

Standard POS HSA Plans

PLAN NAME	Deductible				Coinsurance		Out-of-Pocket Maximum				Office Visit			
	In-Network		Out-of-Network		In-Network	Out-of-Network	In-Network		Out-of-Network		In-Network		Out-of-Network	
	Single	Family	Single	Family	What Participants Pay		Single	Family	Single	Family	PCP	Specialist	PCP	Specialist
LFS24HSAP1750_0	\$1,750	\$3,500	\$2,500	\$5,000	0%	20%	\$1,750	\$3,500	\$4,000	\$8,000	\$0*	\$0*	20%*	20%*
LFS24HSAP1750_20	\$1,750	\$3,500	\$3,000	\$6,000	20%	40%	\$2,000	\$4,000	\$6,000	\$12,000	\$25*	\$75*	40%*	40%*
LFS22HSAP2000_0	\$2,000	\$4,000	\$3,000	\$6,000	0%	20%	\$2,000	\$4,000	\$5,000	\$10,000	\$0*	\$0*	20%*	20%*
LFS22HSAP2000_20	\$2,000	\$4,000	\$4,000	\$8,000	20%	40%	\$2,500	\$5,000	\$7,000	\$14,000	\$25*	\$75*	40%*	40%*
LFS22HSAP2500_0	\$2,500	\$5,000	\$3,500	\$7,000	0%	20%	\$2,500	\$5,000	\$6,000	\$12,000	\$0*	\$0*	20%*	20%*
LFS22HSAP2500_20	\$2,500	\$5,000	\$5,000	\$10,000	20%	40%	\$3,000	\$6,000	\$8,000	\$16,000	\$25*	\$75*	40%*	40%*
LFS22HSAP3500_0	\$3,500	\$7,000	\$4,500	\$9,000	0%	20%	\$3,500	\$7,000	\$9,000	\$18,000	\$0*	\$0*	20%*	20%*
LFS22HSAP3500_20	\$3,500	\$7,000	\$7,000	\$14,000	20%	40%	\$5,500	\$11,000	\$11,000	\$22,000	\$25*	\$75*	40%*	40%*
LFS22HSAP4000_0	\$4,000	\$8,000	\$5,000	\$10,000	0%	20%	\$4,000	\$8,000	\$10,000	\$20,000	\$0*	\$0*	20%*	20%*
LFS22HSAP4000_20	\$4,000	\$8,000	\$8,000	\$16,000	20%	40%	\$6,000	\$12,000	\$12,000	\$24,000	\$25*	\$75*	40%*	40%*
LFS22HSAP5000_0	\$5,000	\$10,000	\$6,000	\$12,000	0%	20%	\$5,000	\$10,000	\$13,100	\$26,200	\$0*	\$0*	20%*	20%*
LFS22HSAP5000_20	\$5,000	\$10,000	\$9,000	\$18,000	20%	40%	\$6,550	\$13,100	\$13,000	\$26,000	\$25*	\$75*	40%*	40%*
LFS22HSAP6500_0	\$6,500	\$13,000	\$7,500	\$15,000	0%	20%	\$6,500	\$13,000	\$14,000	\$28,000	\$0*	\$0*	20%*	20%*
LFS22HSAP7000_0	\$7,000	\$14,000	\$8,000	\$16,000	0%	20%	\$7,000	\$14,000	\$16,000	\$32,000	\$0*	\$0*	20%*	20%*
LFS24HSAP8000_0	\$8,000	\$16,000	\$8,000	\$16,000	0%	20%	\$8,000	\$16,000	\$16,000	\$32,000	\$0*	\$0*	20%*	20%*

*Cost per visit after deductible has been met

These summaries are intended to highlight and give a general description of the benefits available. For a complete description of benefits, please refer to the Summary of Participant Responsibility Tables.

Emergency/Urgent Care

	0% Coinsurance Plans		20% Coinsurance Plans	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Room	\$0 after deductible		\$400*	
Urgent Care	\$0*	20% after deductible	\$150*	40% after deductible

MDLIVE® Virtual Visits

Subject to deductible only. Benefits are only available through the Network Health virtual visit provider network.

(Example: Sue has a virtual visit with an online doctor. The cost is \$65. If she has already met her deductible, her out-of-pocket cost is \$0. If Sue has not met her deductible yet, she will pay \$65 for the virtual visit and it will be applied toward her deductible.)

Standard POS HSA Plans Pharmacy

		Standard POS HSA Plans with 0% Coinsurance		Standard POS HSA Plans with 20% Coinsurance	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Retail 30-day supply	Preventive drugs	\$0 per prescription or refill	Not Covered	\$0 per prescription or refill	Not Covered
	Generic drugs	Deductible	Not Covered	\$25 per prescription or refill after deductible	Not Covered
	Preferred drugs	Deductible	Not Covered	\$45 per prescription or refill after deductible	Not Covered
	Non-preferred drugs	Deductible	Not Covered	\$80 per prescription or refill after deductible	Not Covered
	Preferred specialty drugs	Deductible	Not Covered	25% after deductible	Not Covered
	Non-preferred specialty drugs	Deductible	Not Covered	40% after deductible	Not Covered
Mail order 90-day supply	Preventive drugs	\$0 per prescription or refill	Not Covered	\$0 per prescription or refill	Not Covered
	Generic drugs	Deductible	Not Covered	\$65 per prescription or refill after deductible	Not Covered
	Preferred drugs	Deductible	Not Covered	\$120 per prescription or refill after deductible	Not Covered
	Non-preferred drugs	Deductible	Not Covered	\$240 per prescription or refill after deductible	Not Covered
	Preferred specialty drugs	No mail order	Not Covered	No mail order	Not Covered
	Non-preferred specialty drugs	No mail order	Not Covered	No mail order	Not Covered