

# Benefit comparison

January 1, 2026 – December 31, 2026

	Standard POS	Premier POS	HDHP with HSA
<b>IN-NETWORK BENEFITS</b>			
<b>Deductible</b> (individual/family)	\$500 / \$750	\$400 / \$600	\$3,400 / \$6,800 (combined with out of network)
<b>Out-of-pocket maximum</b>	Medical and pharmacy combined: \$3,000/\$6,000	Medical and pharmacy combined: \$2,500/\$5,000	Medical and pharmacy combined: \$4,000 / \$8,000
<b>Inpatient benefits</b>	<b>You pay</b>	<b>You pay</b>	<b>You pay</b>
<b>Hospital</b>	30% after deductible	5% after deductible	0% after deductible
<b>Physician charges</b>	30% after deductible	5% after deductible	0% after deductible
<b>Maternity</b> (Facility charges for delivery)	30% after deductible	5% after deductible	0% after deductible
<b>Mental health and substance abuse</b> (Facility charges)	30% after deductible	5% after deductible	0% after deductible
<b>Outpatient benefits</b>	<b>You pay</b>	<b>You pay</b>	<b>You pay</b>
<b>Referrals to specialist required</b>	No	No	No
<b>Preventive care</b>	No charge	No charge	No charge
<b>Virtual Care through LiveHealth Online</b>	No charge	No charge	No charge
<b>Primary care physician (PCP) or OB-GYN office visit</b>	\$25	\$20	0% after deductible
<b>Vera Whole Health Primary Care</b>	No charge	No charge	0% after deductible
<b>Specialist office visit</b>	\$45	\$40	0% after deductible
<b>Urgent care center</b>	\$25 PCP / \$45 specialist	\$20 PCP / \$40 specialist	0% after deductible
<b>Allergy testing</b>	\$25 PCP / \$45 specialist	\$20 PCP / \$40 specialist	0% after deductible
<b>Allergy serum and injections</b>	\$25 PCP / \$45 specialist	\$10	0% after deductible
<b>Mammogram</b>	No charge	No charge	No charge
<b>Labs, diagnostic X-rays</b>	No charge	No charge	0% after deductible
<b>Advanced diagnostic imaging:</b> in office setting	10% after deductible	5% after deductible	0% after deductible
<b>Advanced diagnostic imaging:</b> all other settings	30% after deductible	5% after deductible	0% after deductible
<b>Maternity outpatient services</b>			
Initial office visit to confirm diagnosis	\$25	\$20	0% after deductible
Pre- and post-natal care and delivery	\$50 per pregnancy	\$50 per pregnancy	0% after deductible
Maternity ultrasounds	No charge	No charge	0% after deductible

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	Standard POS	Premier POS	HDPH with HSA
	You pay	You pay	You pay
<b>Emergency room</b> (waived if admitted to the hospital)	\$250	\$250	0% after deductible
<b>Outpatient surgery facility professional provider</b>	30% after deductible	5% after deductible	0% after deductible
<b>Outpatient therapy: occupational, speech, and physical</b>	\$45	\$25	0% after deductible
<b>Spinal manipulation</b> (30 visit limit per CY)	\$25	\$25	0% after deductible
<b>Outpatient mental health and substance abuse</b>	\$25	\$20	0% after deductible
<b>Durable medical equipment</b>	No charge after deductible	No charge after deductible	0% after deductible
<b>Home healthcare</b> (90 visit limit per CY)	\$45 per visit after deductible	No charge after deductible	0% after deductible
<b>Skilled nursing facility</b> (100 days per admission)	30% after deductible	5% after deductible	0% after deductible
<b>Hospice care</b>	30% after deductible	5% after deductible	0% after deductible
<b>Prescription drugs</b>	<b>Mandatory generic</b>	<b>Mandatory generic</b>	<b>Mandatory generic</b>
<b>Rx deductible</b> (individual/family)	\$150/\$150	\$150/\$150	Plan deductible applies
<b>Retail pharmacy</b> (30 day supply)	After deductible: \$10/\$30/\$55	After deductible: \$10/\$30/\$55	After deductible: \$10/\$30/\$55
<b>Mail order</b> (90 day supply)	After deductible: \$10/\$60/\$165	After deductible: \$10/\$60/\$165	After deductible: \$10/\$60/\$165
<b>Retail 90</b> (90 day supply purchased at a participating retail pharmacy)	After deductible: \$30/\$90/\$165	After deductible: \$30/\$90/\$165	After deductible: \$30/\$90/\$165
<b>Routine vision – Blue View Vision</b>			
<b>Annual routine eye exam</b>	\$15	\$15	\$15 (deductible does not apply)
<b>OUT-OF-NETWORK BENEFITS</b>			
<b>Deductible</b> (Individual/Family)	\$750/\$1,125	\$600/\$900	\$3,400/\$6,800 (combined with in- network)
<b>Coinsurance</b>	30%	30%	30%
<b>Out-of-pocket maximum</b>	\$3,000/\$6,000	\$2,500/\$5,000	\$6,000/\$12,000
<b>Lifetime maximum</b>	Unlimited	Unlimited	Unlimited