



Essential \$5,000 Deductible Plan

	In-Network (You Pay)	Out-of-Network ⁴ (You Pay)
Essential Option Calendar Year Deductible	\$5,000 Self Only / \$15,000 Family	\$10,000 Self Only / \$30,000 Family
Coinsurance (unless otherwise noted)	20%	50%
Out-of-Pocket Maximum (includes deductible)	\$10,000 Self Only / \$20,000 Family	\$20,000 Self Only / \$40,000 Family
Dependent Children Covered	Dependent to Age 27	
Plan Lifetime Maximum	\$5 million	
Pre-Existing Condition Waiting Period	12 Months (prior coverage credit can reduce or eliminate)	
Physician Office Visit (includes Chiropractic care)	\$20 Copay then 50% Coinsurance	Deductible and Coinsurance
Well Child Care Exams and Immunizations (through age 18)	\$20 Copay then 50% Coinsurance No Copay /Coinsurance on immunizations	Deductible and Coinsurance
Adult Preventive Care: Adult Routine Physical Exam	\$20 Copay then 50% Coinsurance	Deductible and Coinsurance
Diagnostic Lab and X-ray²	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital Services¹	\$1,000 Copay then Coinsurance	\$1,000 Copay then Coinsurance
Inpatient Skilled Nursing Services^{1,3}	\$1,000 Copay then Coinsurance	\$1,000 Copay then Coinsurance
Outpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Room (Facility)	\$200 Copay then Coinsurance	\$200 Copay then 20% Coinsurance
Urgent Care	Not Covered	Not Covered
Ambulance	Deductible and Coinsurance	Deductible and 20% Coinsurance
Maternity Services Inpatient Care¹ (includes routine nursery charges)	\$1,000 Copay then Coinsurance	\$1,000 Copay then Coinsurance
Physician Care	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Chemotherapy	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Radiation Therapy	Deductible and Coinsurance	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.

¹Pre-certification required. Human Organ and Tissue Transplant Services - services must be rendered at an approved Anthem transplant facility (In & Out of Network).

²Diagnostic Services (combined office and outpatient facility). Limited to \$300 maximum per person per year - In & Out of Network combined.

³Inpatient Skilled Nursing Care limited to 30 days per calendar year (In & Out of Network combined).

⁴When 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.



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Outpatient Short-term Therapy Services (Includes physical, speech and occupational therapies)	Not Covered	Not Covered
Mental Health - Inpatient¹ Outpatient	\$1,000 Copay then Coinsurance \$20 Copay then 50% Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Substance Abuse – Inpatient¹ Outpatient	\$1,000 Copay then Coinsurance \$20 Copay then 50% Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Surgical Care Including Office Surgery	Deductible and Coinsurance	Deductible and Coinsurance
Human Organ and Tissue Transplant Services¹	Deductible and Coinsurance	Deductible and Coinsurance
Home Health Care (60 visits - In & Out of Network combined)	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Care	Deductible and Coinsurance	Deductible and 20% Coinsurance
Diabetic Equipment and Supplies Diabetic Supplies	Deductible and Coinsurance	Deductible and Coinsurance
Diabetic Equipment	Deductible and Coinsurance	Deductible and Coinsurance
Durable Medical Equipment	Not Covered	Not Covered
Prescription Medicines, including oral contraceptives: Retail (30 day supply) Includes Diabetic test strip Mail order (up to 90 day supply-1 copay per 90 day supply) Includes Diabetic test strip Specialty medications are limited to a 30 day supply regardless of whether they are retail or mail service.	\$10 Copay for Generics only \$10 Copay for Generics only <u>Brand Name Drugs</u> – Not Covered Retail or Mail Order	50% Coinsurance after Deductible for Generics only 50% Coinsurance after Deductible for Generics only <u>Brand Name Drugs</u> – Not Covered Retail or Mail Order

\$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.

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