

Health Savings Account (HSA) Compatible Plans

	In Network (You Pay)	Out-of-Network ⁶ (You Pay)
Option 1	\$2,500 Self Only / 5,000 Family ¹	
Calendar Year Deductible ¹		
Coinsurance (applies to certain services)	0%	20%
Out-of-pocket Maximum	\$2,500 Self Only / \$5,000 Family	\$4,500 Self Only / \$9,000 Family
Option 2	\$5,000 Self Only / \$10,000 Family ¹	
Calendar Year Deductible ¹		
Coinsurance (applies to certain services)	0%	20%
Out-of-pocket Maximum	\$5,000 Self Only / \$10,000 Family	\$7,000 Self Only / \$14,000 Family
Dependent Children Covered	To Age 25	
Plan Lifetime Maximum	Unlimited	
Preexisting Condition Waiting Period	330 Days (prior coverage credit can reduce or eliminate)	
Physician Office Visit (includes Chiropractic care)	Deductible	Deductible and coinsurance
Well Child Care Exams and Immunizations (through age 18)	Nothing	Balance between approved amt. & provider's actual billed charges
Adult Preventive Care		
Adult Routine Physical Exam (1 per year - \$500 limit, including routine lab and X-Ray services) (for colonoscopy see "Outpatient Services")	Anything over \$500	Deductible and coinsurance plus anything over \$500
Routine GYN Exam and Pap Smear 2 routine exams per year	Nothing	Deductible and coinsurance
Routine Mammography (1 per year age 40+)	Nothing	Deductible and coinsurance
Routine PSA/DRE Testing (1per year)	Nothing	Deductible and coinsurance
Diagnostic Lab and X-Ray	Deductible	Deductible and coinsurance
Inpatient Hospital Services²	Deductible	Deductible and coinsurance
Inpatient Skilled Nursing Services^{2,4}	Deductible	Deductible and coinsurance
Outpatient Services	Deductible	Deductible and coinsurance
Emergency Room	Deductible	Deductible
Urgent Care	Deductible	Deductible and coinsurance
Ambulance (includes air transport)	Deductible	Deductible and coinsurance

This is a summary of benefits only and does not replace the legal contract or certificate which identifies all covered services, additional details, limitations and exclusions of the coverage.

¹ If you have 2-person or family coverage, the full family deductible must be satisfied before this plan will pay benefits. One person can satisfy the family deductible.

² Pre-certification required. A penalty of \$500 may apply if you fail to obtain pre-certification.

³Benefit limitations for Mental Health and Substance abuse are combined limits.

⁴Inpatient Skilled Nursing Care limited to 45 days per calendar year.

⁵Short-term therapies limited to combined 45 visits per calendar year.

⁶When utilizing the services of an out-of-network provider, patient will be responsible for the balance between the approved amount and provider's actual billed charges



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Maternity Services		
Inpatient Care² (includes routine nursery charges)	Deductible	Deductible and coinsurance
Physician Care	Deductible	Deductible and coinsurance
Outpatient Chemotherapy	Deductible	Deductible and coinsurance
Outpatient Radiation Therapy	Deductible	Deductible and coinsurance
Outpatient Short-term Therapy Services (Includes physical, speech and occupational therapies) ⁵	Deductible	Deductible and coinsurance
Mental Health³ - Inpatient² (limit 30 days)	Deductible	Deductible and coinsurance
Outpatient (limit 30 visits)	Deductible	Deductible and coinsurance
Substance Abuse³ - Inpatient² Limit 37 days (7 days detox per admission): 2 admissions per lifetime)	Deductible	Deductible and coinsurance
Outpatient (limit 60 visits)	Deductible	Deductible and coinsurance
Surgical Care Including Office Surgery	Deductible	Deductible and coinsurance
Human Organ and Tissue Transplant Services²	Deductible	Deductible and coinsurance
Home Health Care (unlimited visits)	Deductible	Deductible and coinsurance
Hospice	Deductible	Deductible and coinsurance
Diabetic Equipment and Supplies		
Diabetic Supplies	Deductible	Deductible and coinsurance
Diabetic Equipment (includes insulin pumps)	Deductible	Deductible and coinsurance
Durable Medical Equipment Prosthetics limited to \$15,000 per year	Deductible	Deductible and coinsurance
Prescription Medicines, including oral contraceptives:		
Retail (30 day supply)	Deductible	Not covered
Mail Order (up to 90 day supply)	Deductible	Not covered
24-Hour coverage included!	\$2,000 Accident Policy included!	

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