



### Essential POS \$5,000 Deductible Plan

	In-Network (You Pay)	Out-of-Network <sup>5</sup> (You Pay)
<b>Essential Option –</b> 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	\$10,000 Self Only / \$20,000 Family	\$20,000 Self Only / \$40,000 Family
<b>Dependent Children Covered</b>	Dependent to Age 27	
<b>Plan Lifetime Maximum</b>	\$2 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	Deductible and Coinsurance
<b>Well Child Care Exams and Immunizations</b> (through age 18)	\$20 Copay then 50% Coinsurance No Copay /Coinsurance on immunizations	Deductible and Coinsurance
<b>Adult Preventive Care:</b>  <b>Adult Routine Physical Exam</b>	\$20 Copay then 50% Coinsurance	Deductible and Coinsurance
<b>Diagnostic Lab and X-ray<sup>2</sup></b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Inpatient Hospital Services<sup>1</sup></b>	\$1,000 Copay then Coinsurance	\$1,000 Copay then Coinsurance
<b>Inpatient Skilled Nursing Services<sup>3,4</sup></b>	\$1,000 Copay then Coinsurance	\$1,000 Copay then Coinsurance
<b>Outpatient Services</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Emergency Room</b>	\$200 Copay then Coinsurance	\$200 Copay then 20% Coinsurance
<b>Urgent Care</b>	Not Covered	Not Covered
<b>Ambulance</b>	Deductible and Coinsurance	Deductible and 20% Coinsurance
<b>Maternity Services</b> <b>Inpatient Care<sup>2</sup></b> (includes routine nursery charges)	\$1,000 Copay then Coinsurance	\$1,000 Copay then Coinsurance
<b>Physician Care</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Outpatient Chemotherapy</b>	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.

<sup>1</sup>Pre-certification required.

<sup>2</sup>Diagnostic Services (combined office and outpatient facility). Limited to \$300 maximum-In & Out of Network combined.

<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 & Out of Network combined).

<sup>5</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.



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<b>Outpatient Radiation Therapy</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Outpatient Short-term Therapy Services</b> (Includes physical, speech and occupational therapies) <sup>5</sup>	Not Covered	Not Covered
<b>Mental Health - Inpatient<sup>2</sup></b>	\$1,000 Copay then Coinsurance	Deductible and Coinsurance
<b>Outpatient</b>	\$20 Copay then 50% Coinsurance	Deductible and Coinsurance
<b>Substance Abuse – Inpatient<sup>2</sup></b>	\$1,000 Copay then Coinsurance	Deductible and Coinsurance
<b>Outpatient</b>	\$20 Copay then 50% 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 (60 visits -In &amp; Out Network combined)</b>	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>	Not Covered	Not Covered
<b>Prescription Medicines, including oral contraceptives:</b>		
<b>Retail (30 day supply)</b> Includes Diabetic test strip	Both Retail and Mail Order  \$10 Copay for Generics only	50% Coinsurance after Deductible
<b>Mail order (up to 90 day supply)</b> Includes Diabetic test strip Specialty medications are limited to a 30 day supply regardless of whether they are retail or mail service.	Brand Name Drugs –Not Covered	Not covered

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