Plan Limits at Hospitals

Details and Cost Examples

Background

Hospitals are the most expensive place to receive medical care, yet routine surgical procedures continue to be referred to hospitals. Many surgical procedures can be performed safely—and at a lower cost to you—outside the hospital setting, such as at an outpatient facility, Ambulatory Surgical Center (ASC), or at a physician's office.

Effective January 1, 2025, your plan will pay up to a set dollar limit for certain procedures provided at an in-network hospital. The limit may be less than the cost of the procedure, which means you will have to pay any balance due above the plan limit for your procedure. **The covered procedures and limits are below, and an example cost summary is shown on the following page.**

Procedure	In-Network Hospital Plan Limit
Arthroscopy	$6,000
Cataract Surgery	$2,000
Colonoscopy	$1,500
Gall Bladder Removal Surgery	$5,000
Hysteroscopy	$3,500
Tonsillectomy (under age 12)	$3,000
Upper GI Endoscopy with biopsy	$2,000
Upper GI Endoscopy without biopsy	$1,500

What you need to know:

- If the procedure is performed outside a hospital setting, you will only be responsible for your applicable annual deductible and/or coinsurance.
- The in-network hospital Plan limits do not apply to out-of-network hospital services. The Plan's applicable out-of-network coverage provisions continue to apply.
- There are certain exceptions that may apply to receive coverage at in-network hospitals with no Plan limits. For example, exceptions may apply due to patient safety or distance required to travel to get to an in-network hospital.

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Cost Summary Examples

Scenario 1: You receive gall bladder removal surgery at an **Ambulatory Surgical Center (ASC).** The negotiated fee for the surgery at the ASC is **$4,000.** Under this scenario, you pay your portion of the applicable in-network annual deductible and/or coinsurance, as outlined below.

	Medical Program Option			
	High HSA	Low HSA	Basic PPO	Network Only EPO
1. **Negotiated Fee at an ASC**	$4,000	$4,000	$4,000	$4,000
2. Your Deductible / Copay	$3,000	$1,650	$500	$250
3. Your Coinsurance	$200	$470	$700	$0
4. Total Amount You Will Pay *(sum of rows 2 & 3)*	$3,200	$2,120	$1,200	$250

Scenario 2: You receive gall bladder removal surgery at an **In-Network Hospital.** The negotiated fee at the hospital is **$12,000** and the in-network hospital Plan Limit is **$5,000.** Under this scenario, you pay your portion of the applicable in-network annual deductible and/or coinsurance, **plus the amount due in excess of the plan limit.** For example:

	Medical Program Option			
	High HSA	Low HSA	Basic PPO	Network Only EPO
1. **Negotiated Fee at an In-Network Hospital**	$12,000	$12,000	$12,000	$12,000
2. Your Deductible / Copay	$3,000	$1,650	$500	$250
3. Your Coinsurance	$1,800	$2,070	$2,300	$0
4. Remaining Amount Due to Hospital *(row 1 minus rows 2 & 3)*	$7,200	$8,280	$9,200	$11,750
5. **Plan Limit**	$5,000	$5,000	$5,000	$5,000
6. Amount Due in Excess of Plan Limit *(difference of rows 4 & 5)*	$2,200	$3,280	$4,200	$6,750
7. Total Amount You Will Pay *(sum of rows 2, 3, & 6)*	$7,000	$7,000	$7,000	$7,000

Summary of Example Scenarios:

	Medical Program Option			
	High HSA	Low HSA	Basic PPO	Network Only EPO
1. Amount You Pay at an ASC	$3,200	$2,120	$1,200	$250
2. Amount You Pay at an In-Network Hospital	$7,000	$7,000	$7,000	$7,000
3. **Amount You Save by Going to an ASC** *(difference between rows 1 & 2)*	**$3,800**	**$4,880**	**$5,800**	**$6,750**

Notes:
Any amount you pay that exceeds the plan limit will not apply toward meeting any annual deductible or out-of-pocket maximum. Both scenarios assume applicable in-network deductibles have not been met.

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Sample Scenario Term Definitions

Coinsurance
Once you meet your deductible, you pay a percentage of the cost of services, or coinsurance. This percentage varies if your care is in-network or out-of-network.

Copay
A flat dollar amount you pay each time you receive covered treatment, services, or supplies.

Deductible
An amount you owe during a coverage period (usually one year) for covered health care services before your plan begins to pay.

Negotiated Fee
The pre-negotiated (lower) rate charged by a provider for in-network services. You are responsible for all or a portion of the fee based on the medical program option you select and whether you have met your deductible and/or out-of-pocket maximum.

Plan Limit
The maximum amount your health plan will pay for specific in-network procedures.