

Services	Standard Plan	High Ded. H.S.A. Plan
Annual Deductible <i>Single / Family</i>	\$500 / \$1,500	\$3,000 / \$6,000 ** Embedded
* Annual Out of Pocket Max. <i>Single / Family</i>	\$2,500 / \$5,500 (Including Deductible)	\$3,000 / \$6,000 (Including Deductible)
	Ded. x 3 & OOP x 2	** Embedded
Maximum Lifetime Benefit while covered under this plan	\$2,000,000	
Benefit Limits		
Hospital Room & Board & Miscellaneous Charges	80%, after Deductible	100 %, after Deductible
Inpatient Physician Services (<i>Primary Care or Specialist</i>)	80%, after Deductible	100%, after Deductible
Primary Care Physician Office Visit Charge	\$20 Co-payment, 100%	100%, after Deductible
Other Services Performed in PCP Office	Included under office co-pay all except surgery	100%, after Deductible
Specialist Office Visit Charge	\$20 Co-payment, 100%	100%, after Deductible
Other Services Performed in Specialist Office	80%, after Deductible	100%, after Deductible
Surgical and Anesthesia Services	80%, after Deductible	100%, after Deductible
Diagnostic X-Ray & Laboratory Services	80%, after Deductible	100%, after Deductible
Skilled Nursing Facility, Extended Care Facility	80%, after Deductible	100%, after Deductible
Home Health Care	80%, after Deductible	100%, after Deductible
Physical Therapy Services	80%, after Deductible	\100%, after Deductible
Radiation, Chemotherapy, Dialysis Services	80%, after Deductible	100%, after Deductible
Chiropractic Services	80%, after Ded (<i>\$500 per Cal Yr.</i>)	100%, after Ded (<i>\$500 per Cal. Yr.</i>)
Ambulance Services	80%, after Deductible	100%, after Deductible
Emergency Room *	80%, after Deductible	100%, after Deductible
* Please Note: Accident related Emergency services received in the Emergency Room are NOT subject to the deductible		
Durable Medical Equipment, Prosthetics, Orthotics	80%, after Deductible	100%, after Deductible
Mental/Nervous & Substance Abuse Treatment		
Inpatient Mental/Nervous & Substance Abuse Services	80%, after Ded. (<i>30 days per Cal. Year</i>)	100%, after Ded. (<i>30 days per Cal. Year</i>)
Outpatient Mental/Nervous & Substance Abuse Services	50%, after Ded. (<i>30 visits per year</i>)	100%, after Ded. (<i>30 visits per year</i>)
Preventive/Wellness Care		
	\$500 Calendar Year Maximum per Covered Person for Preventive/Wellness Care	
Routine exams, screenings, labs, immunizations	\$20 Co-payment, then 100%	100%, No deductible
Yearly Mammogram (<i>routine only</i>)	\$20 Co-payment, then 100%	100%, No deductible
Prescription Drug Benefit		
Pharmacy Option Co-payment	\$10 Generic / \$25 & 25% Brand	100%, after Deductible
Mail Order Option Co-payment	Three Times co-pay for Three Month Supply	100%, after Deductible
Dental Benefits		
	\$1,000 Ann. Max. Per Person	Optional, Normally excluded under H.S.A.
Deductible	\$50 Calendar Year / \$150 per Family Unit	
Preventive Dental	100%, No Deductible (2 per year)	
Basic Dental	80%, After Deductible	
Major Dental	50%, After Deductible	
Orthodontics	Not Covered	

* Rx & Dr Co-pays do not apply towards O.O.P.

** "Embedded" defined : Benefits are paid after individual family members meet individual Deductibles.