

Medical Benefit Highlights

Woods Services PPO HSA \$3,000/100%

Covered Services	Your Costs (You pay)	
Benefits per Contract Year	In-Network	Out-of-Network
Deductible (Aggregate) ¹ Individual/Family	\$3,000/\$6,000	\$5,000/\$10,000
Out-of-Pocket Maximum (Embedded) ² Individual/Family	\$6,750/\$13,500	\$10,000/\$20,000
Coinsurance	0%	50%
Preventive Services	In-Network	Out-of-Network
Preventive Care	No charge no deductible	50% no deductible
Physician Services	In-Network	Out-of-Network
Primary Care Physician (PCP) Office Visit	No charge after deductible	50% after deductible
Specialist Office Visit	No charge after deductible	50% after deductible
Retail Health Clinic Visit	No charge after deductible	50% after deductible
Urgent Care Visit	No charge after deductible	50% after deductible
Therapy Services	In-Network	Out-of-Network
Physical Therapy (60 visits/year) ³	No charge after deductible	50% after deductible
Occupational Therapy (60 visits/year) ³	No charge after deductible	50% after deductible
Speech Therapy (20 visits/year) ⁴	No charge after deductible	50% after deductible
Emergency Services	In-Network	Out-of-Network
Emergency Room	No charge after deductible	Covered at In-Network level
Emergency Ambulance	No charge after deductible	Covered at In-Network level
Non-Emergency Ambulance	No charge after deductible	50% after deductible
Hospital Services	In-Network	Out-of-Network
Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year) ⁵	10% after deductible	50% after deductible

Maternity Hospital Services ⁵	10% after deductible	50% after deductible
Inpatient Professional Services (includes Maternity)	No charge after deductible	50% after deductible
Outpatient Surgery	In-Network	Out-of-Network
Freestanding	10% after deductible	50% after deductible
Hospital Based	10% after deductible	50% after deductible
Outpatient Professional Services	No charge after deductible	50% after deductible
Outpatient Diagnostics	In-Network	Out-of-Network
Diagnostic Medical (EKG)	No charge after deductible	50% after deductible
Routine Radiology (X-Ray)	No charge after deductible	50% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)	No charge after deductible	50% after deductible
Outpatient Lab and Pathology	In-Network	Out-of-Network
Freestanding	No charge after deductible	50% after deductible
Hospital Based	No charge after deductible	50% after deductible
Other Medical Services	In-Network	Out-of-Network
Spinal Manipulations (20 visits/year) ⁴	No charge after deductible	50% after deductible
Standard Injectables	No charge after deductible	50% after deductible
Allergy Injections	No charge after deductible	50% after deductible
Biotech/Specialty Injectables	No charge after deductible	50% after deductible
Chemotherapy	No charge after deductible	50% after deductible
Dialysis	No charge after deductible	50% after deductible
Skilled Nursing Facility (120 days/year) ⁴	No charge after deductible	50% after deductible
Home Health (60 visits/year) ⁴	No charge after deductible	50% after deductible
Hospice	No charge after deductible	50% after deductible
Durable Medical Equipment (DME)	No charge after deductible	50% after deductible
Mental Health – Outpatient (includes serious mental illness and substance abuse)	No charge after deductible	50% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse) ⁵	10% after deductible	50% after deductible

¹ Aggregate deductible: For family coverage, the entire family deductible must be met before copayments or coinsurance are applied for an individual member.

² Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.

³ Cognitive Therapy, Occupational Therapy, and Physical Therapy combined visit limit in and out-of-network.

⁴ Combined in and out of network.

⁵ Inpatient hospital out of network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.

This list is not comprehensive. Benefits and exclusions are further described in your Plan Document. Some services require pre-authorization.