HSA 20 Plan Summary

Deductible, coinsurance and copay represent WHAT YOU PAY. Benefits apply after calendar year deductible is met, unless otherwise noted as "no deductible," "copay" or "covered in full."

IN = In-network **OUT** = Out-of-network	Individual		Family	
	IN	**OUT**	**IN**	**OUT**
Annual Deductible PCY	$3,000	$6,000	$6,000	$12,000
Coinsurance* (What you pay)	20%	50%	20%	50%
Annual Coinsurance Maximum PCY	$2,000	Unlimited	$4,000	Unlimited
Out-of-Pocket Maximum (Deductible + Coinsurance Max)	$5,000	Unlimited	$10,000	Unlimited
Office Visit Cost Share	20%	50%	20%	50%

COVERED SERVICES	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER†**
PREVENTIVE CARE		
Preventive Exams (includes routine medical exam, sports physical, men's and women's health exam and well baby exam) $300 PCY	Covered in full‡	Deductible applies first, then you pay 50%
Preventive Screenings (includes Pap smear, PSA testing, home colon cancer screening, cholesterol screening and bone density test)		
Immunizations (unlimited)		
HEALTH EDUCATION		
Diabetes Health Education & Training (unlimited)	Deductible applies first, then you pay 20%	Deductible applies first, then you pay 50%
Nicotine Dependency Treatment	Not covered	
PROFESSIONAL CARE		
Office Visit and Urgent Care	Deductible applies first, then you pay 20%	Deductible applies first, then you pay 50%
Inpatient and Outpatient Professional Services		
ALTERNATIVE CARE		
Spinal & Other Manipulations (includes chiropractic)◊	Deductible applies first, then you pay 20%	Deductible applies first, then you pay 50%
Acupuncture & Naturopathic Services	Not covered	
DIAGNOSTIC SERVICES		
Diagnostic X-ray & Imaging	Deductible applies first, then you pay 20%	Deductible applies first, then you pay 50%
Laboratory Services		
Mammography	Covered in full‡	
PHARMACY		
Prescription Drug Benefit (up to 30-day supply)	Deductible applies first, then you pay 20% (Preventive generic cardiac drugs: covered in full)	
EMERGENCY CARE		
Emergency Room Care	Deductible applies first, then you pay 20%	
Ambulance Transportation (air and ground)		
FACILITY CARE		
Outpatient Care	Deductible applies first, then you pay 20%	Deductible applies first, then you pay 50%
Inpatient Care (hospital room and board)		
Skilled Nursing Facility 60 days PCY		
OTHER SERVICES		
Rehabilitation (including Physical, Occupational, Speech, Massage Therapy; Chronic Pain; Cardiac & Pulmonary Rehabilitation) Outpatient: 20 visits PCY; Inpatient: 20 days PCY	Deductible applies first, then you pay 20%	Deductible applies first, then you pay 50%
Behavioral Health Care/Mental Health Outpatient: 10 visits PCY; Inpatient: 7 days PCY		
Home Health Care (covered only if prescribed in lieu of hospitalization)		
Hospice Care Inpatient: 10 days; Respite: 240 hours; home visits unlimited		
Transplants $250,000 lifetime benefit	Deductible applies first, then you pay 20%	Not covered
LIFETIME MAXIMUM	$3 Million	

* All coinsurance amounts are the member's percentage of allowable charges after deductible.

† Balance billing may apply when an out-of-network provider is used.

‡ Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.

◊ Spinal & other manipulations have unlimited office visits.

NOTE: All coinsurance amounts are based on allowable charges.
PCY = Per Calendar Year

LIFEWISE | HEALTH PLAN OF ARIZONA

This is only a summary of the major benefits provided by our HSA 20 plan. It is not a contract.

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