Medical & Prescription Plans

	Anchor Plan		Anchor Plus Plan		Anchor Choice Plan with HSA (HSA Qualified Plan)	
State HSA Contribution* – Single / Family	**N/A**		**N/A**		**$1,600* / $3,200***	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Medical Deductible – Single / Family	$1,000 / $2,000	$2,000 / $4,000	$500 / $1,000	$1,000 / $2,000	$1,600 / $3,200	$2,250 / $4,500
Coinsurance	10%	30%	10%	30%	10%	30%
Out-of-Pocket Maximum – Single / Family	$2,000 / $4,000	$6,000 / $12,000	$1,000 / $2,000	$5,000 / $10,000	$3,000 / $6,000	$4,500 / $9,000
Preventive Care	Covered in full	Coinsurance after deductible	Covered in full	Coinsurance after deductible	Covered in full	Coinsurance after deductible
Office Visit (non-preventive)						
PCP	$15 Copay	Coinsurance after deductible	$15 Copay	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible
Specialist	$25 / $50 Copay**	Coinsurance after deductible	$25 / $50 Copay**	Coinsurance after deductible	10% / 30% after deductible**	Coinsurance after deductible
Chiropractic Care	$15 Copay	Coinsurance after deductible	$15 Copay	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible
Diagnostic Test (X-ray, blood work)	No charge	Coinsurance after deductible	No charge	Coinsurance after deductible	Coinsurance after deductible, no charge if preventive	Coinsurance after deductible
Imaging (CT/PET scans, MRIs)	Coinsurance after deductible***	Coinsurance after deductible	Coinsurance after deductible***	Coinsurance after deductible	Coinsurance after deductible***	Coinsurance after deductible
Inpatient Hospital	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible
Outpatient Surgery	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible
Mental Health / Substance Use Disorder						
Inpatient	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible
Outpatient	$15 Copay	Coinsurance after deductible	$15 Copay	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible

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Medical & Prescription Plans

	Anchor Plan		Anchor Plus Plan		Anchor Choice Plan with HSA (HSA Qualified Plan)	
State HSA Contribution* – Single / Family	**N/A**		**N/A**		**$1,600* / $3,200***	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Blue Cross Blue Shield of Rhode Island *(Continued)*						
Emergency Room	$150 Copay	$150 Copay	$125 Copay	$125 Copay	Coinsurance after deductible	10% Coinsurance after deductible
Ambulance	Covered in full	Covered in full	Covered in full	Covered in full	Coinsurance after deductible	10% Coinsurance after deductible
Urgent Care	$50 Copay	Coinsurance after deductible	$50 Copay	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible
Physical Therapy, Occupational Therapy, Speech Therapy	$15 Copay	Coinsurance after deductible	$15 Copay	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible
CVS caremark®						
Prescription Deductible – Single / Family	None	None	None	None	Combined	Combined
Out-of-Pocket Maximum – Single / Family	Combined	None	Combined	None	Combined	Combined
Retail (30-day supply) 4-Tier: generic / preferred brand / non-preferred brand / specialty	$10/$35/$60/$100 Copay	$10/$35/$60/$100 Copay	$10/$35/$60/$100 Copay	$10/$35/$60/$100 Copay	$10/$35/$60/$100 Copay after deductible****	Coinsurance after deductible
Mail Order (90-day supply)*** 3-Tier: generic / preferred brand / non-preferred brand	$20/$70/$120 Copay	Not covered	$20/$70/$120 Copay	Not covered	$20/$70/$120 Copay after deductible	Not covered

* *State HSA contributions are made biannually with half deposited in January and the other half deposited in July, and they are NOT pro-rated for employees that enroll after January 1 and July 1.*

** *Amount shown reflects your costs with a referral/without a referral.*

*** *Covered in full after deductible if a freestanding imaging center not affiliated with a hospital group is used.*

**** *You pay the full cost prior to meeting your deductible unless the drug is on the preventive therapy list.*

***** *Specialty drugs are limited to a 30-day supply.*