Benefits-at-a-Glance



Plan Category Choice Plus HSA Plan Basics BG5D Prinary Care Physician Required? No Electronic Referrals No Required to see Specialists? No Out of Network Benefits? Yes Pediatric Dental & Vision No Medical Deductible Type Emb Deductible 56.000 Individual \$6.660 Family \$12,000 Out-of Pocket Deductible Individual \$6.660 Family \$13,300 Coinsurance Covered 100% Office Visits DED Office Visits DED Office Visits DED Minor Lab Testing and X-ray — Physician Office DED Minor Lab Testing and X-ray — Prestanding Facility DED Minor Lab Testing and X-ray — Prestanding Facility DED Minor Lab Testing and X-ray — Freestanding DED Minor Lab Testing and X-ray — Hospital DED Outpatient Services - Freestanding Facility DED Major Diagnostit: and Imaging Services	Medical Plan	
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	Plan Notes	*2019 HSA Contribution Limits: Single: \$3,500, Family: \$7,000

L This information is a brief, general description of your coverage; it is not a contract and does not replace your Certificate of Coverage/ Summary Plan Description. For a complete list of your coverage, including exclusions and limitations relating to your coverage, please read your Certificate of Coverage/Summary Plan Description. If descriptions, percentages, and dollar amounts conflict with official benefit coverage documents, the official benefits coverage documents prevail.

*Emb = Embedded Deductible= All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

*NonEmb = Non-Embedded Deductible = No one in the family is eligible for benefits until the family deductible is met.