SUMMARY OF BENEFITS PPO 500

SUMMARY OF BENEFITS PPO 500		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
MEDICAL DEDUCTIBLE, PER PLAN YEAR - Network and Non-Network Deductibles are not combined.		
Per Covered Person	$500	$1,000
Per Family Unit	$1,500	$3,000
Each year, each Covered Person will be responsible for satisfying the Medical Deductible before the Plan begins to pay benefits. If members of an enrolled family pay Deductible expenses in a year equal to the Family Unit Deductible, the Plan Year Deductible for all family members will be considered to have been met.		
MEDICAL MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR - Network and Non-Network Out-of-Pocket amounts are not combined.		
Per Covered Person	$3,400	$8,400
Two Party	$6,800	$16,800
Per Family Unit	$10,000	$26,800
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the medical plan out-of-pocket maximum and are never paid at 100%, unless required by law: • Cost containment penalties • Amounts over the Maximum Allowable Amount • Outpatient Prescription Drug charges		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Plan Year maximum is 60 days total which may be split between Network and Non-Network providers.		
Percentage Payable – unless otherwise stated.	80% after deductible for Covered Services from contracted (in network) providers. Members are not responsible for covered charges in excess of Maximum Allowable Amounts.	70% after deductible for Covered Services from non-contracted (out of network) providers. Members are always responsible for covered charges in excess of Maximum Allowable Amounts, except as described in the Surprise Medical Bills Notice.
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Abortion – Elective	80% after deductible	70% after deductible
Acupuncture Services	80% after deductible; 12 visits Plan Year maximum	70% after deductible; 12 visits Plan Year maximum
Advanced Imaging (Including CAT Scans, MRI, PET Scans) - Pre-authorization is required.	80% after deductible	70% after deductible; $800 maximum per procedure
Ambulance Service - Pre-authorization is required for non-emergent transport.	80% after deductible	80% after deductible;
Bariatric Surgical Procedures – Services for bariatric surgical procedures are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.		
Bariatric Surgical Procedures - Facility	80% after deductible	Not covered
Bariatric Surgical Procedures - Physician	80% after deductible	Not covered
Bariatric Surgical Procedures – Travel Charges - Coverage is available when the closest BDCSC or CME is 50 miles or more from the Covered Person's residence.	100%; deductible waived; $3,000 maximum per surgery	

SUMMARY OF BENEFITS PPO 500		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Blood	80% after deductible	70% after deductible
Diabetes Education	100% after $30 copayment; deductible waived	100% after $50 copayment; deductible waived
Diabetes Supplies (such as insulin pumps and glucometers)	80% after deductible	70% after deductible
Dialysis	80% after deductible	70% after deductible; $350 maximum per visit for all services and supplies
Durable Medical Equipment - Pre-authorization is required.	80% after deductible	70% after deductible
Emergency Room Visit – Including professional services	80% after $150 copayment and deductible; Copayment waived if admitted	80% after $150 copayment and deductible; Copayment waived if admitted
Foot Orthotics - Pre-authorization is required.	80% after deductible	70% after deductible
Hearing Aids	80% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.	80% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.
Home Health Care - Pre- authorization is required.	80% after deductible; 100 visits Plan Year maximum; one visit by a home health aide equals four hours or less	70% after deductible; 100 visits Plan Year maximum; one visit by a home health aide equals four hours or less
Hospice Care	100%; deductible waived	70% after deductible
Bereavement Counseling	100%; deductible waived	70% after deductible
Hospital Services		
Inpatient - the semiprivate room rate. Pre-authorization is required.	80% after deductible	70% after deductible Failure to obtain pre-authorization may result in a financial penalty or total denial of coverage for Non-Anthem Blue Cross PPO Hospitals or residential treatment centers
Ambulatory/Outpatient Surgery Facilities.* Pre-authorization is required for certain procedures.	80% after deductible	70% after deductible; Ambulatory Surgical Centers are limited to $350 per admit for all services
Outpatient Services - Pre-authorization is required for certain services.	80% after deductible	70% after deductible
Infusion Therapy (Pre-authorization is required)	80% after deductible	70% after deductible; $600 per day maximum for all home infusion services and supplies
Jaw Joint Conditions / Temporomandibular Joint Syndrome (TMJ)	80% after deductible	70% after deductible
Lab & X-ray – includes pre-admission testing.	80% after deductible	70% after deductible
LiveHealth Online telemedicine: Medical & Behavioral Health	100% after $10 copayment, deductible waived	N/A

SUMMARY OF BENEFITS PPO 500		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Telemedicine Not Provided by LiveHealth Online: Medical & Behavioral Health	Covered the same as any other care based on type of service rendered	Covered the same as any other care based on type of service rendered
Mental Disorders		
Inpatient - the facility's semiprivate room rate - Pre-authorization is required; waived for emergencies.	80% after deductible	70% after deductible. Failure to obtain pre- authorization may result in a financial penalty or total denial of coverage for Non-Anthem Blue Cross PPO Hospitals or residential treatment centers
Outpatient - Pre-authorization is required for certain services.	80% after deductible	70% after deductible
Office Setting	100% after $30 copayment; deductible waived	100% after $50 copayment; deductible waived
Nutritional Evaluation and Counseling – coverage for eating disorders only	80% after deductible	70% after deductible
Organ Transplants – for recipient and donor. Charges are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.	Covered the same as any other care based on type of service rendered	Not covered
Bone Marrow / Stem Cell Unrelated Donor Searches	80% after deductible; $30,000 maximum per transplant	70% after deductible; $30,000 maximum per transplant
Accommodations and Travel Charges – benefits are available when the closest CME or BDCSC is 75 miles or more from the recipient's or donor's residence.	100%; deductible waived; $10,000 maximum per transplant	
Physician Services		
Inpatient visits	80% after deductible	70% after deductible
Office visits	100% after $30 copayment; deductible waived	100% after $50 copayment; deductible waived
Specialist Office Visits	100% after $40 copayment; deductible waived	100% after $60 copayment; deductible waived
Office Visit Services – including Minor Surgery, Lab, X-ray, and Supplies	80% after deductible	70% after deductible
Second Surgical Opinion	100% after $30 copayment or $40 specialist copayment; deductible waived	100% after $50 copayment or $60 specialist copayment; deductible waived
Surgery (Inpatient and Outpatient)	80% after deductible	70% after deductible
Assistant Surgeon and Anesthesiologists	80% after deductible	70% after deductible
Allergy injections, serum and testing	80% after deductible	70% after deductible
Contraceptive Methods	100%; deductible waived	70% after deductible
Pregnancy		
Prenatal visits	100%; deductible waived	100% after $50 copayment; deductible waived
Postnatal visits	100% after $30 copayment; deductible waived	100% after $50 copayment; deductible waived
Delivery and All Other Services	Covered the same as any other care based on type of service rendered	Covered the same as any other care based on type of service rendered

SUMMARY OF BENEFITS PPO 500		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Preventive Care – Services as defined by the Patient Protection Affordable Care Act for both Network and Non-Network Providers.		
Routine Well Care – All ages	100%; deductible waived	70% after deductible
Smoking/Tobacco Cessation – (See prescription drug benefits for coverage regarding medications)	100%; deductible waived	Not covered
Prosthetics Pre-authorization is required for certain prosthetics	80% after deductible	70% after deductible
Rehabilitation – includes Physical and Occupational Therapies. Additional visits allowed if Medically Necessary	80% after deductible; 24 visits Plan Year maximum with spinal manipulation / chiropractic	70% after deductible; 24 visits Plan Year maximum with spinal manipulation / chiropractic
Sex Change / Transgender Surgical Procedures - Pre-authorization is required	80% after deductible	Not covered
Sex Change / Transgender Surgery Travel Charges – Coverage is available when the closest surgical facility is 75 miles or more from the Covered Person's residence.	100%; deductible waived; $10,000 maximum per surgery or series of surgeries	
Skilled Nursing Facility – the facility's semiprivate room rate. Pre-authorization is required	80% after deductible; 100 days Plan Year maximum	70% after deductible; 100 days Plan Year maximum
Speech Therapy	80% after deductible	70% after deductible
Spinal Manipulation / Chiropractic	80% after deductible; 24 visits Plan Year maximum combined with Rehabilitation	70% after deductible; 24 visits Plan Year maximum combined with Rehabilitation
Substance Abuse		
Inpatient - the facility's semiprivate room rate - Pre- authorization is required; waived for emergencies.	80% after deductible	70% after deductible. Failure to obtain pre-authorization may result in a financial penalty or total denial of coverage for Non-Anthem Blue Cross PPO Hospitals or residential treatment centers
Outpatient - Pre-authorization is required for certain services.	80% after deductible	70% after deductible
Office Setting	100% after $30 copayment; deductible waived	100% after $50 copayment; deductible waived
Urgent Care – includes physician services	100% after $30 copayment; deductible waived	100% after $30 copayment; deductible waived
Voluntary Sterilization		
Female	100%; deductible waived	70% after deductible
Male	80% after deductible	70% after deductible
Wigs – after chemotherapy	Not covered	Not covered

*If Emergency Services are provided at an Ambulatory Surgical Center, the Plan's terms and conditions for coverage (including cost sharing and whether prior authorization applies) may be different than what is shown above, to conform with the requirements of the No Surprises Act.

PRESCRIPTION DRUG BENEFIT SUMMARY PPO 500

Please refer to the Employee ID card for the Prescription Drug Administrator's phone number.

Please contact the Prescription Drug Administrator for additional information.

Dispense As Written (DAW) Penalty. If the Covered Person or the Covered Person's doctor requests a brand- name medicine when a generic alternative is available, the Covered Person will pay the brand copay plus the difference in cost between the brand-name and the generic medicine.

SUMMARY OF BENEFITS PPO 500		
COVERED CHARGES	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
PRESCRIPTION DRUG MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR - Network and Non-Network Out-of-Pocket amounts are not combined.		
Per Covered Person	$1,600	Unlimited
Per Family Unit	$3,200	Unlimited
Copayments apply toward the out-of-pocket maximum. Once the out-of-pocket maximums are reached, the Plan will pay 100% for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the prescription drug plan out-of-pocket maximum and are never paid at 100%: • Charges for Medical Services • Charges in excess of the prescription drug plan Maximum Allowable Amount		
Retail Pharmacy Option (30 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $15 copayment	100% of Maximum Allowable Amount after $15 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after $35 copayment	100% of Maximum Allowable Amount after $35 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after $50 copayment	100% of Maximum Allowable Amount after $50 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Retail 90 Maintenance Drug Pharmacy Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $23 copayment	100% of Maximum Allowable Amount after $23 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after $53 copayment	100% of Maximum Allowable Amount after $53 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after $75 copayment	100% of Maximum Allowable Amount after $75 copayment, the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount

Mail Order Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $23 copayment	Not covered
Tier 2 - Preferred Brand Name Drugs	100% after $53 copayment	Not covered
Tier 3 - Non-Preferred Brand Name Drugs	100% after $75 copayment	Not covered
Tier 4 - Specialty Pharmacy – must be obtained through Specialty Mail Order Service. 30-day supply only.	100% after $150 copayment	Not covered

In addition, it is the Plan Administrator's intent to comply with federal law regarding preventive care benefits under the Patient Protection and Affordable Care Act. All prescriptions which qualify for the preventive care benefit, as defined by the appropriate federal regulatory agencies, and which are provided by a network-participating pharmacy, will be covered at 100% with no deductible or co-insurance required.

Refer to the Prescription Drug Section for details on the Prescription Drug benefit.