

# 2025

## Benefits Guide



**OneHealth** 

*The following does not apply  
to NY, WA, NM, MT, MN*

# Dental Plans

## Comprehensive coverage for a healthy, confident smile

Keeping your smile healthy means making time for routine cleanings and exams, with coverage that also extends to fillings, major dental procedures, and even orthodontics for mid and high plans. With a **PPO dental plan**, you'll have the flexibility to choose care from both in-network and out-of-network providers, ensuring your oral health is protected at every stage of life.

Key Dental Benefits	Low Plan	Mid Plan	High Plan
	In-Network	In-Network	In-Network
<b>Benefit Maximum (preventative, basic, and major services combined)</b>			
<i>Per Individual</i>	\$1,000	\$2,000	\$3,000
<b>Annual Deductible (Calendar Year)</b>			
<i>Individual</i>	\$50	\$50	\$50
<i>Family</i>	\$150	\$150	\$150
<b>Covered Services</b>			
<i>Preventative Services</i>	100%	100%	100%
<i>Basic Services</i>	80%	80%	90%
<i>Major Services</i>	50%	50%	60%
<i>Orthodontia (child only)</i>	N/A	\$1,000	\$1,500

See Carrier Summary Plan Design for complete coverages and exclusions

Watch This Quick Video To Learn More About Dental Insurance!



### To find a Dental Provider:

Go to: <https://www.equitable.com/dentalprovider> and follow the prompts for the PPO network in your area.

We are proud to offer you dental plans through Equitable, featuring one of the **largest dental networks nationally** with access to over **136,000 dentists at more than 500,000 locations.**

	Low Plan	Mid Plan	High Plan
	\$1,000 Max	\$2,000 Max	\$3,000 Max
	Monthly Rate	Monthly Rate	Monthly Rate
<b>Member Only</b>	\$36.68	\$42.89	\$62.22
<b>Member + Spouse</b>	\$70.59	\$82.58	\$119.83
<b>Member + Dependent(s)</b>	\$95.88	\$115.00	\$156.25
<b>Full Family</b>	\$130.84	\$155.83	\$215.59

# Vision Plan

## Clear coverage for all your vision care needs

Protecting your eyesight means allowing for routine visits to the optometrist for eye exams, as well as coverage for **glasses and contacts**. Make sure your eyes remain in great shape at any age - no matter how much time you spend staring at digital screens.



Key Vision Benefits	In-Network
Exam (Once every 12 months)	\$10
Frames (Once every 12 months)	\$150 Allowance
Contact Lenses (in lieu of glasses)	\$150 Allowance
<b>Lenses (Once every 12 months):</b>	
Single Vision Lenses	\$10
Lined Bifocal Lenses	\$10
Lined Trifocal Lenses	\$10
Lenticular Lenses	\$10
<b>Additional Discounts</b>	
Laser Corrective Surgery	Up to 15% off the usual charge
Glasses (additional pairs)	20% off retail price

**Watch This Quick Video To Learn More About Vision Insurance!**



**We are proud to offer vision plans through Guardian and VSP, giving you access to one of the most extensive networks of eye care professionals in the nation. With over 70,000 access points, including independent practices and retail locations, VSP ensures comprehensive coverage to meet your vision care needs wherever you are.**

### To find a Vision Provider:

Go to: <https://vsp.com/eye-doctor> and select the Choice Network, or call VSP at (800) 877-7195

	Monthly Rate
Member Only	\$12.68
Member + Spouse	\$25.31
Member + Dependent(s)	\$27.84
Full Family	\$40.51

# Accident Insurance

## Protection for when the unexpected happens

Accident insurance from Equitable provides comprehensive coverage for injuries sustained **both at work and at home**. Members and their dependents can use the cash benefits however they need, whether to satisfy deductibles, cover out-of-pocket medical expenses, or manage household bills during recovery.



**Watch This Quick Video To Learn More About Accident Insurance!**



Key Accident Benefits	Benefit Schedule
<b>Initial Accident Benefit</b>	
<i>Coverage Type</i>	On & Off The Job
<i>Annual Wellness Benefit</i>	\$50
<b>Initial Accident Benefit</b>	
<i>Accident Emergency Treatment</i>	\$150
<i>Accident Follow Up Visits (Up to 10 visits)</i>	\$75
<b>Schedule of Additional Benefits</b>	
<i>Ambulance Air / Ground</i>	\$2,000 / \$400
<i>X-Ray</i>	\$100
<i>Fractures</i>	\$750 - \$12,000
<i>Dislocations</i>	\$500 - \$10,000
<i>Lacerations</i>	\$35 - \$500
<i>Burns</i>	\$400 - \$20,000
<i>Occupational/Physical Therapy (Up to 10 visits)</i>	\$100
<i>Medical Device</i>	\$500
<b>Accident Related Hospitalization</b>	
<i>Hospital / ICU Admission</i>	\$2,000 / \$3,000
<i>Hospital Confinement Per Day</i>	\$400
<i>Additional ICU Admission Per Day (15 day max)</i>	\$500
<i>Companion Lodging Per Day (30 day max)</i>	\$100
<b>Life and Dismemberment Losses</b>	
<i>Accidental Death</i>	Up To \$50,000
<i>Accidental Death Common Carrier</i>	Up To \$200,000
<i>Catastrophic Loss / Dismemberment</i>	Up To \$25,000

See Carrier Summary Plan Design for complete coverages and exclusions

**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.**

	Monthly Rate
Member Only	\$29.01
Member + Spouse	\$51.68
Member + Dependent(s)	\$60.37
Full Family	\$82.99

# Hospital Indemnity

## Coverage for expenses due to a hospital stay

Hospital indemnity insurance from Equitable provides a range of covered benefits, including **support for maternity stays** as well as both planned and unexpected surgeries. Members and their dependents can use the cash benefits however they choose, whether to cover deductibles, pay medical expenses, or manage household bills during recovery.

**Watch This Quick Video To Learn More About Hospital Indemnity Plans!**



Key Accident Benefits	Low Plan	High Plan
<b>First Day Benefits</b>		
<i>First Day Hospital Confinement</i>	\$1,000 Once Per Year	\$2,000 Once Per Year
<i>First Day Intensive Care Unit (ICU) Confinement</i>	\$2,000 Once Per Year	\$4,000 Once Per Year
<b>Confinement Benefits (Per Year Benefits)</b>		
<i>Daily Hospital Confinement</i>	\$200, up to 31 days	\$300, up to 31 days
<i>Daily ICU Confinement</i>	\$400, up to 10 days	\$500, up to 10 days
<i>Daily Rehabilitation Unit Confinement</i>	\$50, up to 60 days	\$50, up to 60 days
<i>Daily Well Baby Nursery Confinement</i>	\$100, up to 3 days per child	\$200, up to 3 days per child
<b>Schedule of Additional Benefits</b>		
<i>Annual Wellness Screening (Per Insured)</i>	\$50	\$50
<i>Emergency Room Treatment – Accident Only</i>	\$100	\$200
<i>Daily Family Care</i>	\$100, up to 5 days per year	\$200, up to 5 days per year
<i>Daily Lodging</i>	\$100, up to 5 days per year	\$200, up to 5 days per year
<i>Daily Transportation</i>	\$100, up to 5 days per year	\$200, up to 5 days per year

See Carrier Summary Plan Design for complete coverages and exclusions

9 Month Maternity Waiting Period For Coverage



**Unexpected hospital stays can create financial strain, even with insurance. With high medical costs, hospital indemnity insurance provides cash benefits to help cover out-of-pocket expenses and ease the burden.**

**Did you know? Hospital costs average \$2,607 per day throughout the United States**

	Low Plan	High Plan
	Monthly Rate	Monthly Rate
Member Only	\$31.90	\$59.59
Member + Spouse	\$67.24	\$126.01
Member + Dependent(s)	\$54.33	\$101.13
Full Family	\$89.66	\$167.56

# Critical Illness Coverage

## Lump sum payment upon diagnosis of a covered condition

Life can take an unexpected turn with a serious diagnosis, but your financial security doesn't have to. Critical illness insurance provides a **lump sum cash benefit** when you need it most, letting you focus on recovery instead of expenses. Even with life, disability, and health insurance, unexpected costs can arise, and this plan helps cover gaps.

Covered Conditions	Benefit Amounts
<b>Core Conditions</b>	
Heart Attack	100%
Stroke	100%
Major Organ Failure	100%
End-stage Heart Failure	100%
End-stage Kidney Disease	100%
Coma	100%
Blindness	100%
Paralysis	100%
Loss of Speech	100%
Complete Loss of Hearing	100%
Advanced ALS	100%
Advanced Alzheimers	100%
Advanced Parkinsons	100%
Severe Burns	100%
<b>Cancer Conditions</b>	
Cancer Conditions	100%
Cancer in Situ	25%
Skin Cancer	5%
<b>Childhood Specific Conditions</b>	
Down Syndrome	100%
Cerebral Palsy	100%
Complex Congenital Heart Disease	100%
Cystic Fibrosis	100%
Spina Bifida	100%
Cleft Lip/Palate	100%
Type 1 Diabetes Mellitus	100%
Muscular Dystrophy	100%

See Carrier Summary Plan Design for complete coverages and exclusions  
Includes Annual Wellness Benefit of \$50 per covered policyholder

**Did you know that 66% of U.S. bankruptcies are tied to medical issues, like high care costs or lost income? Nearly 40% of people face a cancer diagnosis in their lifetime, and a heart attack occurs every 40 seconds, making the financial impact of critical illness devastating.**

Benefits and coverage are subject to change. Please refer to the carrier's policy for exact details.

		\$10,000 Benefit	\$20,000 Benefit	\$30,000 Benefit	\$40,000 Benefit
		Monthly Premium			
Age Band	<24	\$6.18	\$12.36	\$18.54	\$24.72
	25-29	\$6.70	\$13.39	\$20.09	\$26.78
	30-34	\$8.84	\$17.69	\$26.53	\$35.38
	35-39	\$13.31	\$26.62	\$39.92	\$53.23
	40-44	\$19.93	\$39.86	\$59.80	\$79.73
	45-49	\$29.35	\$58.70	\$88.06	\$117.41
	50-54	\$42.12	\$84.24	\$126.36	\$168.48
	55-59	\$54.55	\$109.10	\$163.66	\$218.21
	60-64	\$66.28	\$132.55	\$198.83	\$265.10
	65-69	\$83.50	\$166.99	\$250.49	\$333.98
	70-74	\$111.64	\$223.27	\$334.91	\$446.54
	75+	\$148.88	\$297.77	\$446.65	\$595.54

**Watch This Quick Video To Learn More About Critical Illness Plans!**



### Add a Child Rider

Requires Employee Coverage

Max % of Employee Benefit: 50%

Covers All Eligible Children

Child Benefit Rider	Monthly Premium
\$5,000	\$0.45
\$10,000	\$0.90
\$15,000	\$1.35
\$20,000	\$1.80



*The following does not apply  
to NY, WA, NM, MT, MN*

Benefit Summary	1,000 Classic	1,500 Classic	2,500 Classic	3,500 Classic
<b>Benefits</b>	In-Network	In-Network	In-Network	In-Network
<b>Deductible</b> Individual / Family	\$1,000 / \$2000	\$1,500 / \$3,000	\$2,500 / \$5,000	\$3,500 / \$7,000
<b>Coinsurance</b> Plan Pays /Member Pays	80% / 20%	80% / 20%	80% / 20%	80% / 20%
<b>Out-of-Pocket Maximum</b> Individual / Family	\$5,000 / \$10,000	\$7,350 / \$14,700	\$7,350 / \$14,700	\$7,350 / \$14,700
<b>Routine Preventive Services (Non Diagnostic)</b>	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived
<b>Lifetime Maximum</b>	No Maximum	No Maximum	No Maximum	No Maximum
<b>Co-Pay</b>				
<b>Primary Care Co-Pay</b>	\$20	\$30	\$30	\$45
<b>Specialist Co-Pay</b>	\$40	\$60	\$60	\$90
<b>Chiropractic Care Co-Pay</b> Limited to 20 visits per benefit period	\$20	\$20	\$20	\$20
<b>Urgent Care</b>	\$40	\$80	\$80	\$90
<b>Embedded No Cost Services</b>				
<b>Telemedicine</b>	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
<b>Virtual Primary Care</b>	Included	Included	Included	Included
<b>Advocacy Services</b>	Included	Included	Included	Included
<b>Facility &amp; Professional Services (Patient Responsibility)</b>				
<b>Inpatient Hospital</b> (patient responsibility)	20% after deductible	20% after deductible	20% after deductible	20% after deductible
<b>Out Patient Services</b> <b>Surgical Services (Procedure &amp; Anesthesia)</b>	20% after deductible	20% after deductible	20% after deductible	20% after deductible
<b>Emergency Room</b>	20% after deductible	20% after deductible	20% after deductible	20% after deductible
<b>Laboratory &amp; Diagnostic Services (Patient Responsibility)</b>				
<b>Free Standing Lab &amp; Diagnostic Services</b> (Lab & x-ray)	0% after deductible	0% after deductible	0% after deductible	0% after deductible
<b>Complex Diagnostic Services</b> (CT, MRI, Ultra Sound, PET, Nuclear Med.)	20% after deductible	20% after deductible	20% after deductible	20% after deductible
<b>Professional Fees</b>	20% after deductible	20% after deductible	20% after deductible	20% after deductible
<b>Prescription Drug Benefit – **Non participating pharmacies are not covered**</b>				
<b>Prescription Drug</b>	In-Network	In-Network	In-Network	In-Network
<b>Deductible</b>	None	None	None	None
<b>Speciality</b>	Specialty See plan document for more information			
<b>Retail (30 Day Supply)</b>	\$15/\$45/\$85	\$15/\$45/\$85	\$15/\$45/\$85	\$15/\$65/\$100
<b>Generic</b>	Retail: \$15 co-pay	Retail: \$15 co-pay	Retail: \$15 co-pay	Retail: \$15 co-pay
<b>Preferred Brand</b>	Retail: \$45 co-pay	Retail: \$45 co-pay	Retail: \$45 co-pay	Retail: \$65 co-pay
<b>Non-Preferred Brand</b>	Retail: \$85 co-pay	Retail: \$85 co-pay	Retail: \$85 co-pay	Retail: \$100 co-pay
<b>Mail Order (31-90 Day Supply)</b>	\$45/\$90/\$150	\$45/\$90/\$150	\$45/\$90/\$150	\$45/\$90/\$150
<b>Generic</b>	Mail Order: \$45 co-pay	Mail Order: \$45 co-pay	Mail Order: \$45 co-pay	Mail Order: \$45 co-pay
<b>Preferred Brand</b>	Mail Order: \$90 co-pay	Mail Order: \$90 co-pay	Mail Order: \$90 co-pay	Mail Order: \$90 co-pay
<b>Non-Preferred Brand</b>	Mail Order: \$150 co-pay	Mail Order: \$150 co-pay	Mail Order: \$150 co-pay	Mail Order: \$150 co-pay
<b>Non-Network Services (Patient Responsibility)</b>				
<b>Coinsurance</b> Plan Pays/Member Pays	60% / 40%	60% / 40%	60% / 40%	60% / 40%
<b>Deductible</b> Individual/Family	\$2,000 / \$4,000	\$3,000 / \$6,000	\$5,000 / \$10,000	\$7,000 / \$14,000
<b>Out of Pocket Maximum</b> Individual/Family	\$10,000 / \$20,000	\$14,700 / \$29,400	\$14,700 / \$29,400	\$14,700 / \$29,400

NOTE: Precertification 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.

Benefit Summary	5,000 Classic	7,350 Value	3,500 HSA	5,000 HSA
<b>Benefits</b>	In-Network	In-Network	In-Network	In-Network
<b>Deductible</b> Individual / Family	\$5,000 / \$10,000	\$7,350 / \$14,700	\$3,500 / \$7,000	\$5,000 / \$10,000
<b>Coinsurance</b> Plan Pays /Member Pays	80% / 20%	100%	80% / 20%	80% / 20%
<b>Out-of-Pocket Maximum</b> Individual / Family	\$7,350 / \$14,700	\$7,350/\$14,700	\$6,550/\$13,100	\$7,350 / \$14,700
<b>Routine Preventive Services (Non Diagnostic)</b>	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived
<b>Lifetime Maximum</b>	No Maximum	No Maximum	No Maximum	No Maximum
<b>Co-Pay</b>				
<b>Primary Care Co-Pay</b>	\$45	\$50	20% after deductible	20% after deductible
<b>Specialist Co-Pay</b>	\$90	\$100	20% after deductible	20% after deductible
<b>Chiropractic Care Co-Pay</b> <small>Limited to 20 visits per benefit period</small>	\$20	\$20	20% after deductible	20% after deductible
<b>Urgent Care</b>	\$90	\$100	20% after deductible	20% after deductible
<b>Embedded No Cost Services</b>				
<b>Telemedicine</b>	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
<b>Virtual Primary Care</b>	Included	Included	Included	Included
<b>Advocacy Services</b>	Included	Included	Included	Included
<b>Facility &amp; Professional Services (Patient Responsibility)</b>				
<b>Inpatient Hospital</b> <small>(patient responsibility)</small>	20% after deductible	0% after deductible	20% after deductible	20% after deductible
<b>Out Patient Services</b> <b>Surgical Services (Procedure &amp; Anesthesia)</b>	20% after deductible	0% after deductible	20% after deductible	20% after deductible
<b>Emergency Room</b>	20% after deductible	0% after deductible	20% after deductible	20% after deductible
<b>Laboratory &amp; Diagnostic Services (Patient Responsibility)</b>				
<b>Free Standing Lab &amp; Diagnostic Services</b> <small>(Lab &amp; x-ray)</small>	0% after deductible	0% after deductible	0% after deductible	0% after deductible
<b>Complex Diagnostic Services</b> <small>(CT, MRI, Ultra Sound, PET, Nuclear Med.)</small>	20% after deductible	0% after deductible	20% after deductible	20% after deductible
<b>Professional Fees</b>	20% after deductible	0% after deductible	20% after deductible	20% after deductible
<b>Prescription Drug Benefit – **Non participating pharmacies are not covered**</b>				
<b>Prescription Drug</b>	In-Network	In-Network	In-Network	In-Network
<b>Deductible</b>	None	None	Medical Deductible	Medical Deductible
<b>Speciality</b>	Specialty See plan document for more information			
<b>Retail (30 Day Supply)</b>	\$15/65/\$100	\$15/65/\$100	\$15/65/\$100	\$15/65/\$100
<b>Generic</b>	Retail: \$15 co-pay	Retail: \$15 co-pay	Retail: \$15 co-pay	Retail: \$15 co-pay
<b>Preferred Brand</b>	Retail: \$65 co-pay	Retail: \$65 co-pay	Retail: \$65 co-pay	Retail: \$65 co-pay
<b>Non-Preferred Brand</b>	Retail: \$100 co-pay	Retail: \$100 co-pay	Retail: \$100 co-pay	Retail: \$100 co-pay
<b>Mail Order (31-90 Day Supply)</b>	\$45/\$90/\$150	\$45/\$90/\$150	\$45/\$90/\$150	\$30/\$130/\$200
<b>Generic</b>	Mail Order: \$45 co-pay	Mail Order: \$45 co-pay	Mail Order: \$45 co-pay	Mail Order: \$30 co-pay
<b>Preferred Brand</b>	Mail Order: \$90 co-pay	Mail Order: \$90 co-pay	Mail Order: \$90 co-pay	Mail Order: \$130 co-pay
<b>Non-Preferred Brand</b>	Mail Order: \$150 co-pay	Mail Order: \$150 co-pay	Mail Order: \$150 co-pay	Mail Order: \$200 co-pay
<b>Non-Network Services (Patient Responsibility)</b>				
<b>Coinsurance</b> Plan Pays/Member Pays	60% / 40%	50% / 50%	60% / 40%	60% / 40%
<b>Deductible</b> Individual/Family	\$7,000 / \$14,000	\$14,700 / \$29,400	\$7,000 / \$14,000	\$10,000 / \$20,000
<b>Out of Pocket Maximum</b> Individual/Family	\$14,700 / \$29,400	\$14,700 / \$29,400	\$13,100 / \$26,200	\$14,700 / \$29,400

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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