2019 Medical Plan Highlights
Non-Medicare Eligible Hourly Retirees

		Preferred Provider Plan (PPO)	
		In Network	***Out-of-Network***
	Deductibles	$350 per person $800 family maximum	$700 per person $1,600 family maximum
	Co-Insurance	80% / 20%	60% / 40%
	Annual Out-Of-Pocket Maximum (excludes Deductible and Co-payments)	$1,700 per person $3,400 per family	$2,900 per person $5,800 per family
	Lifetime Maximum	$1,000,000 (maximum of $300,000 of total can be Out-of-Network)	
PREVENTIO	Routine Adult Physical Exams (including PSA)	All preventative services combined subject to $400 per person per annual maximum	
		$15 Co-payment - No deductible	No Coverage
	Routine GYN exam and PAP test (annual)	$15 Co-payment - No deductible	Deductible/Co-Insurance
	Routine Mammograms	Covered 100%	Deductible/Co-Insurance
	Well Child Care	$15 Co-payment - No deductible; Age 6 & under	No Coverage
	Immunizations	$15 Co-payment - No deductible; Age 6 & under	Deductible/Co-Insurance Age 6 & under
HOSPITAL	Semi-Private Room and Board	Deductible/Co-Insurance	
	Physician/Surgical Services	Deductible/Co-Insurance	
	Lab Tests	Deductible/Co-Insurance	
	Anesthesiology/Pathology and Radiology Services	Deductible/Co-Insurance	
	Inpatient Physical Rehabilitation	Deductible/Co-Insurance	
OUTPATIENT	Primary Care Physician and Specialist Office Visits	$15 Co-payment - No deductible	Deductible/Co-Insurance
	Surgical Care	Deductible/Co-Insurance	
	Tests/Treatments in Diagnostic Facility	Deductible/Co-Insurance	
	Tests/Treatments in Physician's Office	Deductible/Co-Insurance	
	Laboratory Tests/X-Rays	Deductible/Co-Insurance	
	Physical, Occupational and Restorative Speech Therapy	$15 Co-payment - No deductible	Deductible/Co-Insurance
		Up to 25 days per calendar year	
	Radiation/Chemotherapy	Deductible/Co-Insurance	
	Durable Medical Equipment	Deductible/Co-Insurance	

2019 Medical Plan Highlights
Non-Medicare Eligible Hourly Retirees

		Preferred Provider Plan (PPO)	
		In Network	***Out-of-Network***
MATERNITY	Infertility Counseling, Testing and Treatment	Deductible/Co-Insurance $5,000 Lifetime Maximum	
	Prenatal/Postnatal Care	$15 Co-payment for initial visit, then Deductible/Co-Insurance	Deductible/Co-Insurance
	Hospital Care for Mother and Child	Deductible/Co-Insurance	
OTHER CARE	Emergency Room Fee	*$50 Co-payment - No deductible (waived if admitted)	
	Urgent Care Facility	*$25 Co-payment - No ded. (waived if admitted)	*$25 Co-payment - No ded. (waived if admitted)
	Ambulance Services Traditional, Air or Boat (Medically Necessary)	Deductible/Co-Insurance	
	Skilled Nursing Facility Care	Deductible/Co-Insurance - Up to 100 days per calendar year	
	Home Health Care	Deductible/Co-Insurance - Up to 100 days per calendar year	
	Chiropractic	$15 Co-payment - No Deductible	Deductible/Co-Insurance
		Up to $1,000 per calendar year	
	Hearing Aids	Covered 100% (includes initial testing & fitting) Up to $3,000 per 3 year period	
	Allergy Testing/Therapy	Lesser of $15 Co-payment or actual charge	Deductible/Co-Insurance
	Hospice	Covered 100% - No deductible - $12,000 Lifetime maximum	
RX	Anthem Prescription Drug Program Retail (Up to a 30 day supply)	20% Co-Insurance - After $250 per person combined retail & mail order annual deductible Retail - Minimum $7; Maximum $70 No coverage for Non-formulary	
	Anthem Prescription Drug Program Mail Order (Up to a 90 day supply)	20% Co-Insurance -After $250 per person combined retail & mail order annual deductible Mail Order - Minimum $14; Maximum $140 No coverage for Non-formulary	

Note:

a) This benefit highlight is a summary only. It does not fully describe your benefit coverage. For details on your benefit coverage, please contact Anthem at 1-833-861-1322.

b) All Co-payments are on a per visit basis unless otherwise specifically stated

c) To be considered for coverage, all claims must be for medically necessary services or supplies.

**** If not a medical emergency -- Deductible / Co-Insurance may appy***