



# 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		\$1,650* / \$3,300*	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network



<b>Medical Deductible – Single / Family</b>	\$1,000 / \$2,000	\$2,000 / \$4,000	\$500 / \$1,000	\$1,000 / \$2,000	\$1,650 / \$3,300	\$2,250 / \$4,500
<b>Coinsurance</b>	10%	30%	10%	30%	10%	30%
<b>Out-of-Pocket Maximum – Single / Family</b>	\$2,000 / \$4,000	\$6,000 / \$12,000	\$1,000 / \$2,000	\$5,000 / \$10,000	\$3,000 / \$6,000	\$4,500 / \$9,000
<b>Preventive Care</b>	Covered in full	Coinsurance after deductible	Covered in full	Coinsurance after deductible	Covered in full	Coinsurance after deductible
<b>Office Visit (non-preventive)</b>						
PCP	\$15 Copay	Coinsurance after deductible	\$15 Copay	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible
Specialist	\$25 Copay	Coinsurance after deductible	\$25 Copay	Coinsurance after deductible	10% after deductible	Coinsurance after deductible
<b>Chiropractic Care</b>	\$15 Copay	Coinsurance after deductible	\$15 Copay	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible
<b>Diagnostic Test (X-ray, blood work)</b>	No charge	Coinsurance after deductible	No charge	Coinsurance after deductible	Coinsurance after deductible, no charge if preventive	Coinsurance after deductible
<b>Imaging (CT/PET scans, MRIs)</b>	Coinsurance after deductible**	Coinsurance after deductible	Coinsurance after deductible**	Coinsurance after deductible	Coinsurance after deductible**	Coinsurance after deductible
<b>Inpatient Hospital</b>	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible
<b>Outpatient Surgery</b>	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible
<b>Mental Health / Substance Use Disorder</b>						
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



# 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		\$1,650* / \$3,300*	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network



(Continued)

<b>Emergency Room</b>	\$150 Copay	\$150 Copay	\$125 Copay	\$125 Copay	Coinsurance after deductible	10% Coinsurance after deductible
<b>Ambulance</b>	Covered in full	Covered in full	Covered in full	Covered in full	Coinsurance after deductible	10% Coinsurance after deductible
<b>Urgent Care</b>	\$50 Copay	Coinsurance after deductible	\$50 Copay	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible
<b>Physical Therapy, Occupational Therapy, Speech Therapy</b>	\$15 Copay	Coinsurance after deductible	\$15 Copay	Coinsurance after deductible	Coinsurance after deductible	Coinsurance after deductible



<b>Prescription Deductible – Single / Family</b>	None	None	None	None	Combined	Combined
<b>Out-of-Pocket Maximum – Single / Family</b>	Combined	None	Combined	None	Combined	Combined
<b>Retail (30-day supply)</b> 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
<b>Mail Order (90-day supply)*****</b> 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.

\*\* Covered in full after deductible if 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.

\*\*\*\* With enrollment in the PrudentRx program, specialty drugs on the program list from an in-network pharmacy have no out-of-pocket cost. Choosing not to participate in PrudentRx, specialty fills will be subject to 30% coinsurance. If you are enrolled in the Anchor Choice plan with HSA, you must fully satisfy your deductible before you are eligible to obtain your specialty drug at no out-of-pocket cost, unless you have been prescribed a medication that is qualified as "preventive care" by the IRS.

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