



Deductible PPO/POS Plans

	In Network (You Pay)	Out-of-Network ³ (You Pay)
Option 1	\$300 Self Only / \$600 Family	
Calendar Year Deductible	\$300 Self Only / \$600 Family	
Coinsurance (applies only to certain services)	20%	40%
Out-of-Pocket Maximum (excludes copays)	\$800 Self Only / \$1,600 Family	\$1,300 Self Only / \$2,600 Family
Option 2	\$500 Self Only / \$1,000 Family	
Calendar Year Deductible	\$500 Self Only / \$1,000 Family	
Coinsurance (applies only to certain services)	20%	40%
Out-of-Pocket Maximum (excludes copays)	\$1,250 Self Only / \$2,500 Family	\$2,000 Self Only / \$4,000 Family
Option 3	\$1,000 Self Only / \$2,000 Family	
Calendar Year Deductible	\$1,000 Self Only / \$2,000 Family	
Coinsurance (applies only to certain services)	20%	40%
Out-of-Pocket Maximum (excludes copays)	\$2,000 Self Only / \$4,000 Family	\$3,000 Self Only / \$6,000 Family
Option 4	\$2,500 Self Only / \$5,000 Family	
Calendar Year Deductible	\$2,500 Self Only / \$5,000 Family	
Coinsurance (applies only to certain services)	20%	40%
Out-of-Pocket Maximum (excludes copays)	\$3,500 Self Only / \$7,000 Family	\$4,500 Self Only / \$9,000 Family
Dependent Children Covered	Dependent to Age 27	
Plan Lifetime Maximum	\$5 million	
Preexisting Condition Waiting Period	12 months (prior coverage credit can reduce or eliminate)	
Physician Office Visit (includes Chiropractic care)	\$30 Copay	Deductible and Coinsurance
Well Child Care Exams and Immunizations (through age 18)	\$30 Copay- office visit No Copay/Coinsurance for immunizations	Deductible and Coinsurance
Adult Preventive Care		
Adult Routine Physical Exam	\$30 Copay	Deductible and Coinsurance
Routine GYN Exam & Pap Smear	\$30 Copay	Deductible and Coinsurance
Routine Mammography	\$30 Copay	Deductible and Coinsurance
Routine PSATesting	\$30 Copay	Deductible and Coinsurance
Diagnostic Lab and X-ray	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital Services¹	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Skilled Nursing Services¹	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. A penalty may apply if you fail to obtain pre-certification.

²Durable 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

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.



Deductible PPO Plans		
	In Network (You Pay)	Out-of-Network⁵ (You Pay)
Outpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Room	\$100 Copay, waived if admitted	\$100 Copay, waived if admitted
Urgent Care	\$35 Copay	Deductible and Coinsurance
Ambulance	Deductible and Coinsurance	Deductible and 20% Coinsurance
Maternity Services		
Inpatient Care¹ (includes routine nursery charges)	Deductible and Coinsurance	Deductible and 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
Outpatient Short-term Therapy Services (Includes physical, speech and occupational therapies)	Deductible and Coinsurance	Deductible and Coinsurance
Mental Health² - Inpatient¹	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient	Deductible and Coinsurance	Deductible and Coinsurance
Substance Abuse² - Inpatient¹	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient	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 (90 visits)	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 Equipment²	Deductible and Coinsurance	Deductible and Coinsurance
Prescription Medicines:		
Retail (30 day supply) Includes diabetic test strip	Tier 1 - \$10 Copay Tier 2 - \$30 Copay Tier 3 - \$50 Copay	50%, minimum \$50
Mail order (up to 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.	Tier 1 - \$20 Copay Tier 2 - \$60 Copay Tier 3 - \$100 Copay	Not Covered

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