LOW OPTION HSA PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $3,000 $6,000	 $6,000 $12,000
Coinsurance After Deductible	20%	40%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital and medical expenses)	Unlimited	
Out-of-Pocket Maximum (includes deductibles and copays) Individual Family	 $5,000 $10,000	 $10,000 $20,000
Physician Office Visits and Other In-office Services Primary Care Physician	20% coinsurance, after deductible	40% coinsurance, after deductible
Specialist	20% coinsurance, after deductible	40% coinsurance, after deductible
Preventative Care Benefits (routine exams, x-rays/tests immunizations, well baby care and mammograms)	No Charge	40% coinsurance, after deductible
Diagnostic Tests (X-rays and blood work)	20% coinsurance, after deductible	40% coinsurance, after deductible
Imaging Services (CT and MRI scans requires prior authorization)	20% coinsurance, after deductible	40% coinsurance, after deductible
Ambulance	20% coinsurance, after deductible	20% coinsurance, after deductible
Emergency Room (Waived if admitted)	20% coinsurance, after deductible	20% coinsurance, after deductible
Urgent Care Services	20% coinsurance, after deductible	20% coinsurance, after deductible

LOW OPTION HSA PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Hospital Benefits Daily Hospital Room and Board, Semi Private and other allowable expenses	20% coinsurance, after deductible	40% coinsurance, after deductible
Outpatient Surgery Center (Includes ambulatory surgery centers)	20% coinsurance, after deductible	40% coinsurance, after deductible
Maternity Care Services -Office Visits	20% coinsurance, after deductible	40% coinsurance, after deductible
-Professional & Facility	20% coinsurance, after deductible	40% coinsurance, after deductible
Mental and Substance Use Disorder -Residential	20% coinsurance, after deductible	40% coinsurance, after deductible
-Inpatient	20% coinsurance, after deductible	40% coinsurance, after deductible
-Outpatient	20% coinsurance, after deductible	40% coinsurance, after deductible
ABA Therapy	20% coinsurance, after deductible	40% coinsurance, after deductible
Home Health Care (30 visits for out-of-network providers)	20% coinsurance, after deductible	40% coinsurance, after deductible
Hospice Care Services	20% coinsurance, after deductible	40% coinsurance, after deductible
Skilled Nursing Facility (Limited to 100 days per calendar year.)	20% coinsurance, after deductible	40% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price)	20% coinsurance, after deductible	40% coinsurance, after deductible

LOW OPTION HSA PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
External Prosthetic Devices	20% coinsurance, after deductible	40% coinsurance, after deductible
-Wigs, toupee or hair pieces (Limited up to 2 per diagnosis/course of treatment. Does not cover for the diagnosis of androgentic alopecia-male pattern baldness)	20% coinsurance, after deductible, and any amount over $350 maximum	40% coinsurance, after deductible, and any amount over $350 maximum
Physical, Occupational and Speech Therapy (Limited up to 60 combined visits per calendar year)	20% coinsurance, after deductible	40% coinsurance, after deductible
Chiropractic Care Services (Maximum of 12 visits per calendar year)	20% coinsurance, after deductible	40% coinsurance, after deductible
Acupuncture Services (Limited to 12 visits per calendar year)	20% coinsurance, after deductible	40% coinsurance, after deductible
Hearing Aids (Limited to children under the age 12 years of age- 1 pair every 24 months)	20% coinsurance, after deductible	40% coinsurance, after deductible
Temporomandibular Joint Disorder (TMJ)	20% coinsurance, after deductible	40% coinsurance, after deductible
Dental Anesthesia and Hospital for Children Under 5 Years Old or Disabled	20% coinsurance, after deductible	40% coinsurance, after deductible
Removal of Impacted Teeth	20% coinsurance, after deductible	40% coinsurance, after deductible

LOW OPTION HSA PLAN

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Generic Drugs	20% coinsurance, after deductible	Not Covered
Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Specialty Drugs	20% coinsurance, after deductible	Not Covered
Mail-Order 90-Day Supply		
Generic Drugs	20% coinsurance, after deductible	Not Covered
Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	20% coinsurance, after deductible	Not Covered