2024
Benefits Guide

OneHealth

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Dental Plans

We are pleased to offer comprehensive PPO plans and flexible features that can be easily paired to meet your dental needs.

Sun Life Dental Network: Our Dental plans offer one of the nation's largest PPO networks. It's easy for members to receive quality dental care from a network dentist near home or work.

The following is a high-level overview of the coverage available.

Key Dental Benefits	Class 1 In-Network	Class 2 In-Network
Benefit Maximum (preventative, basic, and major services combined)		
Per Individual	$1,000	$2,000
Annual Deductible (Calendar Year)		
Individual	$50	$50
Family	$150	$150
Covered Services		
Preventative Services	100%	100%
Basic Services Individual / Family	80%	80%
Major Services Individual / Family	50%	50%
Orthodontia (Child Only)	N/A	50% up to $1,000

See Carrier Summary Plan Design for complete coverages and exclusions

Dental*	Class 1	Class 2
Member Only	$28.11	$32.87
Member and Spouse	$55.68	$65.12
Member and Child(ren)	$75.62	$90.68
Member and Family	$103.18	$122.93

*Monthly Rates

To find a Dental Provider:
Go to: https://sunlife.com/findadentist
and follow the prompts for the PPO network in your area.

Vision Plan

We are proud to offer you a vision plans through Sun Life. Our flexible plan will help you maximize your benefits and reduce your out-of-pocket costs if you choose a provider who participates in the Sun Life network.

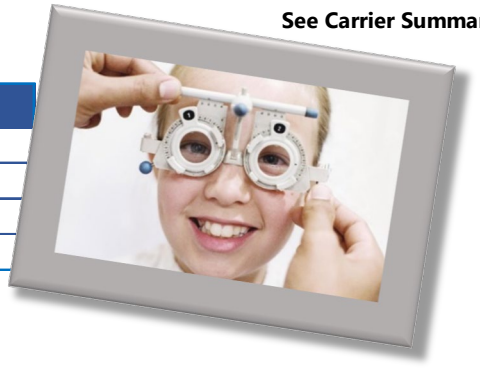
To find a Vision Provider:
Go to: https://vsp.com
and select the Choice Network,
or call VSP at (800) 877-7195

Key Vision Benefits	Class 2 In-Network
Exam (Once every 12 months)	$10
Lenses (Once every 12 months)	
Single Vision	$10
Bifocal	$10
Trifocal	$10
Frames (once every 12 months)	$150 Allowance
Contact Lenses (in lieu of glasses)	$150 Allowance

See Carrier Summary Plan Design for complete coverages and exclusions

Vision*	
Member Only	$11.53
Member and Spouse	$23.05
Member and Child(ren)	$25.35
Member and Family	$36.83

*Monthly Rates



Hospital Indemnity

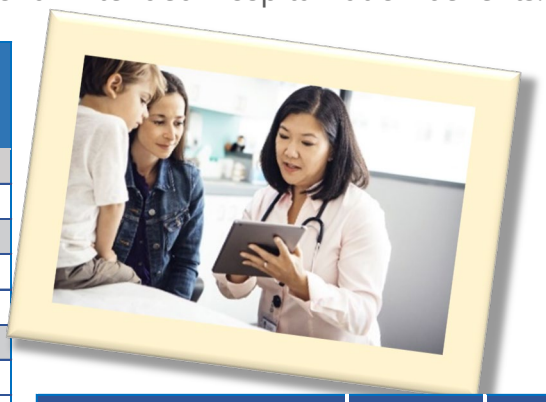
Hospital Indemnity helps members with out-of-pocket medical costs incurred with a hospital stay. Sun Life's plan provides flexible options to make it easy to meet cost and coverage goals. Members with hospital stays of 10 days or more may receive additional Extended Hospitalization benefits.

Hospital Indemnity Benefits	$1,000	$2,000
First Day Benefits (Once per Benefit Year)		
First Day Hospital (24 Hour Minimum)	$1,000 per day	$2,000 per day
Confinement Benefits (Up to 30 days, payable with the First Day Benefit)		
Hospital Confinement	$100 per day	$200 per day
ICU Confinement	$100 per day	$200 per day
Additional & Enhanced Benefits (per Benefit Year)		
Extended Hospitalization*	$100 per day	$200 per day
Wellness Screening**	$50 per day	$50 per day

*Additional Extended Hospitalization benefit pays after 10 consecutive days in a row beginning with your first day in a regular hospital room or the ICU

**Wellness Screening pays 1 day per insured per benefit year

See Carrier Summary Plan Design for complete coverages and exclusions



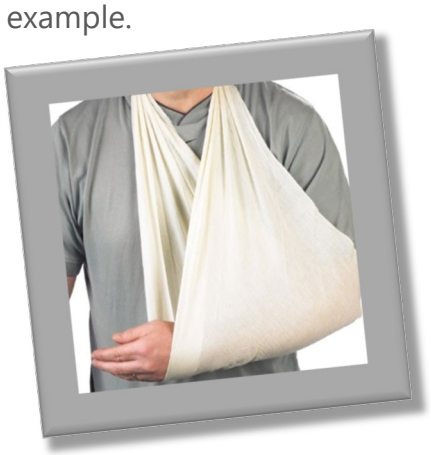
Hospital Indemnity*	$1,000	$2,000
Member Only	$24.44	$45.65
Member and Spouse	$51.51	$96.54
Member and Child(ren)	$41.62	$77.48
Family	$68.69	$128.37

*Monthly Rates

Accident Insurance

Accidents happen in places where you and your family spend the most time – at work, in the home, and on the playground – and they're unexpected. How you care for them shouldn't be.

Accident insurance from Sun Life offers a wide range of covered benefits. Injured members and their dependents may use the case benefits however they want—to satisfy deductibles, pay out-of-pocket medical expenses, or pay household bills for example.



Voluntary Accident Insurance	High
Sample Benefits List	
Accident Emergency Treatment	$150
Ambulance Air/Ground	$2,000 / $400
Hospital / ICU Admission (either/or)	$2,000 / $3,000
Hospital / ICU Confinement (per day)	$400 / $500
Companion Lodging (per day)	$100
Dislocation	$200 - $8,000
Fractures	$300 - $10,000
Lacerations	$35 - $500
Burns	$400 - $20,000
X-Ray	$100
Accident Follow Up Doctors Visit	$100
Occupational / Physical Therapy (per day)	$50
Appliance	$500
Accident Dismemberment (loss of one item)	$1,500 - $15,000
Catastrophic (loss of two or more items)	up to $25,000
Accidental Death	up to $50,000

See Carrier Summary Plan Design for complete coverages and exclusions

Accident Plan*	High
Member Only	$22.28
Member and Spouse	$39.69
Member and Child(ren)	$46.37
Family	$63.74

*Monthly Rates

Critical Illness Insurance with Cancer Coverage

Even those of us who plan for the unexpected with life, disability, and health insurance may discover that some expenses can remain unpaid. Without adequate protection, sufferers of critical illnesses might have to pull from their saving or rely on other financial sources in their time of need.

Cancer coverage may include invasive and non-invasive cancers. Cancer may be standalone or offered with standard core benefits.

Critical Illness Insurance	
Core Conditions	% of Face Amount Paid
Heart Attack (Myocardial Infarction)	100%
Stroke	100%
Major Organ Failure	100%
End-Stage Kidney Disease	100%
Coronary Artery Bypass Graft	25%
Angioplasty	5%
Cancer Conditions	% of Face Amount Paid
Invasive Cancer	100%
Non-Invasive Cancer	25%
Annual Wellness Screening Benefit (Once per insured per benefit year)	
All Insured Family Members	$50

See Carrier Summary Plan Design for complete coverages and exclusions

Critical Illness / Cancer Plan	
Age Band*	**Rates****
Under age 25	$0.48
25 - 29	$0.52
30 - 34	$0.69
35 - 39	$1.04
40 - 44	$1.56
45 - 49	$2.30
50 - 54	$3.29
55 - 59	$4.25
60 - 64	$5.16
65 - 69	$6.46
70 - 74	$8.62
75 and over	$11.44
Child Benefit Coverage	**Rate**
All Age Bands to age 26	$0.09

* Issue age rating applies - premiums will not increase due to age
**Monthly Rate basis: Per $1,000 of coverage. Spouse rates are same as member. Spouse Rates based on members age

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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	$0 Copay	$0 Copay	$0 Copay	$0 Copay
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.

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.

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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	$0 Copay	$0 Copay	$0 Copay	$0 Copay
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.

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