New HSA 6

Your Summary *of* Benefits

Anthem

PLAN 2

Trends International, LLC
Blue Access® for Health Savings Accounts Option 6
Effective 01/01/2015

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Covered Benefits	Network	Non-Network
Deductible Family coverage requires the family deductible to be met before coinsurance applies. The single deductible **does not** apply to family coverage.	Single: $3,000 Family: $6,000	Single: $6,000 Family: $12,000
Out-of-Pocket Limit	Single: $6,450 Family: $12,900	Single: $12,900 Family: $25,400
Physician Home and Office Services (PCP/SCP) Primary Care Physician(PCP)/Specialty Care Physician (SCP) · Including Office Surgeries, allergy serum, allergy injections and allergy testing	20% / 20%	50%
Preventive Care Services Services included but not limited to: Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening.	No Cost Share	50%
Emergency and Urgent Care · **Emergency Room Services @Hospital (facility/other covered services)** *(copayment waived if admitted)* · **Urgent Care Center Services**	20% 20%	20% 50%
Inpatient and Outpatient Professional Services Include but are not limited to: · Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	20%	50%
Inpatient Facility Services Unlimited days except for: · 60 days Network/Non-Network combined for physical medicine / rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) · 90 days Network/Non-Network combined for skilled nursing facility	20%	50%
Outpatient Surgery Hospital / Alternative Care Facility · Surgery and administration of general anesthesia	20%	50%
Other Outpatient Services (including but not limited to): · Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. · Home Care Services (Network/Non-network combined) 100 visits (excludes IV Therapy) · Durable Medical Equipment, Orthotics, and Prosthetics · Physical Medicine Therapy Day Rehabilitation programs · Ambulance Services	20% 20%	50% 20%

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Covered Benefits	Network	Non-Network
Outpatient Therapy Services **(Combined Network & Non-Network limits apply)** · Physician Home and Office Visits (PCP/SCP) · Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: · Physical therapy: 20 visits · Occupational therapy: 20 visits · Manipulation therapy: 12 visits · Speech therapy: 20 visits · Cardiac Rehabilitation: 36 visits · Pulmonary Rehabilitation: 20 visits · Accidental Dental Coverage $3000 per accident	20% / 20% 20%	50% 50%
Behavioral Health Services: **Mental Health and Substance Abuse (1)** · Inpatient Facility Services · Physician Home and Office Visits · Other Outpatient Services @ Hospital/Alternative Care Facility	20% 20% /20% 20%	50% 50% 50%
Human Organ and Tissue Transplants · Acquisition and transplant procedures, harvest and storage.	No Cost Share	50%
Prescription Drugs: **Network Tier structure equals 1/2/3 (and 4 if applicable)** · **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip · **Home Delivery** (90-day Supply) Includes diabetic test strip -Specialty medications are limited to a 30 day supply regardless of whether they are retail or home delivery. Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits.	20% 20%	50%(2) Not Covered

Notes:
All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
· Deductible(s) apply only to all covered medical services listed with a percentage (%) coinsurance and copayment, including prescription drug cost shares.
· Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
· Dependent age: to the end of the month in which the child attains age 26.
· 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment. No cost share means no deductible/copayment/coinsurance up to the maximum allowable amount.
· PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/ gynecology, geriatrics or any other Network provider as allowed by the plan.
· SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
· Benefit period = Calendar Year
· Behavioral Health: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
· Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
· Private Duty Nursing - limited to 82 visits/Calendar Year and 164 visits/lifetime.
· Additional vision services covered as part of Preventive Services on series 500 plans.
· Hospice: Network copayment/coinsurance up to the maximum allowable amount for 500 series plans.

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· Elective abortions not covered unless otherwise noted in your Certificate of Coverage.
(1) We encourage you to refer to the Schedule of Benefits for limitations.
(2)Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
Precertification:
· Members are encouraged to always obtain prior approval when using Non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-Existing Exclusion Period:*None.*

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Authorized group signature (if applicable) Carol Wilson	*Date* 11-13-14
Underwriting signature (if applicable)	*Date*

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