



Essential \$5,000 Deductible Plan

| | In-Network (You Pay) | Out-of-Network ³ (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 | 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) | \$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-ray | Deductible and Coinsurance | Deductible and Coinsurance |
| Inpatient Hospital Services¹ | \$1,000 Copay then Coinsurance | Deductible and Coinsurance |
| Inpatient Skilled Nursing Services^{1,2} | \$1,000 Copay then Coinsurance | Deductible and Coinsurance |
| Outpatient Services | Deductible and Coinsurance | Deductible and Coinsurance |
| Emergency Room (Facility) copay waived if admitted | \$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 | 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 |

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).

²Inpatient Skilled Nursing Care limited to 30 days per calendar year (In & Out of Network combined).

³When 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 | \$1,000 Copay then 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. | | |
| 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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