

	Anthem Gold PPO 2250/0%/2250 w/ HSA TradRX		Anthem Silver PPO 3500/50%/7900 TradRX		Anthem Gold Pathway HMO 1000/20%/5600		Anthem Gold PPO 750/20%/5250		Anthem Platinum PPO 250/20%/3500	
	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Annual Deductible										
Single / Family	\$2,250 / \$4,500	\$6,750 / \$13,500	\$3,500 / \$7,000	\$10,500 / \$21,000	\$1,000 / \$3,000	Not covered	\$750 / \$2,250	\$2,250 / \$4,500	\$250 / \$750	\$2,000 / \$4,000
Annual Out-of-Pocket Maximum										
Single / Family	\$2,250 / \$4,500	\$7,875 / \$15,750	\$7,900 / \$15,800	\$23,700 / \$47,400	\$5,600 / \$11,200	Not covered	\$5,250 / \$10,500	\$15,750 / \$31,500	\$3,500 / \$7,000	\$10,500 / \$21,000
Office Visit										
Primary Care	0% coinsurance	50% coinsurance	\$50/visit	50% coinsurance	\$25/visit	Not covered	\$20/visit for first 3, then 20% coinsurance	50% coinsurance	\$15/visit	50% coinsurance
Specialist	0% coinsurance	50% coinsurance	\$75/visit	50% coinsurance	\$50/visit	Not covered	\$20/visit for first 3, then 20% coinsurance	50% coinsurance	\$25/visit	50% coinsurance
Preventative Services	No charge	50% coinsurance	No charge	50% coinsurance	No charge	Not covered	No charge	50% coinsurance	No charge	50% coinsurance
Diagnostic Test & Imaging	0% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	20% coinsurance	Not covered	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Outpatient Surgery	0% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	20% coinsurance	Not covered	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Emergency										
Emergency Room	0% coinsurance	Covered as In-Network	\$500/visit	Covered as In-Network	\$300/visit	Not covered	\$300/visit	Covered as In-Network	\$300/visit	Covered as In-Network
Emergency Medical Transportation	0% coinsurance	Covered as In-Network	50% coinsurance	Covered as In-Network	20% coinsurance	Not covered	\$300/trip	Covered as In-Network	20% coinsurance	Covered as In-Network
Urgent Care	0% coinsurance	50% coinsurance	\$75/visit	50% coinsurance	\$50/visit	Not covered	20% coinsurance	50% coinsurance	\$35/visit	50% coinsurance
Hospital Stay	0% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	20% coinsurance	Not covered	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Mental Health/Behavioral Health/Substance Abuse Services										
Office Visit	0% coinsurance	50% coinsurance	\$50/visit	50% coinsurance	\$25/visit	Not covered	\$20/visit for first 3, then 20% coinsurance	50% coinsurance	\$15/visit	50% coinsurance
Other Outpatient	0% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	20% coinsurance	Not covered	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Other Outpatient	0% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	20% coinsurance	Not covered	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Inpatient Services	0% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	20% coinsurance	Not covered	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Pregnancy										
Office visits, childbirth/delivery professional & facility services	0% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	20% coinsurance	Not covered	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Monthly Cost (Varies by Age)*										
Age 30										
Employee	\$134		\$111		\$114		\$136		\$149	
Per Child Cost**	\$181		\$150		\$155		\$184		\$201	
Spouse/Domestic Partner Cost	\$268		\$222		\$229		\$273		\$299	
Age 50										
Employee	\$211		\$175		\$180		\$215		\$235	
Per Child Cost**	\$181		\$150		\$155		\$184		\$201	
Spouse/Domestic Partner Cost	\$422		\$350		\$361		\$431		\$471	

Limitations, exceptions and other important information are provided in the summary of benefits and coverage for each plan. In the event that the information in this summary differs from the plan description, the plan description will prevail.

*For the purpose of this document, we assume that your spouse is the same age as you and that your children are 18 years old or less. Your quoted price will change based on the actual age of your spouse and children.

**Children beyond the first three are covered at no additional cost.

Vision		
	In-Network	Non-Network
Co-Pay		
First Service Provided	Not applicable	
Exams	Exams \$10.00	
Materials	\$25	
	Waived for conventional & planned replacement contact lenses	
How Often Can I Obtain Service?*		
Exams	Once/year	
Lenses	Once/year	
Frames	Once every other year	
Materials	Once/year	
Eye Exams	Copay applies	Amount over \$39
Lenses		
Single Vision	Copay applies	Amount over \$23
Lined Bifocal	Copay applies	Amount over \$37
Lined Trifocal	Copay applies	Amount over \$49
Lenticular	Copay applies	Amount over \$64
Contact Lenses		
Conventional	Amount over \$130	Amount over \$100
Planned Replacement & Disposable	Amount over \$130	Amount over \$100
Medically Necessary	Copay applies	Amount over \$210
Evaluation & Fitting	15% off professional fee	Not covered
Frames	\$130, 20% discount on amount over \$130	Amount over \$46
Lens & Frame Allowance	No discounts	No discounts
Cosmetic Extras	Discounted at average 20%-25% off providers UCR	No discounts
Laser Correction Surgery	Average 15% discount off usual price or 5% off promotional price	No discounts
Monthly Cost**		
Employee	\$9	
Child Cost***	\$7	
Spouse/Domestic Partner Cost	\$6	

Dental				
	Calendar Year Deductible		Coinsurance (Policy Pays)	
	In-Network	Non-Network	In-Network	Non-Network
Preventative	\$0	\$0	100%	100%
Basic	\$50	\$50	80%	80%
Major	\$50	\$50	50%	50%
Combined Family Deductible	Max deductible 3 times the per person deductible amount. Deductibles for basic and major procedures are combined for in-network and non-network.			
Combined Maximum	Maximums for preventative, basic, and major procedures combined. In-network and non-network maximums are \$1,000 per person.			
Orthodontia - Child				
	In-Network	Non-Network	In-Network	Non-Network
Lifetime Deductible	\$0	\$0	50%	50%
Lifetime Maximum	\$1,000	\$1,000		
Monthly Cost**				
Employee	\$40			
Child Cost***	\$68			
Spouse/Domestic Partner Cost	\$41			

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*Members will receive 20% off unlimited additional pairs of prescription glasses and non prescription sunglasses valid through any VSP doctor within 12 months of the last covered exam.

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***Children beyond the first child are covered at no additional cost.