



| Health Savings Account (HSA) \$2,500 Deductible Compatible Plans          |   |   |
|---|---|---|
|   | In-Network<br>(You Pay)                                   | Out-of-Network <sup>6</sup><br>(You Pay)    |
| <b>\$2,500 Deductible Option</b><br>Calendar Year Deductible <sup>1</sup> | \$2,500 Self Only / \$5,000 Family <sup>1</sup>           |   |
| Coinsurance (applies only to certain services)<br>Out-of-Pocket Maximum   | 20%<br>\$5,000 Self Only / \$10,000 Family                | 40%<br>\$10,000 Self Only / \$20,000 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><br>(includes Chiropractic care)             | Deductible  | Deductible and Coinsurance                  |
| <b>Well Child Care Exams and Immunizations</b><br>(through age 18)        | Covered in Full (up to maximum allowable amount)          | Deductible and Coinsurance                  |
| <b>Adult Preventive Care</b>  |   |   |
| <b>Adult Routine Physical Exam</b>  | Covered in Full (up to maximum allowable amount)          | Deductible and Coinsurance                  |
| <b>Routine GYN Exam &amp; Pap Smear</b>                                   | Covered in Full (up to maximum allowable amount)          | Deductible and Coinsurance                  |
| <b>Routine Mammography</b>  | Covered in Full (up to maximum allowable amount)          | Deductible and Coinsurance                  |
| <b>Routine PSA Testing</b>  | Covered in Full (up to maximum allowable amount)          | Deductible and Coinsurance                  |
| <b>Diagnostic Lab and X-ray</b>   | Deductible and Coinsurance                                | Deductible and Coinsurance                  |
| <b>Inpatient Hospital Services<sup>2</sup></b>                            | Deductible and Coinsurance                                | Deductible and Coinsurance                  |
| <b>Inpatient Skilled Nursing Services<sup>2,4</sup></b>                   | Deductible and Coinsurance                                | Deductible and Coinsurance                  |
| <b>Outpatient Services</b>  | Deductible and Coinsurance                                | Deductible and Coinsurance                  |
| <b>Emergency Room</b>   | Deductible and Coinsurance                                | Deductible and 20% Coinsurance              |
| <b>Urgent Care</b>  | Deductible and Coinsurance                                | Deductible and Coinsurance                  |
| <b>Ambulance</b>  | Deductible and Coinsurance                                | Deductible and 20% 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.

<sup>2</sup>Pre-certification required.

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

<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.

FHCW- Anthem \$2,500 H S A-2010



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|--|----------------------------------|--|
|  | In-Network<br>(You Pay)          | Out-of-Network <sup>6</sup><br>(You Pay) |
| <b>Maternity Services</b>  |                                  |  |
| <b>Inpatient Care<sup>2</sup></b><br>(includes routine nursery charges)  | Deductible and Coinsurance       | Deductible and Coinsurance               |
| <b>Physician Care</b>  | Deductible and Coinsurance       | Deductible and Coinsurance               |
| <b>Outpatient Chemotherapy</b>   | Deductible and Coinsurance       | Deductible and Coinsurance               |
| <b>Outpatient Radiation Therapy</b>  | Deductible and Coinsurance       | Deductible and Coinsurance               |
| <b>Outpatient Short-term Therapy Services</b><br>(Includes physical, speech and occupational therapies) <sup>5</sup> | Deductible and Coinsurance       | Deductible and Coinsurance               |
| <b>Mental Health - Inpatient<sup>2</sup></b>   | Deductible and Coinsurance       | Deductible and Coinsurance               |
| <b>Outpatient</b>  | Deductible and Coinsurance       | Deductible and Coinsurance               |
| <b>Substance Abuse – Inpatient<sup>2</sup></b>   | Deductible and Coinsurance       | Deductible and Coinsurance               |
| <b>Outpatient</b>  | Deductible and Coinsurance       | Deductible and Coinsurance               |
| <b>Surgical Care Including Office Surgery</b>  | Deductible and Coinsurance       | Deductible and Coinsurance               |
| <b>Human Organ and Tissue Transplant Services<sup>2</sup></b>  | Deductible and Coinsurance       | Deductible and Coinsurance               |
| <b>Home Health Care</b> (100 visits -In & Out Network combined)  | Deductible and Coinsurance       | Deductible and Coinsurance               |
| <b>Hospice Care</b>  | Deductible and Coinsurance       | Deductible and 20% Coinsurance           |
| <b>Diabetic Equipment and Supplies</b>   |                                  |  |
| <b>Diabetic Supplies</b>   | Deductible and Coinsurance       | Deductible and Coinsurance               |
| <b>Diabetic Equipment</b>  | Deductible and Coinsurance       | Deductible and Coinsurance               |
| <b>Durable Medical Equipment<sup>3</sup></b>   | Deductible and Coinsurance       | Deductible and Coinsurance               |
| <b>Prescription Medicines:</b>   |                                  |  |
| <b>Retail</b> (30 day supply)<br>Includes Diabetic test strip  | 20% Coinsurance after Deductible | Deductible and Coinsurance               |
| <b>Mail order</b> (up to 90 day supply)<br>Includes Diabetic test strip  | 10% Coinsurance after Deductible | Not covered                              |
| Specialty medications are limited to a 30 day supply regardless of whether they are retail or mail service.          |                                  |  |

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