

Anthem BCBS PPO Plan

PLAN FEATURES	NETWORK	NON-NETWORK
Network	Blue Cross Blue Shield Network	N/A
Annual Deductible	\$500 per member; \$1,000 aggregate amount per family	\$750 per member; \$1,500 aggregate amount per family
Annual Out-of-Pocket Maximum	\$2,500 per member; \$5,000 aggregate amount per family	\$3,750 per member; \$7,500 aggregate amount per family
Lifetime Maximum Benefit	Unlimited	Unlimited
Office Visit/Exam	80% after deductible	60% after deductible
Outpatient Specialist Visit	80% after deductible	60% after deductible
<b>Preventive Benefits</b>		
Adult Periodic Exams with Preventive Tests	100%, no deductible	60% after deductible
Well Woman Exams	100%, no deductible	60% after deductible
Mammograms (annual exam for women ages 35 and up)	100%, no deductible	60% after deductible
Well Child Care	100%, no deductible	60% after deductible
Diagnostic X-ray and Lab Tests	100%, no deductible	60% after deductible
<b>Inpatient Hospital Services</b>		
Pre-authorization of services is required		
Semiprivate Room and Board (including services and supplies)	80% after deductible	60% after deductible
<b>Surgical Services</b>		
Outpatient Facility Charge	80% after deductible	60% after deductible
<b>Emergency Services</b>		
Emergency Room	80% after deductible	80% after deductible
<b>Maternity Services</b>		
Maternity Office Visit	80% after deductible	60% after deductible
Maternity Hospital Care	80% after deductible	60% after deductible
<b>Mental Health Benefits</b>		
Inpatient Care	80% after deductible	60% after deductible
Outpatient Care	80% after deductible	60% after deductible

PLAN FEATURES	NETWORK	NON-NETWORK
<b>Alcohol and Substance Abuse</b>		
Inpatient Care	80% after deductible	60% after deductible
Outpatient Care	80% after deductible	60% after deductible
<b>Prescription Drugs (provided through Anthem)</b>		
<b>Retail</b> (30-day supply)		Partial reimbursement available
Generic	\$10	
Brand Name	\$30	
Non-preferred Brand Name	\$50	
<b>Mail Order</b> (90-day supply, eliminates one-month cost) <sup>[1]</sup>		Not covered
Generic	\$20	
Brand Name	\$60	
Non-preferred Brand Name	\$100	
<b>Other Services and Supplies</b>		
Durable Medical Equipment and Prosthetic Devices	80% after deductible	60% after deductible
Home Health Care (100 visits per calendar year)	80% after deductible	60% after deductible
Skilled Nursing or Extended Care Facility (100 days per admission)	80% after deductible	60% after deductible
Hospice Care (Limited to 30 visits per calendar year)	80% after deductible	60% after deductible
Chiropractic Services (Limited to 30 visits per calendar year)	50% after deductible	50% after deductible
<b>Outpatient Rehabilitative Therapy Services</b>		
Physical Therapy (Limited to 60 visits per calendar year combined for Physical Therapy and Occupational Therapy)	80% after deductible; services performed by chiropractors/podiatrists: 50% after deductible	60% after deductible; services performed by chiropractors/podiatrists: 50% after deductible

<sup>[1]</sup> If you take a “maintenance medication” on an ongoing basis, you may purchase your initial prescription and one refill from a retail pharmacy. Thereafter, you must purchase the medication through mail order or pay the full cost.

PLAN FEATURES	NETWORK	NON-NETWORK
Occupational Therapy (Limited to 60 visits per calendar year combined for Physical Therapy and Occupational Therapy)	80% after deductible; services performed by chiropractors/podiatrists: 50% after deductible	60% after deductible; services performed by chiropractors/podiatrists: 50% after deductible
Speech Therapy (Limited to 20 visits per calendar year)	80% after deductible	60% after deductible

### Cigna Dental PPO High and Low Option Plans

The following table shows the key features of the Cigna Dental PPO High and Low Option Plans.

PLAN FEATURES	CIGNA DENTAL PPO HIGH PLAN		CIGNA DENTAL PPO LOW PLAN	
	Network	Non-Network	Network	Non-Network
Network	Cigna DPPO Advantage	N/A	Cigna DPPO Advantage	N/A
<b>Deductibles and Maximums</b>				
Deductible	\$50 per member \$100 aggregate amount per family	\$100 per member \$200 aggregate amount per family	\$75 per member \$150 aggregate amount per family	\$150 per member \$300 aggregate amount per family
Annual Maximum (includes preventive services, excludes orthodontia, combined network and non-network)	\$1,500	\$1,000	\$1,250	\$750
<b>Preventive Services</b>				
Routine Cleanings, Oral Exams, Bitewing X-rays (twice each calendar year)	100%	100%	100%	100%
Full Mouth X-rays	100% (one complete set every three years)			
Panoramic X-rays	100% (once every three years)			
Fluoride Treatments	100% (once each calendar year for children under age 19)			
Sealants	100% (one treatment per posterior tooth every three years for children under age 14)			
Space Maintainers	100%			

PLAN FEATURES	CIGNA DENTAL PPO HIGH PLAN		CIGNA DENTAL PPO LOW PLAN	
	Network	Non-Network	Network	Non-Network
Therapeutic and Emergency Care (to relieve pain)	100%			
<b>Basic Services</b>				
Extractions, Fillings, Oral Surgery, Anesthesia, Periodontal Treatments, Endodontics, Root Canal Therapy, Denture Adjustment and Repairs	80% after deductible	60% after deductible; subject to UCR	70% after deductible	50% after deductible; subject to UCR
<b>Major Services</b>				
Bridges, Crowns, Gold Fillings, Dentures, Implants	70% after deductible	50% after deductible; subject to UCR	60% after deductible	40% after deductible; subject to UCR
Orthodontics Treatment	50% deductible, to a lifetime maximum of \$1,500	50% of UCR after deductible, to a lifetime maximum of \$1,000	50% deductible, to a lifetime maximum of \$1,250	50% of UCR after deductible, to a lifetime maximum of \$750
TMJ Treatment	80% of the cost to a maximum \$1,000 lifetime benefit	80% of UCR to a maximum \$1,000 lifetime benefit	80% of the cost to a maximum \$1,000 lifetime benefit	80% of UCR to a maximum \$1,000 lifetime benefit

## VISION PLAN

Optional vision coverage provides you with routine eye exams and corrective lenses through a network of eye care professionals. Vision coverage is offered through Vision Service Plan (VSP).

### Vision Service Plan (VSP) Benefits

PLAN COVERAGE	VSP	
	Network	Non-Network

Exam (once every calendar year)	100% after \$10 copay	Up to \$45, after \$10 copay
Frames (once every other calendar year)	Up to \$50 wholesale and up to \$150 retail after \$10 materials copay	Up to \$47, after \$10 materials copay
Lenses (once every calendar year)	Covered in full after \$10 materials copay	Single: Up to \$45, after \$10 materials copay Lined Bifocal: Up to \$65, after \$10 materials copay Lined Trifocal: Up to \$85, after \$10 materials copay Lenticular: Up to \$125, after \$10 materials copay
Contact Lenses (covered in lieu of frames and lenses once every calendar year)	Medically Necessary: Covered in full after \$10 materials copay Elective: Up to \$120 No additional copay	Medically Necessary: Up to \$210 Elective: Up to \$105
<b>Note:</b> You pay only one \$10 materials copay whether you purchase frames, lenses, or both. The materials copay also applies to medically necessary contact lenses.		