductible $100 Copay After Deductible Not Covered	$100 Copay After Deductible $250 Copay After Deductible $100 Copay After Deductible Not Covered	$100 Copay After Deductible $250 Copay After Deductible $100 Copay After Deductible Not Covered
Inpatient Services (Precertification Required) • Inpatient Hospital Care Facility ◦ Non-ICU stays limited to 2 hospitalizations per benefit year; 10-day limit per hospitalization • Inpatient Hospital Surgical Services (All Fees) ◦ 2 surgeries per benefit year; Elective Surgeries not covered • Intensive Care Unit ◦ Stays limited to 2 hospitalizations per benefit year; 10-day limit per hospitalization	$1,000 Copay After Deductible	$1,000 Copay After Deductible	$1,000 Copay After Deductible	$1,000 Copay After Deductible	$1,000 Copay After Deductible

PLAN	VL $250	VL $500	VL $750	VL $1,000	VL $1,500
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	100% of Allowable	100% of Allowable	100% of Allowable	100% of Allowable	100% of Allowable
Mental Health, Behavioral Health, and/or Substance Use Disorder Services					

• Inpatient Care Mental Health Facility
  ◦ Facility and professional fees included in the inpatient hospitalization limit; 15 days per benefit year maximum
• Outpatient Mental Healthcare Services
  ◦ 15-day visit limit
	$250 Copay After Deductible
	$50 Copay After Deductible
		$250 Copay After Deductible
		$50 Copay After Deductible
			$250 Copay After Deductible
			$50 Copay After Deductible
				$250 Copay After Deductible
				$50 Copay After Deductible
					$250 Copay After Deductible
					$50 Copay After Deductible

Other Covered Services - Illness or Injury					
Therapy 16 visits per benefit year maximum combined • Physical & Occupational Therapies • Speech Therapy • Cardiac Rehabilitation Therapy	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible
Pregnancy/Maternity • Routine Vaginal Delivery • Routine C-section Delivery • All Other Maternity Service (Other maternity services included: office visits, lab work, radiology, prenatal/postnatal care, etc. Excluded: Genetic testing, unless medically necessary.)	$250 Copay After Deductible $500 Copay After Deductible 100% Covered	$250 Copay After Deductible $500 Copay After Deductible 100% Covered	$250 Copay After Deductible $500 Copay After Deductible 100% Covered	$250 Copay After Deductible $500 Copay After Deductible 100% Covered	$250 Copay After Deductible $500 Copay After Deductible 100% Covered
Home Health Care 10-day limit per benefit year	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible
Hospice Care 10-day visit limit per benefit year • Residential/Facility	$0 Copay After Deductible	$0 Copay After Deductible	$0 Copay After Deductible	$0 Copay After Deductible	$0 Copay After Deductible
Inpatient Skilled Nursing Facility 10-day visit limit per benefit year	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible
Durable Medical Equipment (DME) Copayment is applied per item received; 5 items per benefit year	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible
Prosthetics and Orthotic Devices See covered items per benefit year; Copayment is applied per item received; 1 item per benefit year	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible
Organ Transplant	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

PLAN		VL $250	VL $500	VL $750	VL $1,000	VL $1,500
Diabetic Nutritional Counseling 1 visit per benefit year		$0 Copay After Deductible	$0 Copay After Deductible	$0 Copay After Deductible	$0 Copay After Deductible	$0 Copay After Deductible
Allergies • Shots (24 visits per benefit year) • Visits/Testing (2 visits per benefit year)		$25 Copay After Deductible $50 Copay After Deductible	$25 Copay After Deductible $50 Copay After Deductible	$25 Copay After Deductible $50 Copay After Deductible	$25 Copay After Deductible $50 Copay After Deductible	$25 Copay After Deductible $50 Copay After Deductible
Prescription Drugs						
Retail Pharmacy Copayments 30-day supply at retail pharmacies Mail order required for maintenance medication after initial 30-day supply	**Generic Maintenance Rx**	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
	Generic Urgently Needed Care Rx	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
	Preferred Brand Name Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available
	Non-Preferred Brand Name Drugs	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	**Generic**	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
	Preferred Brand Name Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available
	Non-Preferred Brand Name Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available