Covered Services	$1,000 Deductible	$2,800 Deductible H.S.A.	$5,000 Deductible H.S.A.
Plan Year Deductible			
In-Network	$1,000 Individual / $2,000 Family	$2,800 Individual / $5,600 Family	$5,000 Individual / $10,000 Family
Out-of-Network	$2,000 Individual / $4,000 Family	Deductible is combined for In-network and Out-of-network services.	Deductible is combined for In-network and Out-of-network services.
Plan Year Out-of-Pocket Expenses			
In-Network	$5,000 Individual / $10,000 Family	$5,000 Individual / $10,000 Family	$5,000 Individual / $10,000 Family
Out-of-Network	$9,000 Individual / $18,000 Family	$10,000 Individual / $20,000 Family	$10,000 Individual / $20,000 Family
Out-of-Network Benefits	30% coinsurance for medical and behavioral health/substance abuse services.	40% coinsurance for medical and behavioral health/substance abuse services.	40% coinsurance for medical and behavioral health/substance abuse services.
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Ambulance Travel	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Autism Spectrum Disorder	Copayment/Coinsurance determined by service received.	20% coinsurance after deductible	Covered 100% after deductible
Behavioral Health			
Inpatient Treatment			
Facility Services	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Professional Provider Services	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Outpatient Treatment			
Facility Services	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Professional Provider Services	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Outpatient Office Visits	$25 copayment	20% coinsurance after deductible	Covered 100% after deductible
Diabetic Education	Applicable office visit copayment	20% coinsurance after deductible	Covered 100% after deductible
Diabetic Equipment	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Diabetic Supplies	See prescription drugs	See prescription drugs	Covered 100% after deductible
Diagnostic Tests and X-rays	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Doctor Visits - Outpatient Office Visit			
Primary Care Physicians	$25 copayment	20% coinsurance after deductible	Covered 100% after deductible
Specialty Care Physicians	$40 copayment	20% coinsurance after deductible	Covered 100% after deductible
Emergency Room / Urgent Care Visits			

Covered Services	$1,000 Deductible	$2,800 Deductible H.S.A.	$5,000 Deductible H.S.A.
Facility Services	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Professional Provider Services	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Diagnostic Tests and X-rays	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Urgent Care	$40 copayment	20% coinsurance after deductible	Covered 100% after deductible
Home Health Services	$0 copayment (90 visit max per plan year)	20% coinsurance after deductible	Covered 100% after deductible
Home Private Duty Nurse's Services	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Hospice Care Services	$0 copayment	20% coinsurance after deductible	Covered 100% after deductible
Hospital Services			
Inpatient Treatment			
Facility Services	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Professional Provider Services	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Diagnostic Tests and X-rays	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Outpatient Treatment			
Facility Services	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Professional Provider Services	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Diagnostic Tests and X-rays	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Infusion Services			
Facility Services	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Professional Provider Services	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Home Services	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Infusion Medications	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Maternity Care			
Professional Provider Services (Prenatal & Postnatal Care)	$25 copayment	20% coinsurance after deductible	Covered 100% after deductible
Delivery			
Provider Services	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Hospital Services	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Outpatient Diagnostic Tests	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Medical Equipment, Appliances, Prosthetics and Supplies	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Prescription Drugs			
Retail - 30 Day Supply			

Covered Services	$1,000 Deductible	$2,800 Deductible H.S.A.	$5,000 Deductible H.S.A.
Generic	$10 copayment	20% coinsurance after deductible	Covered 100% after deductible
Preferred Brand	$30 copayment	20% coinsurance after deductible	Covered 100% after deductible
Non-Preferred Brand	$45 copayment	20% coinsurance after deductible	Covered 100% after deductible
Specialty	$55 copayment	20% coinsurance after deductible	Covered 100% after deductible
Mail Order - 90 Day Supply			
Generic	$20 copayment	20% coinsurance after deductible	Covered 100% after deductible
Preferred Brand	$60 copayment	20% coinsurance after deductible	Covered 100% after deductible
Non-Preferred Brand	$90 copayment	20% coinsurance after deductible	Covered 100% after deductible
Specialty	$110 copayment	20% coinsurance after deductible	Covered 100% after deductible
Shots - Allergy & Therapeutic Injections	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Skilled Nursing Facility (180 day per stay limit per member)	$0 copayment	20% coinsurance after deductible	Covered 100% after deductible
Spinal Manipulations/Other Manual Medical Interventions	$40 copayment	20% coinsurance after deductible	Covered 100% after deductible
Surgery - See Hospital Services			
Therapy Services (Cardiac Therapy, Chemotherapy, Radition Therapy, Respiratory Therapy, Occupational Therapy, Physcial Therapy, and Speech Therapy)	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Facility Services	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Professional Provider Services	20% coinsurance after deductible	20% coinsurance after deductible	Covered 100% after deductible
Telemedicine - Offered via HealthiestYou	No Cost	No Cost	No Cost
Wellness Services			
Well Child Through Age 6	No Cost	No Cost	No Cost
Routine Wellness - Age 7 & Older	No Cost	No Cost	No Cost
Preventive Care (One of Each Per Plan Year, age limits applicable)	No Cost	No Cost	No Cost
Gynecological Exam	No Cost	No Cost	No Cost
Pap Test	No Cost	No Cost	No Cost
Mammography Screening	No Cost	No Cost	No Cost
Prostate Exam	No Cost	No Cost	No Cost
Prostate Specific Antigen Test	No Cost	No Cost	No Cost

Covered Services	$1,000 Deductible	$2,800 Deductible H.S.A.	$5,000 Deductible H.S.A.
Colorectal Cancer Screenings	No Cost	No Cost	No Cost