



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

	In-Network (You Pay)	Out-of-Network ⁵ (You Pay)
\$5,000 Deductible Option Calendar Year Deductible ¹	\$5,000 Self Only / \$10,000 Family ¹	
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
Dependent Children Covered	Dependent to Age 27	
Plan Lifetime Maximum	Unlimited	
Pre-Existing Condition Waiting Period (prior coverage credit can reduce or eliminate)	12 months (excludes members under age 19)	
Physician Office Visit (includes Chiropractic care)	Deductible and Coinsurance	Deductible and Coinsurance
Well Child Care Exams and Immunizations (through age 18)	Covered in Full	Deductible and Coinsurance
Adult Preventive Care⁶		
Adult Routine Physical Exam	Covered in Full	Deductible and Coinsurance
Routine GYN Exam & Pap Smear	Covered in Full	Deductible and Coinsurance
Routine Mammography	Covered in Full	Deductible and Coinsurance
Routine PSA Testing	Covered in Full	Deductible and Coinsurance
Routine Colonoscopy	Covered in Full	Deductible and Coinsurance
Diagnostic Lab and X-ray	Deductible	Deductible and Coinsurance
Inpatient Hospital Services²	Deductible	Deductible and Coinsurance
Inpatient Skilled Nursing Services^{2,3}	Deductible	Deductible and Coinsurance
Outpatient Services	Deductible	Deductible and Coinsurance
Emergency Room (Facility)	Deductible	Deductible
Urgent Care	Deductible	Deductible and Coinsurance
Ambulance	Deductible	Deductible
Maternity Services		
Inpatient Care² includes routine nursery charges	Deductible	Deductible and Coinsurance
Physician Care	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.

¹If 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.

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

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

⁴Short-term therapies limited to 20-visit limit combined In & Out of Network.

⁵When 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.

⁶Benefits based on services rendered in a physicians office setting.



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Outpatient Chemotherapy	Deductible	Deductible and Coinsurance
Outpatient Radiation Therapy	Deductible	Deductible and Coinsurance
Outpatient Short-term Therapy Services⁴ (Includes physical, speech and occupational therapies) ⁵	Deductible	Deductible and Coinsurance
Mental Health - Inpatient²	Deductible	Deductible and Coinsurance
Outpatient	Deductible	Deductible and Coinsurance
Substance Abuse – Inpatient²	Deductible	Deductible and Coinsurance
Outpatient	Deductible	Deductible and Coinsurance
Surgical Care Including Office Surgery	Deductible	Deductible and Coinsurance
Human Organ and Tissue Transplant Services²	Deductible	Deductible and Coinsurance
Home Health Care (100 visits - In & Out Network combined)	Deductible	Deductible and Coinsurance
Hospice Care	Deductible	Deductible
Diabetic Equipment and Supplies		
Diabetic Supplies	Deductible	Deductible and Coinsurance
Diabetic Equipment	Deductible	Deductible and Coinsurance
Durable Medical Equipment	Deductible	Deductible and Coinsurance
Prescription Medicines		
Retail (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
Mail order (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
Specialty Medication (30 day supply retail and mail order) Tier 4 - Specialty Medication - 25% coinsurance, \$150 out of pocket maximum		
\$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.		
Vision Benefit(underwritten by EyeMed Vision Care)		
Annual Eye Exam: Participating Provider \$5 copay- Non-Participating \$30 Maximum Benefit		
Eyewear: Participating Provider Only- frames, prescription lenses, and contact lenses available at discounted prices.		

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