PLAN COMPARISON:

Summary of Benefits & Coverage

Rates effective as of January 1, 2025
PPO in-network and out-of-network benefits

MM $4,900 Deductible

MM $7,250 Deductible

Choose your National PPO network:

PHCS

cigna healthcare

Anthem

PLAN	MM $4,900		MM $7,250	
NETWORK	**INN**	**OON**	**INN**	**OON**
Payment for Services				
In-network Provider: The provider network is shown on your I.D. card. For help in locating In-network Providers, click here.				
Maximum Annual Benefit	Unlimited		Unlimited	
Deductible The amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable. Individual Family	$4,900 $9,800	$9,800 19,600	$7,250 $14,500	$14,500 $29,000
Coinsurance The percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met.	20%	50%	20%	50%
Out-of-Pocket Limit Includes Deductible, Coinsurance & Copayments. Individual Family	$9,200 $18,400	$18,400 $36,800	$9,200 $18,400	$18,400 $36,800
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.				

PLAN	MM $4,900		MM $7,250	
NETWORK	**INN**	**OON**	**INN**	**OON**
Covered Services - Illness or Injury				

Physician Office Services
• Primary Care Physician
  ◦ Office visits only
• Specialist Office Visit
  ◦ No referral needed
• 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

Telemedicine • Virtual Primary Care • Urgent Care • Mental Health	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Emergency Services (Precertification Required) • Emergency Room Care • Emergency Medical Transportation ◦ Ground / Air ambulance services.	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
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
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

PLAN	MM $4,900		MM $7,250	
NETWORK	**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
Mental Health, Behavioral Health and/or Substance Use Disorder Services				
• Inpatient Care Mental Health Facility ◦ 30 days per calendar year maximum • Outpatient Mental Healthcare Services	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Other Covered Services - Illness or Injury				
Therapies 35 days per calendar year maximum combined • Physical & Occupational Therapies • Speech Therapy • Cardiac Rehabilitation Therapy	$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
Home Health Care 60 visit limit per Benefit Year	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
Inpatient Skilled Nursing Facility 30 day visit limit per Benefit Year	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
Organ Transplant	20% After Deductible	Not Covered	20% After Deductible	Not Covered

PLAN		MM $4,900		MM $7,250	
NETWORK		**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
	Generic Urgently Needed Care Rx	$10 Copay	OON Deductible & Coinsurance	$10 Copay	OON Deductible & Coinsurance
	Generic Maintenance Rx	$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
	Non-Preferred Brand Name Drugs Urgently Needed Care Rx	$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
	Specialty Drugs	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
	Generic	$20 Copay	OON Deductible & Coinsurance	$20 Copay	OON Deductible & Coinsurance
	Preferred Brand Name Drugs	$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
	Specialty Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available