

Effective Date
Carrier
Plan Name
Benefit Summary

7/1/2024

Anthem Blue Cross
HSA 1600 - \$10/30 Rx

Eligible Employees

	In-Network	Out-of-Network
General Plan Information		
Annual Deductible/Individual	\$1,600 medical/prescription/MH-SA in/out of network combined	\$1,600 medical/prescription/MH-SA in/out of network combined
Annual Deductible/Family	\$3,200 medical/prescription/MH-SA in/out of network combined	\$3,200 medical/prescription/MH-SA in/out of network combined
Coinsurance	90%	70%
Office Visit/Exam	90%	70%
Outpatient Specialist Visit	90%	70%
Annual Out-of-Pocket Limit/Individual	\$3,000	\$9,000
Annual Out-of-Pocket Limit/Family	\$6,000	\$18,000
Lifetime Plan Maximum	Unlimited	Unlimited
Inpatient Hospital Services		
Inpatient Hospitalization	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% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)
Emergency Services		
Emergency Room	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.
Outpatient Care	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.
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.
Outpatient Care		
Outpatient Services	90%	70%
Prescription Drug Benefits		
Prescription Drug Deductible	\$1,600 ind/\$3200 fam medical/prescription/MH-SA in/out of network combined	\$1,600 ind/\$3200 fam medical/prescription/MH-SA in/out of network combined
Generic	\$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 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)
Number of Days Supply	30 days	30 days
Mail Order		
Generic	\$20 copay after deductible; provided by Express Scripts	Not covered
Brand (Formulary/Preferred)	\$60 copay after deductible; provided by Express Scripts	Not covered
Number of Days Supply for Mail Order	90 days	Not covered
Other Services and Supplies		
Chiropractic Services	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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