LiveWell

Platinum Plan

January 1, 2023 – December 31, 2023

Member Services 1-833-988-1265

Some services may require pre-certification before services are covered by the Plan.

When using out-of-network providers, members are responsible for any difference between the Maximum Allowed Amount and the amount the provider actually charges, as well as any copayments, deductibles, and/or applicable coinsurance.

Deductibles, Coinsurance, and Maximums	In-Network Benefit Level	Out-of-Network Benefit Level
Calendar Year Deductible*		
▪ Individual	$600	$1,400
▪ Family	$1,200	$2,800
Coinsurance	Member pays 20% Plan pays 80%	Member pays 30% Plan pays 70%
Calendar Year Out-of-Pocket Maximum* (includes calendar year deductible)		
▪ Individual	$4,500	$8,000
▪ Family	$9,000	$16,000
Lifetime Maximum	Unlimited	Unlimited

*Deductibles and out-of-pocket maximums are amounts cross accumulate. One family member may reach his or her Individual deductible and be eligible for coverage on health care expenses before other family members. The medical and pharmacy copayments, deductible(s), and coinsurance on this plan will apply toward the out-of-pocket maximums. The following do not apply to out-of-pocket maximums: non-covered items, plan premiums, any balance billing due to Out-of-Network services or any services deemed not medically necessary by Medical Management and/or Anthem.

Covered Services	In-Network Benefit Level	Out-of-Network Benefit Level
Preventive Care Services for Children and Adults (preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations, and physician visits) ▪ Well-child care, immunizations ▪ Periodic health examinations ▪ Annual gynecology examinations ▪ Mammogram ▪ Prostate screenings	Member pays 0% (not subject to deductible)	Member pays 30% after deductible
Physician Office Visits for Illness and Injury (including labs, x-rays, and diagnostic procedures) ▪ Primary Care Physician (PCP) ▪ Specialist Physician ▪ LiveHealth Online	$30 copayment $45 copayment $10 copayment	Member pays 30% after deductible
Maternity Physician Services ▪ Global obstetrical care (prenatal, delivery and postpartum services)	$750 copayment, no deductible	Member pays 30% after deductible

Covered Services	In-network Benefit Level	Out-of-Network Benefit Level
Allergy Services ▪ Office visits, testing and the administration of allergy injections ▪ PCP ▪ Specialist ▪ Allergy injection serum	$30 copayment $45 copayment Member pays 20% after deductible	Member pays 30% after deductible
Office Surgery (surgery and administration of general anesthesia)	Member pays 20% after deductible	Member pays 30% after deductible
Office Therapy Services ▪ Physical Therapy, Speech Therapy and Occupational Therapy: 60 visits each per calendar year ▪ Chiropractic Care/Manipulation Therapy: 20 visits per calendar year	Member pays 20% after deductible	Member pays 30% after deductible
Urgent Care	$75 copayment	Member pays 30% after deductible
Other Therapy Services ▪ Chemotherapy, radiation therapy, cardiac rehabilitation (there is no Cardiac Rehabilitation visit max on this plan; authorization required) and respiratory/pulmonary therapy	Member pays 20% after deductible	Member pays 30% after deductible
Foot Orthotics (when medically necessary and prescribed by a physician) ▪ Maximum of 1 per year	Member pays 20% after deductible	Member pays 30% after deductible
Temporomandibular Joint Dysfunction (TMJ)	Paid at the level of services billed	Member pays 30% after deductible
Emergency Room Services ▪ Life-threatening illness or serious accidental injury only (copay waived if admitted) ▪ Non-emergency use of the emergency room	$500 copay, waived if admitted Member pays 20% after $500 copayment and deductible	$500 copay, waived if admitted Member pays 30% after $500 copayment and deductible
Outpatient Surgery at Hospital ▪ Facility surgery charges ▪ Diagnostic x-ray and lab services ▪ Physician services (anesthesiologist, radiologist, pathologist)	Member pays 20% after deductible	Member pays 30% after deductible
Inpatient Facility Services ▪ Daily room, board, and general nursing care at semi-private room rate, ICU/CCU charges; other medically necessary hospital charges such as diagnostic x-ray and lab services; newborn nursery care ▪ Physician services (anesthesiologist, radiologist, pathologist)	Member pays 20% after deductible	Member pays 30% after deductible
Skilled Nursing Facility ▪ 100-day limit per calendar year	Member pays 20% after deductible	Member pays 30% after deductible
Private Duty Nursing (RN and LPN's)	Member pays 20% after deductible	Member pays 30% after deductible
Mental Health Services ▪ Inpatient (facility and physician fee) ▪ Outpatient (facility) ▪ Outpatient (office visit including LiveHealth Online)	Member pays 20% after deductible Member pays 20% after deductible Member pays 0%	Member pays 30% after deductible
▪ **Substance Abuse Services** ▪ Inpatient (facility and physician fee) ▪ Outpatient (facility) ▪ Outpatient (office visit including LiveHealth Online)	Member pays 20% after deductible Member pays 20% after deductible Member pays 0%	Member pays 30% after deductible
Home Health Care Services ▪ 120 visits per calendar year	Member pays 20% after deductible	Member pays 30% after deductible
Hospice Care Services ▪ Inpatient and outpatient services covered under the hospice treatment program	Member pays 0% (not subject to deductible)	Member pays 0% (not subject to deductible)
Durable Medical Equipment (DME)	Member pays 20% after deductible	Member pays 30% after deductible

Hearing Aids	Member pays 20% after deductible	Member pays 30% after deductible
Ambulance Services (covered when medically necessary)	Member pays 0% no deductible	Member pays 0% no deductible

Prescription Drugs

Note:

- Prescription Drug coverage is included with your medical plan election and is provided through Ingenio Rx.
- All member cost shares (copayments and coinsurance) for pharmacy benefits will apply to the Medical Plan Out-of-Pocket Maximums.
- Members must file a claim form for reimbursement when using an out-of-network pharmacy.
- Mail order drugs can only be obtained through Ingenio Mail Order program.
- Specialty drugs can only be obtained through Ingenio specialty pharmacy
- You may contact Ingenio customer service at 1-833-267-2133 or online at www.anthem.com

	In- Network	Out-of-Network
Retail Drugs – Generic (up to a 30-day supply)	Member pays $20 copayment	Member pays $20 copayment
Retail Drugs – Brand (up to a 30-day supply)	Member pays $40 copayment	Member pays $40 copayment
Retail Drugs- Brand Drug (generic equivalent available)	Member pays $60 copayment	Member pays $60 copayment
Specialty Drugs (brand and generic)	30% up to $250 per prescription	30% up to $250 per prescription
Mail Order Drugs – Generic (up to a 90-day supply)	Member pays $26 copayment	Not covered
Mail Order Drugs – Brand (up to a 90-day supply)	Member pays $53 copayment	Not covered
Mail Order Drugs – Brand when a generic equivalent is available (up to a 90-day supply)	Member pays $80 copayment	Not covered
Specialty Drugs (brand and generic)	30% up to $250 per prescription	Not covered

Summary of Limitations and Exclusions

Your *Benefit Booklet* will provide you with complete benefit coverage information. Some key limitations and exclusions, however, are listed below:

- Routine physical examinations necessitated by employment, foreign travel or participation in school athletic programs
- Services for Custodial Care
- Care or treatment that is not medically necessary
- Cosmetic surgery, except to restore function altered by disease or trauma
- Dental care, except for accidental injury to natural teeth
- Occupational related illness or injury
- Treatment, drugs or supplies considered experimental or investigational

See Summary Plan Description for Complete Details