



### Health Savings Account (HSA) \$5,000 Deductible Compatible Plan

	In-Network (You Pay)	Out-of-Network <sup>6</sup> (You Pay)
<b>\$5,000 Deductible Option</b> Calendar Year Deductible <sup>1</sup>	\$5,000 Self Only / \$10,000 Family <sup>1</sup>	
Coinsurance (applies only to certain services)	0%	30%
Out-of-Pocket Maximum (includes deductible)	\$5,800 Self Only / \$11,600 Family	\$11,600 Self Only / \$23,200 Family
<b>Dependent Children Covered</b>	Dependent to Age 27	
<b>Plan Lifetime Maximum</b>	\$5 million	
<b>Pre-Existing Condition Waiting Period</b>	12 months (prior coverage credit can reduce or eliminate)	
<b>Physician Office Visit</b> (includes Chiropractic care)	Deductible and Coinsurance	Deductible and Coinsurance
<b>Well Child Care Exams and Immunizations</b> (through age 18)	Covered in Full	Deductible and Coinsurance
<b>Adult Preventive Care<sup>7</sup></b>		
<b>Adult Routine Physical Exam</b>	Covered in Full	Deductible and Coinsurance
<b>Routine GYN Exam &amp; Pap Smear</b>	Covered in Full	Deductible and Coinsurance
<b>Routine Mammography</b>	Covered in Full	Deductible and Coinsurance
<b>Routine PSA Testing</b>	Covered in Full	Deductible and Coinsurance
<b>Routine Colonoscopy</b>	Covered in Full	Deductible and Coinsurance
<b>Diagnostic Lab and X-ray</b>	Deductible	Deductible and Coinsurance
<b>Inpatient Hospital Services<sup>2</sup></b>	Deductible	Deductible and Coinsurance
<b>Inpatient Skilled Nursing Services<sup>2,4</sup></b>	Deductible	Deductible and Coinsurance
<b>Outpatient Services</b>	Deductible	Deductible and Coinsurance
<b>Emergency Room (Facility)</b>	Deductible	Deductible
<b>Urgent Care</b>	Deductible	Deductible and Coinsurance
<b>Ambulance</b>	Deductible	Deductible
<b>Maternity Services</b>		
<b>Inpatient Care<sup>2</sup></b> includes routine nursery charges	Deductible	Deductible and Coinsurance
<b>Physician Care</b>	Deductible	Deductible and Coinsurance

This is a summary of benefits only and does not replace the legal contract or certificate which identifies all covered services, additional details, limitations and exclusions of the coverage.

<sup>1</sup>If you have 2-person or family coverage, the full family deductible must be satisfied before this plan will pay benefits. One person can satisfy the family deductible.

<sup>2</sup>Pre-certification required. Human Organ and Tissue Transplant Services - services must be rendered at an approved Anthem transplant facility (In & Out of Network).

<sup>3</sup>Durable Medical Equipment and Orthotics (excluding Prosthetic Devices, Limbs and Medical Supplies) \$4,000 benefit maximum; Prosthetic Devices \$4,000 benefit maximum; Prosthetic Limbs-\$10,000 benefit maximum. In & Out of Network combined.

<sup>4</sup>Inpatient Skilled Nursing Care limited to 30 days per calendar year. In and Out of Network combined.

<sup>5</sup>Short-term therapies limited to 20-visit limit combined In & Out of Network.

<sup>6</sup>When utilizing the services of an out-of-network Anthem provider, patient will be responsible for the balance between the approved amount and provider's actual billed charges. Patient is paid directly and is responsible to reimburse the out-of-network provider.

<sup>7</sup>Benefits based on services rendered in a physicians office setting.



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<b>Outpatient Chemotherapy</b>	Deductible	Deductible and Coinsurance
<b>Outpatient Radiation Therapy</b>	Deductible	Deductible and Coinsurance
<b>Outpatient Short-term Therapy Services<sup>5</sup></b> (Includes physical, speech and occupational therapies) <sup>5</sup>	Deductible	Deductible and Coinsurance
<b>Mental Health - Inpatient<sup>2</sup></b>	Deductible	Deductible and Coinsurance
<b>Outpatient</b>	Deductible	Deductible and Coinsurance
<b>Substance Abuse – Inpatient<sup>2</sup></b>	Deductible	Deductible and Coinsurance
<b>Outpatient</b>	Deductible	Deductible and Coinsurance
<b>Surgical Care Including Office Surgery</b>	Deductible	Deductible and Coinsurance
<b>Human Organ and Tissue Transplant Services<sup>2</sup></b>	Deductible	Deductible and Coinsurance
<b>Home Health Care</b> (100 visits - In & Out Network combined)	Deductible	Deductible and Coinsurance
<b>Hospice Care</b>	Deductible	Deductible
<b>Diabetic Equipment and Supplies</b>		
<b>Diabetic Supplies</b>	Deductible	Deductible and Coinsurance
<b>Diabetic Equipment</b>	Deductible	Deductible and Coinsurance
<b>Durable Medical Equipment<sup>3</sup></b>	Deductible	Deductible and Coinsurance
<b>Prescription Medicines</b>		
<b>Retail</b> (30 day supply) Includes Diabetic test strip	Tier 1 - \$10 Copay after deductible Tier 2 - \$30 Copay after deductible Tier 3 - \$50 Copay after deductible	50% Coinsurance after deductible, minimum \$75
<b>Mail order</b> (up to 90 day supply) Includes Diabetic test strip	Tier 1 - \$10 Copay after deductible Tier 2 - \$75 Copay after deductible Tier 3 - \$150 Copay after deductible	Not Covered
<b>Specialty Medication</b> ( 30 day supply retail and mail order) Tier 4 - Specialty Medication - 25% coinsurance, \$150 out of pocket maximum		
<b>\$2,000 Accident Policy included (underwritten by The Hartford). Up to \$2,000 reimbursement for out-of-pocket medical expenses incurred as a result of an accident. This benefit is not applicable to illness.</b>		

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