## Benefit In Network - Employee Pays | Out of Network*** - Employee Pays
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**HSA**<br>Employee only: $500 if salary is $85,000 or less; $250 if salary is between $85,001 and $150,000<br>Family: $1,000 if salary is $85,000 or less; $500 if salary is between $85,001 and $150,000<br>$0 if salary greater than $150,000 Employees may elect to contribute additional funds up to annual maximum **HEALTHCARE FSA**<br>If elect HSA, only eligible for limited purpose FSA **ANNUAL DEDUCTIBLE**<br>$2,000 Individual<br>$4,000 Family**<br>$2,000 Individual<br>$4,000 Family**<br>(Integrated Deductible w/ Embedded OPM) $4,000 Individual w/in Family deductible<br>Not combined with Out of Network<br>$8,000 Individual w/in Family deductible<br>Not combined with In Network
**ANNUAL OUT-OF-POCKET MAXIMUM**<br>$5,000 Individual<br>$10,000 Family<br>$5,000 Individual<br>$10,000 Family<br>(Integrated Deductible w/ Embedded OPM) $8,550 Individual w/in Family<br>Plan pays 100% of eligible expenses after this amount has been satisfied.<br>Not combined with Out of Network<br>$20,000 Individual w/in Family<br>Plan pays 100% of eligible expenses after this amount has been satisfied.<br>Not combined with In Network **LIFETIME MAXIMUM BENEFIT**<br>Unlimited Unlimited
**OFFICE VISITS**<br>Innovation Health Facility: 25% after deductible<br>Choice POS II facility: 35% after deductible<br>50% after deductible<br>OFFICE VISITS<br>Innovation Health Facility: 25% after deductible<br>Choice POS II facility: 35% after deductible<br>50% after deductible
**LAB X-RAY DIAGNOSTICS**<br>Innovation Health Facility: 25% after deductible<br>Choice POS II facility: 35% after deductible<br>50% after deductible
**PREVENTIVE CARE**<br>Adult routine care: covered at 100% (not subject to deductible); limit 1 per calendar year. Coverage for enhanced women's health benefits at 100%. Contact plan for specifics.<br>Adult routine care: covered at 50% after deductible; limit 1 per calendar year. Contact plan for specifics.<br>**HOSPITAL CARE**<br>**Inpatient**<br>Innovation Health Facility: 25% after deductible<br>Choice POS II facility: 35% after deductible<br>50% after deductible<br>**Outpatient**<br>Innovation Health Facility: 25% after deductible<br>Choice POS II facility: 35% after deductible<br>50% after deductible
**EMERGENCY CARE**<br>**In-area**<br>Innovation Health Facility: 35% after deductible<br>Choice POS II facility: 35% after deductible<br>35% after deductible. For non-emergent use of the emergency room, employee pays 50% after deductible<br>**Out-of-area**<br>35% after deductible. For non-emergent use of the emergency room, employee pays 50% after deductible
**PRESCRIPTIONS**<br>**Retail**<br>After deductible, $5 generics, 30% brand and 50% non-formulary brand. Certain preventive drugs not subject to deductible.****<br>Not covered
**Mail-Order**<br>After deductible, $5 generics, 30% brand and 50% non-formulary brand. Certain preventive drugs not subject to deductible.****<br>Not covered
**MENTAL HEALTH**<br>**Inpatient**<br>Innovation Health Facility: 25% after deductible<br>Choice POS II facility: 35% after deductible<br>50% after deductible<br>**Outpatient**<br>Innovation Health Facility: 25% after deductible<br>Choice POS II facility: 35% after deductible<br>50% after deductible
**SUBSTANCE ABUSE**<br>**Inpatient Detox and Rehab**<br>Innovation Health Facility: 25% after deductible<br>Choice POS II facility: 35% after deductible<br>50% after deductible<br>**Outpatient**<br>Innovation Health Facility: 25% after deductible<br>Choice POS II facility: 35% after deductible<br>50% after deductible
**CHIROPRACTIC**<br>Innovation Health Facility: 25% after deductible<br>Choice POS II facility: 35% after deductible<br>50% after deductible if medically necessary
**DURABLE MEDICAL EQUIPMENT**<br>Innovation Health Facility: 25% after deductible<br>Choice POS II facility: 35% after deductible<br>50% after deductible
**HEARING AIDS**<br>Innovation Health Facility: 25% after deductible<br>Choice POS II facility: 35% after deductible<br>$2,500 per pair every three years<br>35% after deductible<br>$2,500 per pair every three years
**VISION EXAMS**<br>Not covered Not covered
**EYEWEAR**<br>Not covered Not covered

*APO/FPO addresses are not eligible for HSA plan set-up. A physical U.S. address must be provided.<br>** The family deductible is an aggregate deductible where you must satisfy entire deductible before the plan pays benefits for any member<br>*** Out-of-Network benefits based on Usual, Reasonable, and Customary (URC) charges for the specific service in that geographic region.<br>**** Prescription Drugs are administered by Express Scripts (ESI)<br>Information contained in the summary is designed for general reference only. If there is any conflict between this benefit summary and the plan document/certificate, the plan document/certificate governs.