

Carrier Plan Name	Anthem Blue Cross		Anthem Blue Cross	
	PPO 500 90/70 - \$10/30/10 Rx + Cost		HSA 1650 - \$10/30 Rx	
	In-Network	Out-of-Network	In-Network	Out-of-Network
General Plan Information				
Annual Deductible/Individual	\$500	\$1,000	\$1,650 medical/prescription/MH-SA in/out of network combined	\$1,650 medical/prescription/MH-SA in/out of network combined
Annual Deductible/Family	\$1,500	\$3,000	\$3,300 medical/prescription/MH-SA in/out of network combined	\$3,300 medical/prescription/MH-SA in/out of network combined
Coinsurance	90%	70%	90%	70%
Office Visit/Exam	\$30/Visit; deductible waived	70%	90%	70%
Outpatient Specialist Visit	\$30/Visit; deductible waived	70%	90%	70%
Annual Out-of-Pocket Limit/Individual	\$3,000 Rx not included	\$6,000 Rx not included	\$3,000	\$9,000
Annual Out-of-Pocket Limit/Family	\$9,000 Rx not included	\$18,000 Rx not included	\$6,000	\$18,000
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Inpatient Hospital Services				
Inpatient Hospitalization	90%	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)	90%	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)
Semi-Private Room & Board; Including Services and Supplies	90%	70%	90%	70%
Emergency Services				
Emergency Room	90%	90%	90%	90%
Mental Health Benefits				
Inpatient Care	90% (subject to utilization review; waived for emergency admissions)	70% plus \$500 copay per admission (waived for emergency); there is an additional \$250 copay if a utilization review is not obtained	90% (subject to utilization review; waived for emergency admissions)	70% plus \$500 copay per admission (waived for emergency); there is an additional \$250 copay if a utilization review is not obtained.
Outpatient Care	90%	70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.	90%	70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.
Substance Abuse				
Inpatient Care				
Inpatient Hospitalization	90% (subject to utilization review; waived for emergency admissions)	70% plus \$500 copay per admission (waived for emergency); there is an additional \$250 copay if a utilization review is not obtained	90% (subject to utilization review; waived for emergency admissions)	70% plus \$500 copay per admission (waived for emergency); there is an additional \$250 copay if a utilization review is not obtained.
Inpatient Detoxification Services	90% (subject to utilization review; waived for emergency admissions)	70% plus \$500 copay per admission (waived for emergency); there is an additional \$250 copay if a utilization review is not obtained	90% (subject to utilization review; waived for emergency admissions)	70% plus \$500 copay per admission (waived for emergency); there is an additional \$250 copay if a utilization review is not obtained.
Outpatient Care				
Outpatient Services	90%	70%	90%	70%
Prescription Drug Benefits				
Prescription Drug Deductible			\$1,650 ind/\$3300 fam medical/prescription/MH-SA in/out of network combined	\$1,650 ind/\$3300 fam medical/prescription/MH-SA in/out of network combined
Generic	\$10 copay/Tier 1 Pharmacy \$10 copay +\$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express-scripts.com for a list of pharmacies)	\$10 after deductible /Tier 1 Pharmacy \$10 copay after deductible + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	50% after deductible + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express-scripts.com for a list of pharmacies)
Brand (Formulary/Preferred)	\$30 copay/Tier 1 Pharmacy \$30 copay +\$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express-scripts.com for a list of pharmacies)	\$30 after deductible /Tier 1 Pharmacy \$30 copay after deductible + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	50% after deductible + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express-scripts.com for a list of pharmacies)
Brand (Non-Formulary/Non-preferred)	\$10 copay/Tier 1 Pharmacy \$10 copay +\$15/Tier 2 Pharmacy + cost difference between generic and brand when generic equivalent is available; (see www.express-scripts.com for a list of pharmacies)	50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy + cost difference between generic and brand when generic equivalent is available; (see www.express-scripts.com for a list of pharmacies)	N/A	N/A
Number of Days Supply	30 days	30 days	30 days	30 days
Mail Order				
Generic	\$20 copay provided by Express Scripts	Not covered	\$20 copay after deductible; provided by Express Scripts	Not covered
Brand (Formulary/Preferred)	\$60 copay provided by Express Scripts	Not covered	\$60 copay after deductible; provided by Express Scripts	Not covered
Brand (Non-Formulary/Non-preferred)	\$20 copay plus cost difference between generic and brand when generic equivalent is available; provided by Express Scripts	Not covered	N/A	N/A
Number of Days Supply for Mail Order	90 days	Not covered	90 days	Not covered
Other Services and Supplies				
Chiropractic Services	90% limited to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network combined	70% chiro/phys/occ therapy combined; in/out of network combined	90% limited to 24 visits/calendar year; phys/occ/chiro combined; in/out of network combined	70% limited to 24 visits/calendar year; phys/occ/chiro combined; in/out of network combined

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