Molex CDHP HSA
Anthem National Accounts
HSA Plan Design

Plan Information				
Revision Date	3/5/2020			
Plan Design Name	Molex CDHP HSA			
Classification	Self-Insured National Plan Design			
Effective Date	1/1/2019			
Account Prefix	MAR, MFC (FL), MEG (GA), MFH (WI)			
Group Name	Molex, LLC			
Package/Contract Code	3QZE - Engage Elite Effective 5/1/2019 5AS0 - Engage Elite Plus			
Group/Case Number	174566			
Customer Service Telephone Number	1-833-224-6936			EST
Customer Service Hours of Operation	Monday thru Friday	8am	to	8pm
Service Center Mailing Address (providers send claims to their local plan)	PO Box 105187 Atlanta GA 30348-5187			
Provider Directory/Member Portal Website	www.anthem.com			
Network	BlueCard PPO			
ID card generation	Member level (ID cards for each member/dependent on policy)			
HCR Status	Non-Grandfathered			

	Network	Contract/Package Code	Purchased (Y/N)
Advantage Network :	FL NetworkBlue	3QZF Engage Elite Effective 5/1/2019 5AS1 Engage Elite Plus	Y
	GA Blue Open Access POS	3QZH Engage Elite Effective 5/1/2019 5AS2 Engage Elite Plus	Y
	WI Blue Preferred POS	3QZG Engage Elite Effective 5/1/2019 5AS3 Engage Elite Plus	Y

Eligibility Determination				
Children	Eligible dependents are covered until age		26	(End of Month)
Newborns	Coverage eligibility begins at birth. If dependent is not enrolled claim will be denied.	Member must enroll newborn within 31 days. Anthem can extend benefits to the newborn once enrollment is received, retroactive to the dependent's effective date. Enrollment is updated by Eligibility vendor.		
Disabled Dependents	Covered			
Solicitation of Disabled Dependents	Eligibility determined by:		Eligibility Vendor	
International Employees	Not covered			
Domestic Partners (same sex)	Covered			
Domestic Partners (opposite sex)	Covered			
Same Sex Spouses	Covered			
Surviving Spouse	Covered under COBRA (Survivor needs to be passed under his/her own social security number)			
Sponsored Dependent (Class II)	Not Covered			
COBRA	Covered			
Pre-65 Retirees	Not covered			
Post-65 Retirees	Not covered			

General Information		
Benefit Period	Calendar Year	
Timely Filing	12 months from the date of service	Participating Providers to follow contractual filing limitations.
Foreign Claims	Foreign claims are covered at either the negotiated discount amount or charges using the current exchange rates.	
Benefit Booklets created by:	Account	
Performance Guarantee Account:	Yes	
Vendor/Contact Information		
AIM Specialty Health/ phone number	Purchased	1-888-953-6703
Autism Spectrum Disorder	Purchased	1-844-269-0538
Behavioral Health/Substance Abuse Vendor Name & Phone #	Anthem BH Resource Center	1-833-244-3883
Benefit Office Name & Phone #	Molex Benefits Center	1-855-883-8537
Anthem Engage Elite	Purchased	www.anthem.com
COBRA Vendor Name & Phone #	Molex Benefits Center	1-855-883-8537
Concierge Travel BDC Program & Phone #	Not Selected HealthBase	1-888-691-4584
Dental Vendor Name & Phone #	Delta Dental KS	1-800-234-3375
Disability Vendor Name & Phone #	MetLife	1-888-608-6665
EAP Vendor Name & Phone #	SupportLinc (CuraLinc)	1-888-901-1327
Eligibility Vendor Name & Phone #	Molex Benefits Center	1-855-883-8537
FSA Vendor Name & Phone #	WageWorks	1-877-924-3967
Hearing Vendor Name & Phone #	N/A	
HSA Vendor Name & Phone #	OptumBank	1-844-326-7967
LiveHealth Online (LHO)	Website: www.livehealthonline.com Email: customersupport@livehealthonline.com Phone: 1-855-603-7985	
Managed Care Vendor Name & Phone #	Total Health Total You T2	1-833-224-6936
My Incentive Vendor Name & Phone #	N/A	
Pharmacy Drug Vendor Name & Phone #	CVS/Caremark	1-866-217-4120
Pre-Cert List/Anthem Medical Management System	Enterprise Standard List	ACMP
Qualified Health Expense (QHE) Vendor Name & Phone #	N/A	
Specialty Pharmacy Vendor Name & Phone #	CVS/Caremark	1-866-217-4120
Right Drug Right Channel	Yes = Med to RX	
Stop Loss Vendor Name & Phone #	N/A	
Subrogation Vendor Name & Phone #	Anthem	
Vision Vendor Name & Phone #	VSP	1-800-877-7195
Infertility Vendor Name & Phone #	N/A	N/A

HSA Information	
Items eligible for HSA reimbursement	**Refer to the 213D List**
# of Days for Access to Prior Notional Dollars After Break in Coverage	**365 days**
Notional Dollar Rollover	**No**
Prior Carrier information	
Prior Carrier name and phone #	BCBS of Illinois
Prior Carrier Deductible Credit	No
History conversion required:	No
Lifetime Maximum	No
Deductible credit	No
Out-of-Pocket credit	No
Run out period with other vendors (date)	No

Integration with Other vendors		
Pharmacy Integration	Yes	
If yes, what is integrated?	Deductible	Yes
	Out-of-Pocket	Yes
	Lifetime Maximum	No
FSA integration	No	

Coordination of Benefits (COB) and Medicare		
COB Method:	Pay & Pursue	
COB Solicitation:	COB information is solicited:	Annually
	COB Option Selected:	A- Pay and Pursue 12 months
	(For other please list deviation)	
	A member can update their COB information as follows:	
	Call the Customer Service Center directly and speak to a representative or via IVR process.	
	Complete and return the COB questionnaire	
	Online via the web	
COB Processing:	Par Providers or OON providers are processed based on the in-Network Level of Benefits.	
	Option 1: Hard Non-Duplication: Determine what Anthem would have paid had we been the primary carrier then subtract the other carrier's paid amount.	
	Birthday Rule Applies	
Medicare Method:	Pursue & Pay	
Medicare Processing:	Option 2: Hard Non-Duplication - Medicare is carved out after Anthem's benefit has been determined.	
Medicare Opt Out Processing	When a member or a provider opts out of Medicare we will process the claim: as if Medicare made a payment.	
National Medicare Crossover	Applies - Medicare secondary claims will automatically transmit electronically from the provider to Anthem.	

Primacy rules:

The following rules determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision. This would include Medicare in all cases, except when the law requires that This Plan pays before Medicare.

2. A plan which covers you as a subscriber pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a dependent of an active employee, but (b) before the plan which covers you as a retired subscriber.

3. For a dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the calendar year pays before the plan of the parent whose birthday falls later in the calendar year. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

Exception to rule 3: For a dependent child of parents who are divorced or separated, the following rules will be used in place of Rule 3:

a. If the parent with custody of that child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that child as a dependent pays first.

b. If the parent with custody of that child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:

i. The plan which covers that child as a dependent of the parent with custody.

ii. The plan which covers that child as a dependent of the stepparent (married to the parent with custody).

iii. The plan which covers that child as a dependent of the parent without custody.

iv. The plan which covers that child as a dependent of the stepparent (married to the parent without custody).

c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that child's health care coverage, a plan which covers that child as a dependent of that parent pays first.

4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.

6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

APPEALS - Complaints, Grievances and Appeals (CGA)	
Non-Grandfathered	
Claims Fiduciary:	Anthem
Appeals Address:	Anthem Appeals PO Box 105568 Atlanta GA 30348
Account Level Appeals, Send to:	N/A
Prospective Appeals	
Days to File Appeal:	
Mandatory Level I	The member has 180 days to file a mandatory first level of appeal from the date of the adverse determination.
Voluntary Level II	The member has 60 days to file a voluntary second level of appeal from the date of the first level of appeal adverse determination.
Prospective Decision Time Frame:	
Expedited/Concurrent	Anthem will respond within 72 hours from request of appeal (specialty match).
Mandatory Level I	Anthem will respond within 30 calendar days from request of appeal (specialty match).
Voluntary Level II	Anthem will respond within 30 calendar days from request of appeal.
Retrospective Appeals	
Days to File Appeal:	
Mandatory First Level	The member has 180 days to file a mandatory first level of appeal from the date of the adverse determination.
Voluntary Level II	The member has 60 days to file a voluntary second level of appeal from the date of the first level of appeal adverse determination.
Retrospective Decision Time Frame:	
Mandatory Level I	Anthem will respond within 60 calendar days from request of appeal (specialty match).
Voluntary Level II	Anthem will respond within 60 calendar days.
External Appeals	
All External Appeals are voluntary: If the outcome of the mandatory first level appeal is adverse to the member, they may be eligible for an independent External Review pursuant to federal law. To be eligible, the appeal must be regarding a medical judgment or rescission.	
Days to File Appeal:	The member has four months to file a voluntary external appeal from the day the first level denial is received.
Expedited/Concurrent:	For pre-service claims involving urgent/concurrent care, the member may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process.
External Appeal Decision Time Frame:	
Urgent /Expedited:	Independent Review Organization (IRO) has 72 Hours from receipt of the appeal from Anthem.
Standard:	Independent Review Organization (IRO) has 45 Days from receipt of the appeal from Anthem.

ENTERPRISE MANAGED CARE PRIOR AUTHORIZATION REQUIREMENTS	Enterprise Standard List	2019
Medical Management (Anthem arrangement)	1-833-224-6936	
In order to avoid denial of services for hospital/medical benefits please call before receiving services or no later than 2 business days after admission for an emergency admission.		
Precert Penalties		
No Precert on file	If claims are not pre-certified they will be denied for no pre-certification. Once information is received claims can be re-opened based on medical information provided.	
Not Medically Necessary	Any services or days found not to be medically necessary will not be covered.	
Late Notice/Penalty Amount: N/A		
Blue Distinction Bariatric Center of Excellence Requirement - If purchased Bariatric surgeries require the use of a Blue Distinction Center of Excellence and the cases are handled in the National Blue Distinction Bariatric Care Management Department.		Not Purchased
Blue Distinction Tiered Orthopedic Benefit – If purchased Procedures included: Total and Revision Knee Replacements, Total and Revision Hip Replacements, Spinal Discectomy, Spinal Decompressions, Primary and Revision Spinal Fusions, Use of a Blue Distinction Centers+ facility may be required to maximize member benefits		Not Purchased
A.I.M. Specialty Health Services		**Model Type**
Anthem Cancer Quality Care Program		UM
Cardiology		UM
Genetic Testing		N/A
Imaging Level of Care(MRI/CT only)		N/A
Integrated Imaging Management Bundle (Radiology Benefit Management & Cardiology)		RQI
MSK(Musculoskeletal)		N/A
Radiation Therapy		N/A
Radiology Benefit Management		UM
Sleep		UM
Specialty Pharmacy with clinical site of care		UM
Autism Spectrum Disorder		**Purchased Yes/No**
Autism Spectrum Disorder (ASD)		Yes
ABA Therapy		**Precert Yes/No**
ABA Therapy (if pre cert required, Autism Spectrum Disorder Program ASD must be purchased)		Yes
Out-of Network Referrals:		
Out of Network Services for consideration of payment at in-network benefit level (may be authorized, based on network availability and/or medical necessity.) * Precert needed for childbirth if inpatient stay exceeds 48 hrs for normal delivery and 96 hrs after a cesarean delivery. ** Applies penalty per visit. **Global Precert Statement/Rules:** ~ Medicare and COB claims do not require prior authorization. ~ Member is responsible for Precertification of services and would be liable for any penalties applied. ~ Participating provider is responsible for Precertification of services and would be liable for any penalties applied. ~ Bariatric surgery should be pre-certified/pre-authorized when the plan contains documentation of benefits or if surgical procedures for morbid obesity exist. The review applies to plans with steerage toward Blue Distinction Centers of Excellence for Bariatric Surgery or for management of care when steerage does not exist.		

Deductible, Coinsurance, Maximums, & Pricing				
Deductibles:	**In-Network[1]**		**Out-of-Network[2,6]**	
Deductibles	$1,500	Individual	$3,000	Individual
	$3,000	Family	$6,000	Family
Deductible is standardly applied to non-routine services	**In-Network[1]**		**Out-of-Network[2,6]**	
	Yes		Yes	
Common Accident Deductible	N/A			
Deductible - Accumulation Method	Combined professional/institutional			
	Family amount can be satisfied by a family member or a combination of family members. Non-embedded.			
	Deductible amounts accumulate separately for In and Out of Network			
	Pharmacy deductible Integrated?		Yes	
4th Quarter Deductible Carryover	No			
Coinsurance:	**In-Network[1]**		**Out-of-Network[2,6]**	
Coinsurance:	**80%**	Plan coinsurance	**60%**	Plan coinsurance
	20%	Member responsible	**40%**	Member responsible
Preventive Level of Coinsurance:	**100%**	Plan coinsurance	**Not Covered**	Plan coinsurance
	0%	Member responsible	**Not Covered**	Member responsible
Out of Pocket:	**In-Network[1]**		**Out-of-Network[2,6]**	
Out of Pocket/Coinsurance Maximum	$3,425	Individual	$6,850	Individual
	$6,850	Family	$13,700	Family
Out of Pocket - Accumulation method (Coinsurance Type)	Combined professional/institutional			
	4th Quarter Coinsurance Carryover?		No	
	The coinsurance and deductible apply towards the out-of-pocket maximum.			
	Family amount can be satisfied by a family member or a combination of family members (non-embedded).			
	Out of Pocket amounts accumulate separately for In and Out of Network			
	Pharmacy Out-of-Pocket Integrated?		Yes	
Out of Pocket Limit Exclusions	Non-covered services Services deemed not medically necessary by Medical Management and/or Anthem. Penalties for non-compliance Charges over the allowed amount			

Pricing		
Non Participating fee negotiation vendor	Opt In	
Pricing for Non Participating Professional Providers – Maximum Allowed Amount (MAA)	Local Plan Pricing	
Pricing for Non Participating Professional Providers Deviations:	(Any deviations within the standard pricing for professional providers) N/A	
Pricing for Non-Participating Institutional Providers – Maximum Allowed Amount (MAA)	Local Plan Pricing	
Hospital Based Services	Hospital Based services includes Radiology, Pathology, Anesthesia, Assistant Surgeon, Emergency Room Physician	
Pricing for Non Participating Professional Hospital Based Physician Services	Local Plan Pricing	
Hospital Based Provider services rendered by non-par providers are	Covered at the In-Network benefit level.	
Supplemental Accident Benefit	Not Applicable	$
Lifetime Maximum - Applicable to all covered services	Unlimited except for: Infertility Lifetime Max (including RX) - $20,000 TMJ Lifetime Max - $5,000	
Portability of Coverage	Visit and dollar maximums should carry over when member changes package but maintains the same group number	

Benefits	All dollar and visit limits are combined in and out of network, unless otherwise noted. Any benefits with combined visit limits will count services on the same date of services as 1 visit, unless otherwise noted. All services are subject to medical policy, unless otherwise noted.	
Benefit Note	If a member is part of an FDA-approved clinical trial for a life-threatening disease, medical expenses that are currently covered under the plan that happen during that trial will be covered.	
Acupuncture	**In-Network[1]**	**Out-of-Network [2,6]**
Acupuncture Office Professional	Covered	Covered
Coverage limited to pregnancy and chemotherapy	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Allergy	**In-Network[1]**	**Out-of-Network [2,6]**
Allergy Treatment	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Allergy Testing	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Ambulance	**In-Network[1]**	**Out-of-Network [2,6]**
Air Ambulance	Covered	Covered at the INN benefit level
Air Ambulance will suspend for medical necessity	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 80% Deductible: Yes Copay: N/A
Ground Ambulance	Covered	Covered at the INN benefit level
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 80% Deductible: Yes Copay: N/A
Ambulatory Surgical Centers	**In-Network[1]**	**Out-of-Network [2,6]**
Ambulatory Surgical Center Institutional	Covered	Covered
Institutional Outpatient Ambulatory Surgery	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A

Anesthesia	In-Network[1]	Out-of-Network [2,6]
Anesthesia Outpatient Institutional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Anesthesia Inpatient Professional	Covered	Covered
Hospital Based Provider services rendered by non-par providers are Covered at the In-Network benefit level.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Anesthesia Outpatient Professional	Covered	Covered
Hospital Based Provider services rendered by non-par providers are Covered at the In-Network benefit level.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Anesthesia Office Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
ABA Therapy Autism is considered as Mental Health.	In-Network[1]	Out-of-Network [2,6]
ABA Therapy Outpatient Institutional	Covered	Covered
	Covered at the benefit level of services billed	Covered at the benefit level of services billed
ABA Therapy Inpatient Professional	Covered	Covered
	Covered at the benefit level of services billed	Covered at the benefit level of services billed
ABA Therapy Outpatient Professional	Covered	Covered
	Covered at the benefit level of services billed	Covered at the benefit level of services billed
ABA Therapy Office Professional	Covered	Covered
	Covered at the benefit level of services billed	Covered at the benefit level of services billed
Attention Deficit Disorders Includes Autistic Disease, Intellectual Disability, Developmental Delays and Learning Disabilities	In-Network[1]	Out-of-Network [2,6]
ADD/ADHD	Covered	Covered
	Covered at the benefit level of services billed	Covered at the benefit level of services billed
Bariatric Surgery	In-Network[1]	Out-of-Network [2,6]
Bariatric Surgery	Covered	Not Covered
Covered only if done at a BDC+ facility	Covered at the benefit level of services billed	

Biofeedback	In-Network[1]	Out-of-Network [2,6]
Biofeedback Outpatient Institutional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Biofeedback Outpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Biofeedback Office Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Blood Processing and Storage	**In-Network[1]**	**Out-of-Network [2,6]**
Blood	Covered	Covered
Processing and Storage	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Chiropractic Benefits	**In-Network[1]**	**Out-of-Network [2,6]**
Chiropractic Office Professional	Covered	Covered
Limits Apply: Yes 20 Visit Max Per Year Includes Manipulations only regardless of provider specialty	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A

Dental Benefits	In-Network[1]	Out-of-Network [2,6]
Dental	Covered	Covered
Covered for treatment of an injury to sound and natural teeth. Only if treatment is completed within 12 months of the accident	Covered at the benefit level of the services billed	Covered at the Out-of-Network benefit level of the services billed
Diabetes Maintenance	**In-Network[1]**	**Out-of-Network [2,6]**
Diabetes Education/Diabetic Nutritional Counseling Outpatient Institutional	Covered	Covered
When part of HCR services refer to Preventive Care Benefits.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Diabetes Education/Diabetic Nutritional Counseling Outpatient Professional	Covered	Covered
When part of HCR services refer to Preventive Care Benefits.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Diabetes Education/Diabetic Nutritional Counseling Office Professional	Covered	Covered
When part of HCR services refer to Preventive Care Benefits.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Diabetic Supply	Covered	Covered
Diabetic Supplies covered by pharmacy plan are not covered under medical - including lancets syringes insulin etc. Diabetic supplies not covered under Pharmacy are covered by the medical plan.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A

Diagnostic Xray, Lab, and Diagnostic Services (Non Routine)	In-Network[1]	Out-of-Network [2,6]
DXL Outpatient Institutional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
DXL Inpatient Professional	Covered	Covered
Hospital Based Provider services rendered by non-par providers are: Covered at the In-Network benefit level.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
DXL Outpatient Professional	Covered	Covered
Hospital Based Provider services rendered by non-par providers are: Covered at the In-Network benefit level.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
DXL In Office	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
DXL Independent Lab	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
High Diagnostic Imaging	Covered	Covered
Includes MRI/MRA/CAT/PET/SPECT Hospital Based Provider services rendered by non-par providers are: Covered at the In-Network benefit level.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Pre-surgical/Pre-admission testing	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A

Durable Medical Equipment	In-Network[1]	Out-of-Network [2,6]
Durable Medical Equipment	Covered	Covered
(Purchase & Rental) Rental is covered up to the purchase price	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Medical Supply	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Prosthetics and Orthotics	Covered	Covered
Wigs/Toupees limited to 1 per benefit period and limited to a $500 max. Out-Of-Network coverd at the In-Network Deductible and Coinsurance Level at billed charges	Covered at: 80% Deductible: Yes	Covered at: 60% Deductible: Yes
Includes Foot Orthotics based on Medical Necessity.	Copay: N/A	Copay: N/A
Hearing Aid Services Including exams and hearing aid accessories	Covered	Covered
Hardware - Hearing Aids Limit applies: Yes $3,000 Dollar Max Every 3 Years Hearing Aid exam is included in max	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Vision Hardware For Glasses/Contacts after Cataract Surgery refer to Vision/Post Surgical Vision	Not Covered	Not Covered

Emergency Care	In-Network[1]	Out-of-Network [2,6]
Emergency – Emergency Room (Institutional)	Covered	Covered at the INN benefit level
If Prudent Layperson guidelines apply all services will be paid at the in-network level of benefit (accidental injury and medical emergency diagnoses pay as emergency) Yes-Apply Prudent Lay guidelines Quick Care Options	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 80% Deductible: Yes Copay: N/A
Emergency – Emergency Room Physician	Covered	Covered at the INN benefit level
Prudent Layperson guidelines apply (accidental injury and medical emergency diagnoses pay as emergency)	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 80% Deductible: Yes Copay: N/A
Non-Emergency Medical Condition – Emergency Room (Institutional)	Covered	Covered at the INN benefit level
Applies to non-emergency Medical Condition diagnoses (as defined by Prudent Lay). Quick Care Options	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 80% Deductible: Yes Copay: N/A
Non-Emergency Medical Condition– Emergency Room Physician	Covered	Covered at the INN benefit level
Applies to non-emergency Medical Condition diagnoses (as defined by Prudent Lay).	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 80% Deductible: Yes Copay: N/A
Foot Care (Routine)	**In-Network[1]**	**Out-of-Network [2,6]**
Foot Care (Routine)	Not Covered	Not Covered
Hearing	**In-Network[1]**	**Out-of-Network [2,6]**
Hearing Exam (non-routine) Outpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Hearing Exam (non-routine) Office Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A

Home Health/Home Infusion/PDN	In-Network[1]	Out-of-Network [2,6]
Home Health Care	Covered	Covered
Limit applies: Yes 90 Visit Max Per Year Visit maximum is combined In and Out-of-Network Review for Medical Necessity after 90 visits Home Infusion therapy - Services do NOT count toward the Home Health visit maximum.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Home Infusion Therapy	Covered	Covered
Services do NOT count toward the Home Health visit maximum.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Private Duty Nursing	Covered	Covered
Limit applies: Yes 44 Visit Max Per Year Visit maximum is combined In and Out-of-Network Limited to Home Health	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Hospice/Bereavement	**In-Network[1]**	**Out-of-Network [2,6]**
Hospice	Covered	Covered
Respite Care is Covered Limit Applies No	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Bereavement Counseling	Covered	Covered
Limits Apply: No	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Immunizations (non routine)	**In-Network[1]**	**Out-of-Network [2,6]**
Immunizations Outpatient Professional	Not Covered	Not Covered
Immunizations Office Professional	Not Covered	Not Covered
Injections	**In-Network[1]**	**Out-of-Network [2,6]**
Injections Outpatient Professional	Covered	Covered
Includes Administration charge	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Injections Office Professional	Covered	Covered
Includes Administration charge	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A

Inpatient Care - Institutional	In-Network[1]	Out-of-Network [2,6]
Inpatient Accommodations and Ancillaries	Covered	Covered
Accidental Injury General Illness Inpatient Surgery Maternity Sick Newborn Newborn Care (Note: for well newborn) No separate deductible and/or co-pay is applied.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Inpatient Physical Medical Rehab	Covered	Covered
Limits Apply: No	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Skilled Nursing Facility	Covered	Covered
Limits Apply: Yes 120 Days Max Per Year Combined In and Out-of-Network	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Medical While Hospitalized (Inpatient professional services)	**In-Network[1]**	**Out-of-Network [2,6]**
Inpatient Professional Medical Care	Covered	Covered
General Medical Care Consultation, Second Opinion Intensive Care, Monitoring Newborn Care (Note: for well newborn) Includes newborn vision/hearing screening when rendered in an inpatient setting.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A

Alcohol/Substance Abuse	In-Network[1]	Out-of-Network [2,6]
Alcohol/Substance Abuse - Inpatient Institutional	Covered	Covered
Inpatient Accommodations and Ancillaries Methadone Clinics are covered Includes Detox	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Alcohol/Substance - Residential Treatment Centers - Inpatient	Covered	Covered
Inpatient Accommodations and Ancillaries Methadone Clinics are covered Includes Detox	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Alcohol/Substance - Outpatient Institutional	Covered	Covered
Methadone Clinics are covered	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Alcohol/Substance - Intensive Outpatient Therapy (IOP) Institutional	Covered	Covered
Methadone Clinics are covered	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Alcohol/Substance - Partial Hospitalization (PHP) Institutional	Covered	Covered
Partial Hospitalization is considered Outpatient.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Alcohol/Substance - Inpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Alcohol/Substance - Outpatient Professional	Covered	Covered
Methadone Clinics are covered	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Alcohol/Substance - Professional Office	Covered	Covered
Methadone Clinics are covered	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A

Mental Health	In-Network[1]	Out-of-Network [2,6]
Mental Health - Inpatient Institutional	Covered	Covered
Inpatient Accommodations and Ancillaries Eating disorders are covered	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Mental Health - Residential Treatment Centers - Inpatient	Covered	Covered
Inpatient Accommodations and Ancillaries Eating disorders are covered	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Mental Health - Outpatient Institutional	Covered	Covered
Eating disorders are covered	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Mental Health - Intensive Outpatient Therapy (IOP) Institutional	Covered	Covered
Eating disorders are covered	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Mental Health - Partial Hospitalization (PHP) Institutional	Covered	Covered
Partial Hospitalization is considered Outpatient. Eating disorders are covered	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Mental Health - Inpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Mental Health - Outpatient Professional	Covered	Covered
Eating disorders are covered	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Mental Health - Office Professional	Covered	Covered
Eating disorders are covered Online Visits are covered and mirror the professional office Mental Health visit benefit.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A

Nutritional Counseling - (Non Diabetic) **Eating Disorders are covered.**	**In-Network[1]**	**Out-of-Network [2,6]**
Nutritional Counseling Outpatient Institutional	Covered	Covered
When part of HCR services refer to Preventive Care Benefits.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Nutritional Counseling Outpatient Professional	Covered	Covered
When part of HCR services refer to Preventive Care Benefits.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Nutritional Counseling Office Professional	Covered	Covered
When part of HCR services refer to Preventive Care Benefits.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Obstetrics, Family Planning, Sterilization	**In-Network[1]**	**Out-of-Network [2,6]**
Contraceptives – services not included in Women's Health Provision	Covered	Covered
Spermicide, vaginal ring, hormone patch Depo -Estradiol Cypionate - up to 5 MG, and other covered contraceptives included in Women's Health provision but not meeting required Women's Health diagnosis restrictions. Covered for birth control as well as medical conditions	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed.
Contraceptives-covered under Women's Health Provision	Covered	Not Covered
IUDs, injections for Depo-Provera, diaphragm fittings, and any other FDA approved birth control devices (other than the ones listed above as not included in Women's Health). Covered based on the diagnosis restriction within the Women's Health provision.	Covered at the HCR services level. See preventive care.	Not covered

Maternity Care Outpatient Institutional	Covered	Covered
Includes Therapeutic Abortion. Elective Abortion is not covered. Dependent Daughters are covered	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Maternity Care Outpatient Professional	Covered	Covered
Includes Therapeutic Abortion. Elective Abortion is not covered. Dependent Daughters are covered	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Maternity Care Office Professional Visit	Covered	Covered
Includes Therapeutic Abortion. Elective Abortion is not covered. Dependent Daughters are covered	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Infertility Services	Covered	Not Covered
Covered for services to diagnose and treat infertility. Treatment for underlying medical conditions are covered as medical. $20,000 Lifetime Maximum (including RX)	Covered at the benefit level of the services billed.	
Infertility Treatment - Artificial Insemination	Covered	Not Covered
$20,000 Lifetime Maximum (including RX)	Covered at the benefit level of the services billed.	
Infertility Treatment - Invitro Fertilization Includes Invitro, GIFT, & ZIFT	Covered	Not Covered
$20,000 Lifetime Maximum (including RX)	Covered at the benefit level of the services billed.	
Sterilization - services that do not meet Women's Health Provision requirements	Covered	Covered
Reversals are Not Covered	Covered at the benefit level of the services billed.	Covered at the benefit level of the services billed.

Outpatient Hospital Services	In-Network[1]	Out-of-Network [2,6]
Outpatient (Clinic) Institutional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Outpatient Medical Institutional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Outpatient Physician	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A

Professional Physician Services	In-Network[1]	Out-of-Network [2,6]
Consultation, Second Opinion		
Consultation, Second Opinion Outpatient Professional	Covered	Covered
Includes Family Planning	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Consultation, Second Opinion Office Professional	Covered	Covered
Includes Family Planning	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Home Visits		
Home Visits	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Office Visits		
Office Visits Outpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Office Visits Office Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Online Visits		
Online Visit	Covered	Not Covered
Includes LiveHealth Online All other Online providers are NOT Covered	Covered at: 80% Deductible: Yes Copay: N/A	
Onsite Clinics		
Onsite Clinics	N/A	N/A
Retail Health Clinics		
Retail Health Clinics	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Telehealth Visits		
Telehealth Visits	Not Covered	Not Covered
Prescription Drugs under Medical	**In-Network[1]**	**Out-of-Network [2,6]**
	Not Covered	Not Covered

Preventive Care Benefits HCR Full Enterprise Std only	In-Network[1]	Out-of-Network [2,6] HCR Mandates Apply to OON? N/A
HCR services Includes Women's Health provision All other preventive services not listed below (which fall outside HCR). This excludes NewBorn Care. See appropriate topic for NB Care.	Covered at: 100% Deductible: No Copay: N/A Covered at Non-Routine benefit level	Not covered Covered at Non-Routine benefit level
PREVENTIVE CARE BENEFITS (which can fall outside HCR)	**In-Network[1]**	**Out-of-Network [2,6]**
Exam - Routine Adult physical	Covered	Not Covered
Includes routine gynecological exams	Covered at: 100% Deductible: No Copay: N/A	
Exam - Well Child Care	Covered	Not Covered
	Covered at: 100% Deductible: No Copay: N/A	
Immunizations - child and adult (routine)	Covered	Not Covered
Travel Immunizations are not covered.	Covered at: 100% Deductible: No Copay: N/A	
Flu Shot (routine)	Covered	Not Covered
	Covered at: 100% Deductible: No Copay: N/A	
Diagnostic X-rays and Lab tests (routine)	Covered	Not Covered
Includes bone density testing Includes cholesterol screenings Includes routine hearing and vision screenings	Covered at: 100% Deductible: No Copay: N/A	
Prostate Cancer Screening - PSA (routine)	Covered	Not Covered
	Covered at: 100% Deductible: No Copay: N/A	

Colon cancer screenings (routine)	Covered	Not Covered
Routine Fecal Occult Blood Test Routine Barium Enema Routine Sigmoidoscopy or Colonoscopy Facility and anesthesia billed for routine Sigmoidoscopy/Colonoscopy are covered at the same level as the routine Sigmoidoscopy/Colonoscopy.	Covered at: 100% Deductible: No Copay: N/A	
Vision exam (routine)	Covered	Not Covered
	Covered at: 100% Deductible: No Copay: N/A	
Hearing exam (routine)	Covered	Not Covered
	Covered at: 100% Deductible: No Copay: N/A	
Pap smear (routine)	Covered	Not Covered
	Covered at: 100% Deductible: No Copay: N/A	
Mammography (routine)	Covered	Not Covered
	Covered at: 100% Deductible: No Copay: N/A	

Surgery Benefits	In-Network[1]	Out-of-Network [2,6]
Assistant Surgeon Inpatient Professional	Covered	Covered
Hospital Based Provider services rendered by non-par providers are: Covered at the In-Network benefit level.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Assistant Surgeon Outpatient Professional	Covered	Covered
Hospital Based Provider services rendered by non-par providers are: Covered at the In-Network benefit level.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Assistant Surgeon Office Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Oral Surgery	Covered	Covered
Includes removal of impacted teeth Dental Anesthesia is covered only if related to a payable oral surgery.	Covered at the surgical level	Covered at the surgical level
Surgery Outpatient Institutional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Surgery Inpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Surgery Outpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Surgery Office Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A

Therapies	In-Network[1]	Out-of-Network [2,6]
Cardiac Rehab		
Cardiac Rehab Outpatient Institutional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Cardiac Rehab Inpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Cardiac Rehab Outpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Cardiac Rehab Office Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Chemotherapy		
Chemotherapy Outpatient Institutional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Chemotherapy Inpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Chemotherapy Outpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Chemotherapy Office Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A

Dialysis/Hemodialysis Therapy		
Dialysis/Hemodialysis Therapy Outpatient Institutional	Covered	Not Covered
	Covered at: 80% Deductible: Yes Copay: N/A	
Dialysis/Hemodialysis Therapy Inpatient Professional	Covered	Not Covered
	Covered at: 80% Deductible: Yes Copay: N/A	
Dialysis/Hemodialysis Therapy Outpatient Professional	Covered	Not Covered
	Covered at: 80% Deductible: Yes Copay: N/A	
Dialysis/Hemodialysis Therapy Office Professional	Covered	Not Covered
	Covered at: 80% Deductible: Yes Copay: N/A	
Infusion Therapy		
Infusion Therapy Outpatient Institutional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Infusion Therapy Inpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Infusion Therapy Outpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Infusion Therapy Office Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A

Occupational Therapy			
Occupational Therapy Outpatient Institutional		Covered	Covered
Limits Apply:	No	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Occupational Therapy Inpatient Professional		Covered	Covered
		Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Occupational Therapy Outpatient Professional		Covered	Covered
Limits Apply:	No	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Occupational Therapy Office Professional		Covered	Covered
Limits Apply:	No	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Physical Therapy			
Physical Therapy Outpatient Institutional		Covered	Covered
Limits Apply:	No	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Physical Therapy Inpatient Professional		Covered	Covered
		Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Physical Therapy Outpatient Professional		Covered	Covered
Limits Apply:	No	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Physical Therapy Office Professional		Covered	Covered
Limits Apply:	No	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A

Radiation Therapy		
Radiation Therapy Outpatient Institutional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Radiation Therapy Inpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Radiation Therapy Outpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Radiation Therapy Office Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Respiratory Therapy		
Respiratory Therapy Outpatient Institutional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Respiratory Therapy Inpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Respiratory Therapy Outpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Respiratory Therapy Office Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A

Speech Therapy		
Speech Therapy Outpatient Institutional	Covered	Covered
Limits Apply: No Speech therapy rendered for the treatment of psychological speech delay, behavioral problems, attention disorder, conceptual handicap or mental retardation is not covered.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Speech Therapy Inpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Speech Therapy Outpatient Professional	Covered	Covered
Limits Apply: No Speech therapy rendered for the treatment of psychological speech delay, behavioral problems, attention disorder, conceptual handicap or mental retardation is not covered.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Speech Therapy Office Professional	Covered	Covered
Limits Apply: No Speech therapy rendered for the treatment of psychological speech delay, behavioral problems, attention disorder, conceptual handicap or mental retardation is not covered.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
TMJ Appliances Covered	**In-Network[1]**	**Out-of-Network [2,6]**
TMJ Treatment	Covered	Covered
Covered for medical treatment (surgical and non-surgical) Limited to $5,000 per lifetime	Covered at the benefit level of the services billed.	Covered at the benefit level of the services billed.
Transgender Surgery	**In-Network[1]**	**Out-of-Network [2,6]**
Transgender Surgery	Covered	Covered
	Covered at the benefit level of the services billed.	Covered at the benefit level of the services billed.

Transplant Benefits (Non-BDCT Facility)	In-Network[1,3]	Out-of-Network [2,3,6]
Live Donor Health Services	Covered	Covered
Donor benefits are limited to benefits not available to the donor from any other source. Medically necessary charges for the procurement of an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Bone Marrow Donor Search Fee	Not Covered	Not Covered
Organ Transplants (institutional)	Covered	Covered
Donor expenses are covered Artificial Hearts are covered	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Organ Transplants (professional)	Covered	Covered
Donor expenses are covered Artificial Hearts are covered	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Travel and Lodging for Organ Transplants	Covered	Not Covered
See below Travel and Lodging documents for items covered and benefit limits. $10,000 per occurrence	Covered at: 100% Deductible: No Copay: N/A	

Transplants - (BDCT Facility)	In-Network[1,3]	Out-of-Network [2,3,6]
Live Donor Health Services	Covered	
Donor benefits are limited to benefits not available to the donor from any other source. Medically necessary charges for the procurement of an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	Covered at: 80% Deductible: Yes Copay: N/A	N/A
Bone Marrow Donor Search Fee	Not Covered	
Organ Transplants (institutional)	Covered	
Donor expenses are covered Artificial Hearts are covered	BDC+ Facility: 80% Deductible: Yes Copay: N/A BDC Facility: 80% Deductible: Yes Copay: N/A	N/A
Organ Transplants (professional)	Covered	
Donor expenses are covered Artificial Hearts are covered	Covered at: 80% Deductible: Yes Copay: N/A	N/A
Travel and Lodging for Organ Transplants	Covered	
See below Travel and Lodging documents for items covered and benefit limits. $10,000 per occurrence	Covered at: 100% Deductible: No Copay: N/A	N/A

Urgent Care	In-Network[1]	Out-of-Network [2,6]
Urgent Care Outpatient Institutional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Urgent Care Office Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Vision	**In-Network[1]**	**Out-of-Network [2,6]**
Glasses/Contacts after Cataract Surgery	Not Covered	Not Covered
Vision Exam (non-routine) Outpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Vision Exam (non-routine) Office Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Vision Therapy		
Vision Therapy Inpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Vision Therapy Outpatient Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A
Vision Therapy Office Professional	Covered	Covered
	Covered at: 80% Deductible: Yes Copay: N/A	Covered at: 60% Deductible: Yes Copay: N/A

BDC for Specialty Care Benefit Limits – Inpatient & Outpatient	In-Network[1,3]	Out-of-Network[2,3,6]
Bariatric Surgery Tiered Benefit **Selected Yes**	Covered	Not Covered
	BDC+ Facility: 80% Deductible: Yes Copay: N/A BDC Facility: Not Covered Deductible: N/A Copay: N/A PAR Facility: Not Covered Deductible: N/A Copay: N/A	
Bariatric Surgery – Optional Travel Reimbursement **Selected Yes**	Covered	Not Covered
BDC+ Facility Only	BDC+ Facility: 100% Deductible: No Copay: N/A	Not Covered

Notes:
1: Network provider renders care.
2: OON services are those from a provider that does not participate with Anthem or with another Blue Cross and Blue Shield Plan through the BlueCard PPO. Subject to balance billing over allowed amount unless indicated otherwise.
3: Prior Authorization by our Medical Management program is required.
4: Behavioral Health/Substance Abuse services are administered by Anthem Behavioral Health. Prior Authorization is required for inpatient care.
5: Anthem's Medical Management Program must be notified within 48 hours in the event of an emergency admission.
6: The member is responsible for any Deductible, coinsurance and amount above the allowed amount. (This also applies to any claim that receives the in-network reimbursement level for a non-participating provider, for example DME.)
This is a benefit summary only and is subject to the terms, conditions, limitations, and exclusions set forth in the contract.
Failure to comply with our Medical Management Program could result in benefit reductions and/or denial of services.

Transplant & Bariatric Travel & Lodging Guidelines

Meals	Covered/Not Covered
Restaurants & Take Out: Meals and snacks	**Not Covered**
Groceries: Food & beverage (excluding alcohol)	**Not Covered**
Lodging	**Covered/Not Covered**
Hotel	**Covered**
Motel	**Covered**
Apartment rental	**Covered**
Travel	**Covered/Not Covered**
Air, Train & Bus fares	**Covered**
Car rental	**Covered**
Gas	**Covered**
Parking (excluding valet)	**Covered**
Tolls	**Covered**
Mileage: Car Rental – as long as charged by car rental agency	**Covered**
Personal Car mileage – ONLY if the individual does not fly (covered to and from facility)	**Covered**
Lodging: valet parking	**Not Covered**
Travel: personal car mileage (see the exception above)	**Not Covered**
Miscellaneous	**Covered/Not Covered**
Convenience items: telephone, fax	**Not Covered**
Entertainment items: movies, books, and video rentals	**Not Covered**
Furnishing for apartments: cooking utensils, appliances, furniture	**Not Covered**
Groceries: Alcohol, cigarettes, paper products, toiletries; personal hygiene products	**Not Covered**
Misc.: Laundry service or dry cleaning	**Not Covered**
Gratuities of any kind	**Not Covered**
Laundry detergent	**Not Covered**
Moving trucks (e.g. U-haul)	**Not Covered**
Taxes on covered expenses	**Covered**
Lodging allowance: $50 per day for double occupancy	

Travel includes:		
Transportation for two companions if the patient is a minor child No dollar limit amount per fare Travel is reimbursed for patient and companion		
Maximum	$10,000 per occurrence	
Bone Marrow donor search/Travel and Lodging Benefits Questionnaire		
Please address the following benefit questions:	**Yes/No**	**Comments**
Would a transplant approval with the prior carrier be honored?	Yes	
National Donor Search:	**Yes/No**	**Comments**
Is there a National Bone Marrow Donor Search benefit?	No	
If yes, is there a maximum benefit allowance for the National Bone Marrow Donor Search?	N/A	
Can the benefit be used at any par PPO facility?	N/A	
If no, can the benefit only be used at a Blues Distinction Center for Transplant (BDCT) facility?	N/A	
Travel and Lodging Benefit:	**Yes/No**	**Comments**
Is there a travel and lodging benefit?	Yes	
If yes, is there a maximum benefit amount for travel and lodging?	Yes	
If yes, what is the maximum?		$10,000 per occurrence
Is the travel and lodging benefit able to be used for all par PPO facilities?	Yes	
If no, is it for BDC facilities only?	No	
Is there a certain distance the patient must live from the transplant facility to use this benefit?	Yes	
If yes, what is the distance?		50 miles
Lodging:	**Yes/No**	**Comments**
Is there a maximum daily allowance for lodging?	Yes	
If yes, what is it?		**Lodging allowance: $50 per day for double occupancy**
Are there any lodging exclusions? If yes, please attach the exclusions (e.g. alcohol, cigarettes, personal hygiene products, laundry detergent).	Yes	
Travel:	**Yes/No**	**Comments**
Is one companion traveling with an adult patient covered?	Yes	
Are two companions traveling with a child patient 18 years old or younger covered?	Yes	
Are there any travel exclusions? If yes, please attach the exclusions (e.g. valet parking, personal car mileage).	Yes	
Do the above travel and lodging benefits apply for the following conditions:	**Yes/No**	**Comments**
When patient is going for the initial evaluation?	Yes	
When patient is going for follow up care at the transplant facility?	Yes	
Is there a contact person that patients can be referred to for specific donor/travel and lodging benefit questions? If yes, please give contact number:	TBD	TBD
Is there a Prior Authorization requirement for use of these benefits?	TBD	TBD

Exclusions-Enterprise Standard List

ACT OF WAR/MILITARY DUTY:

Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military facilities except as required by law.

CUSTODIAL/CONVALESCENT CARE:

Services for Custodial Care.

Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care.

DENTAL SERVICES:

Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered.

ELIGIBILITY:

Charges for treatment received before coverage under this option began or after it is terminated.

EXPERIMENTAL/INVESTIGATIONAL:

Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are in our judgement, Experimental or Investigational for the diagnosis for which the Participant is being treated.

Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury, as determined by the Claims Administrator.

FOOT CARE:

Foot care only to improve comfort or appearance, routine care of corns, calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for Members with impaired circulation to the lower extremities.

Shoe inserts, orthotics (will be covered if prescribed by a physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed medically necessary).

GOVERNMENT AGENCY/LAWS/PLANS:

Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.

Services paid under Medicare or which would have been paid if the Member had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor after the expiration of the 30 month coordination period whether or not the Participant has enrolled in Medicare Part B.

Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.

Court-ordered services, or those required by court order as a condition of parole or probation [unless Medically Necessary and approved by the Plan].

MEDICATIONS:

Outpatient prescription drugs prescribed by a physician and purchased or obtained from a retail pharmacy or retail pharmacist or a mail service pharmacy are excluded. These may be covered by a separate drug card program but not under this medical plan. Although coverage for Outpatient Prescription Drugs obtained from a retail pharmacy or pharmacist or mail service Pharmacy is excluded, certain Prescription Drugs are covered under your medical benefits when rendered in a Hospital, in a Physician's office, or as part of a Home Health Care benefit. Therefore, this exclusion does not apply to prescription drugs provided as Ancillary Services during an Inpatient stay or an Outpatient Surgical procedure; to prescription drugs used in conjunction with a Diagnostic Service; Chemotherapy performed in the office; home infusion or home IV therapy, nor drugs administered in your Physician's office.

Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.

MEDICALLY NECESSARY:

Care, supplies, or equipment not Medically Necessary, as determined by us, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

Vitamins, minerals and food supplement, as well as vitamin injections not determined to be medically necessary in the treatment of a specific illness. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be medically necessary.

Services for Hospital confinement primarily for diagnostic studies.

Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, except for reconstructive surgery following a mastectomy or when medically necessary to correct damage caused by an accident, an injury or to correct a congenital defect.

MISCELLANEOUS:

Donor Search/Compatibility Fee (except as otherwise indicated on the Plan Design).

Contraceptive Drugs, except for any above stated covered contraceptive services.

Hair transplants, hair pieces or wigs (except when necessitated by disease) wig maintenance, or prescriptions or medications related to hair growth.

Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, or educational interventions, except as expressly provided under "Covered Services".

Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.

Christian Science Practitioner.

Services and supplies for smoking cessation programs and treatment of nicotine addiction, including gum, patches, and prescription drugs to eliminate or reduce the dependency on or addiction to tobacco and tobacco products unless otherwise required by law.

Services provided in a Halfway House.

Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made; services provided to the Member by a local, state, or federal government agency, or by a public school system or school district, except when the plan's benefits must be provided by law; services if the Member is not required to pay for them or they are provided to the Member for free.

SPECIAL CHARGES/SERVICES:

Services or supplies provided by a member of your family or household.

Charges or any portion of a charge in excess of the maximum allowable amount as determined by the Claims Administrator.

Fees or charges made by an individual, agency or facility operating beyond the scope of its license.

Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.

Services for any form of telecommunication, except as expressly provided under covered services

Administrative Charges - Charges for any of the following: failure to keep a scheduled visit; completion of claim forms or medical records or reports unless otherwise required by law; for Physician or Hospital's stand-by services; for holiday or overtime rates; membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provider their test results; specific medical reports including those not directly related to the treatment of the Participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.

Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available.

Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.

SURGERY:

Reversal of vasectomy or tubal ligation.

Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne.

THERAPIES:

Services for outpatient therapy or rehabilitation other than those specifically noted. Excluded forms of therapy include, but are not limited to: primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, in-home wrap around treatment, wilderness therapy, and boot camp therapy.

VISION CARE:

Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition, ie diabetes.

Vision Surgeries - Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.

WEIGHT REDUCTION PROGRAMS:

Services for weight reduction programs, services and supplies. Weight loss programs, including but not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss).

Group Specific Exclusions

1	Services and supplies that do not meet accepted standards of medical/dental practice.
2	Respite Care Service, except as specifically mentioned under the Hospice Care Program.
3	Inpatient Private Duty Nursing Service.
4	Maintenance Care.
5	Services or supplies not specifically mentioned in the benefit booklet.
6	Services and supplies received on an inpatient basis as the result of antisocial actions which are not the result of mental illness.
7	Specialized equipment, special braces, splints, appliances, etc., except as specifically mentioned in the benefit booklet.
8	Prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient or unrelated to the treatment of an illness or injury.
9	Blood derivatives that are not officially classified as drugs.
10	Services and supplies for Human Organ Transplants other than those specifically mentioned in the benefit booklet.
11	Services and supplies to the extent benefits are duplicated because more than one family member is a member of the group and covered separately.
12	Speech therapy rendered for the treatment of psychological speech delay, behavioral problems, attention disorder, conceptual handicap or mental retardation.

Health Care Reform

HCR Grandfathered	Non-Grandfathered
HCR Patient Protection (ER) applies	Yes
HCR Preventive applies	Yes
HCR Preventive Services Apply for Grandfathered Plan	N/A
HCR Annual Maximum applies	Yes
HCR Lifetime Maximum applies	Yes
HCR 2014 EHB Pre-X no longer applies	Yes
HCR Women's Preventive applies	Yes
HCR Women's Preventive apply Cost Share	No
HCR Women's Sterilization/Contraceptive Opt Out	N/A
HCR Religious Exemption Applies	No
FMHP Applies	Yes

Change Log									
Original Plan created by:			**Insert Name of Person who created plan design here and date created**						
Date Entered	**Effective Date of Change**	**UWR#/ CQ#**	**Description of previous state**	**Description of new state**	**Source of Change**	**Updated By**	**Request for Approval**	**Approval Date**	**Approved by:**
07/25/18	01/01/19	IMPL-0439		new BPD	IMPL	L. Adams			
11/05/18	01/01/19	IMPL-0942	routine vision exams not covered	routine vision exams covered	Inflight Change IMPL	L. Adams			
12/20/18	01/01/19	IMPL-0942 & IMPL-1347	FSA Integration - Yes	-- Updated AIM products per revised ASF -- Member must register w/ Optum for infertility services to be paid -- Removed FSA integration	Revision on Inflight Change IMPL-0942 & Inflight Change IMPL-1347	L. Adams			
03/20/19	05/01/19	IMPL 1955	Conttract Code = 3QZE. Advanatage Network Contract codes: FL Network Blue = 3QZF. GA Blue Open Access POS = 3QZH. WI Blue Preferred POS = 3QZG	Conttract Code = 3QZE - Engage Elite Effective 5/1/2019 5AS0 - Engage Elite Plus. . Advanatage Network Contract codes: FL Network Blue = 3QZF Engage Elite. Effective 5/1/2019 5AS1 Engage Elilte Plus. GA Blue Open Access POS = 3QZH Engage Elite. Effective 5/1/2019 5AS2 Engage Elite Plus. WI Blue Preferred POS = 3QZG Engage Elilte. Effective 5/1/2019 5AS3 Engage Elite Plus.	IMPL 1955	W.Pryer			
10/04/19	01/01/19	IMPL 9842	In order for infertility services to be paid the member must register with Optum by calling 866-774-4626	Remove this requirement	IMPL 9842	N.Daniels on			
03/05/20	01/01/19	IMPL 27410		Added: Wigs/Toupees limited to 1 per benefit period and limited to a $500 max. Out-Of-Network coverd at the In-Network Deductible and Coinsurance Level at billed charges	EWM 624412	W.Pryer			