



**HDHP**

Covered Services	In-Network	Out-Of-Network
<b>Essential Health Benefits</b>	Unlimited	
<b>Lifetime Maximum Benefit</b>	Unlimited	
<b>Deductible (non-embedded: Individuals with Family coverage are subject to the Family deductible before Single coinsurance applies)</b>		
Per Covered Person	\$1,350	\$2,700
Per Family	\$2,700	\$5,400
<b>Annual Maximum Out-of-Pocket (embedded)</b>		
<b>(Including all Deductibles and Coinsurance)</b>		
Per Covered Person	\$4650 (Single) / \$6,000 (Family)	\$4,900
Per Family	\$9,300	\$9,800
<b>Physician Services</b>		
Primary Care Physician (PCP) Office Visit	20%* Coins	40%* Coins U&C**
Specialty Care Physician (SCP) Office Visit	20%* Coins	40%* Coins U&C**
Physician eVisit	20%* Coins	40%* Coins U&C**
Physician Telehealth Visit	20%* Coins	40%* Coins U&C**
Physician Services not received in an office setting	20%* Coins	40%* Coins U&C**
<b>Diagnostic Laboratory, Imaging and Radiology</b>	20%* Coins	40%* Coins U&C**
<b>Inpatient Hospitalization</b>	20%* Coins	40%* Coins U&C**
<b>Outpatient Hospital Services</b>	20%* Coins	40%* Coins U&C**
<b>Hospital Emergency Room Services</b>	20%* Coins	
<b>Urgent Care Facility</b>	20%* Coins	40%* Coins U&C**
<b>Urgent Care Physician Services</b>	20%* Coins	40%* Coins U&C**
<b>Emergency Ambulance Services</b>	20%* Coins	
<b>Maternity &amp; Childbirth Expenses</b>	20%* Coins	40%* Coins U&C**
<b>Preventive Health Services (Ages 0 to adult)</b>		
Services with an "A" or "B" rating from the U.S. Preventive Services Task Force as mandated by PHSA Section 2713	\$0	40%* Coins U&C**
Additional preventive services or treatments not mandated by PHSA Section 2713	20%* Coins	40%* Coins U&C**
<b>Preventive Health Services for Children and Adolescents</b>		
Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration	\$0	40%* Coins U&C**
Physician office visits and laboratory tests associated with preventive checkups	\$0	40%* Coins U&C**
<b>Preventive Services for Adults</b>		
Preventive care and screenings for women supported by the Health Resources and Services Administration	\$0	40%* Coins U&C**
<b>Immunizations Ages 0 to Adult (per immunization)</b>		
As recommended by Advisory Committee on Immunization Practices of the CDC as mandated by PHSA Section 2713	\$0	40%* Coins U&C**
Additional immunizations not mandated by PHSA Section 2713	20%* Coins	40%* Coins U&C**
<b>Home Health Care</b>	20%* Coins	40%* Coins U&C**
<b>Skilled Nursing Facility</b>	20%* Coins	40%* Coins U&C**
<b>Hospice Care</b>	20%* Coins	40%* Coins U&C**
<b>Durable Medical Equipment</b>	20%* Coins	40%* Coins U&C**
<b>Disposable Medical Supplies</b>	20%* Coins	40%* Coins U&C**
<b>Prosthetics</b>	20%* Coins	40%* Coins U&C**
<b>Orthotics</b>	20%* Coins	40%* Coins U&C**
<b>Chiropractic Services (Spinal Manipulation)</b>		
<b>Prior Authorization required for office visits in excess of 26 per benefit year</b>		
Office Visit	20%* Coins	40%* Coins U&C**
Other Services	20%* Coins	40%* Coins U&C**

Covered Services	In-Network		Out-Of-Network
<b>Therapy Services (Not Including Chiropractic Services)****</b>			
Physical Therapy	20%* Coins		40%* Coins U&C**
	Annual Benefit of 60 visits (not including Applied Behavioral Analysis)		
Occupational Therapy	20%* Coins		40%* Coins U&C**
	Annual Benefit of 60 visits (not including Applied Behavioral Analysis)		
Speech Therapy	20%* Coins		40%* Coins U&C**
	Annual Benefit of 60 visits (not including Applied Behavioral Analysis)		
<b>Autism Services</b>	<b>Benefits are based on the setting in which Covered Services are Received *****</b>		
<b>Applied Behavior Analysis (ABA)</b> (dependent children through age 18)	20%* Coins		40%* Coins U&C**
	Requires prior authorization		
<b>Dental Anesthesia</b>	20%* Coins		40%* Coins U&C**
<b>Mental Illness/Substance Use Disorder Services</b>			
Office Visit	20%* Coins		40%* Coins U&C**
Other Services	20%* Coins		40%* Coins U&C**
Outpatient Treatment	20%* Coins		40%* Coins U&C**
Hospital Inpatient Treatment	20%* Coins		40%* Coins U&C**
Residential Treatment	20%* Coins		40%* Coins U&C**
<b>Covered Education</b>	20%* Coins		40%* Coins U&C**
<b>Outpatient Prescription Drugs</b>	<b>Retail (30 day supply)</b>	<b>Mail***</b>	<b>Out-Of-Network</b>
Prescription Drug Deductible	Medical Deductible		
Tier 1 - Most Generics (30 day supply)	20%* Coins	20%* Coins	40%* Coins U&C**
Tier 2 - Preferred Brand (30 day supply)	20%* Coins	20%* Coins	40%* Coins U&C**
Tier 3 - Non-Preferred Formulary Brand (30 day supply)	20%* Coins	20%* Coins	40%* Coins U&C**
Tier 4 - Specialty Formulary Brand (30 day supply)	20%* Coins	Not available	Not available
Tier 5 - Preventive	\$0	\$0	Not available

\* Coinsurance applies after Deductible is met.

\*\* U&C is used as an abbreviation for Usual and Customary.

\*\*\* Mail order available on maintenance medications only for a 90 day supply.

\*\*\*\* Copays/Coinsurance for Physical Therapy and Occupational Therapy will not exceed the physician office visit once the deductible is met.

\*\*\*\*\* Coverage for the diagnosis and treatment of Autism Spectrum Disorders will not be subject to any greater Deductible/Co-pay/Co-insurance than is applicable to other physical health care services covered by this Plan.

This is only a brief summary of benefits, which is not intended to be comprehensive. Your Certificate of Coverage is the governing document for benefit information.

"You Pay"	
<b>EE</b>	<b>\$0.00</b>
<b>ES</b>	<b>\$490.35</b>
<b>EC</b>	<b>\$181.65</b>
<b>FA</b>	<b>\$698.25</b>