	CURRENT PLAN 2020-2021	PPO2 2021-2022
Plan Name	**EGWP PPO2**	**BlueMedicare Group PPO Advanced (Employer PPO)**
Plan Type	**Employer PPO**	**Employer PPO**
Contract-Plan Benefit Package	**H5434-801/802**	**H5434-801/802**
Service Area/Counties	**Nationwide**	**Nationwide**
Year	**2020**	**2021**
Plan Financials	**$257.24**	**$257.42**
Plan Premium	Varies by Group	$34.14
Premium Rebate	N/A	**N/A**
Deductible **In- Network**	$0	**$0**
Out-of-Network	$2,000	**$2,000**
Maximum Out Of Pocket (INN only)	$2,000	**$1,000**
Maximum Out Of Pocket (OON only)	$4,000	**$3,000**
Combined Maximum Out Of Pocket	$4,000	**$3,000**
Primary Care Physician (PCP)		
In-Network	$35 Copayment	**$25 Copay**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
Physician Specialist		
In-Network	$50 Copayment	**$45 Copay**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
Inpatient Hospital Acute (Includes Mental Health and Substance Abuse)		
In- Network	$250 Copay Each Day for Days 1-7 $0 Copayment After Day 7	**$200 Copay Each Day for Days 1-7** **$0 Copay After Day 7**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
Inpatient Mental Health (limited to 190 days per lifetime)		
Psychiatric Facility		
In- Network	$250 Copay Each Day for Days 1-7 $0 Copayment Per Days 8-90	**$200 Copay Each Day for Days 1-7** **$0 Copay Per Days 8-90**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
Skilled Nursing Facility (SNF)		
In- Network	$0 Copayment Per Days 1-20 $100 Copay Each Day for Days 21-100	**$0 Copay Per Days 1-20** **$100 Copay Each Day for Days 21-100**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
Cardiac Rehabilitation		
Cardiac/Intensive Cardiac Rehabilitation - All Locations		
In- Network	$40 Copayment	**$40 Copay**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
Pulmonary Rehabilitation (Includes SET for PAD)		
Pulmonary Rehabilitation - All Locations		
In- Network	$30 Copayment	**$30 Copay**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
Emergency Services		
In-Network	$75 Copayment	**$75 Copay**
Out-of-Network	$75 Copayment	**$75 Copay**
Urgent Care Center		
In- Network	$50 Copayment	**$30 Copay**
Out-of-Network	$50 Copayment	**$30 Copay**
Convenient Care Center (e.g. Minute Clinics)		
In-Network	$50 Copayment	**$30 Copay**
Out-of-Network	$50 Copayment	**$30 Copay**
Worldwide Emergency/Urgent Services		
Worldwide Emergency/Urgent Benefit Maximum	$25,000	**$25,000**
Emergency Care		
In-Network	$75 Copayment	**$75 Copay**
Out-of-Network	$75 Copayment	**$75 Copay**
Urgent Care		
In-Network	$75 Copayment	**$75 Copay**
Out-of-Network	$75 Copayment	**$75 Copay**
Worldwide Transportation		
In-Network	Not Covered	**Not Covered**
Out-of-Network	Not Covered	**Not Covered**
Partial Hospitalization (Care for Mental Health)		
In-Network	$40 Copayment	**$40 Copay**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**

Plan Name	EGWP PPO2	BlueMedicare Group PPO Advanced (Employer PPO)
Plan Type	Employer PPO	Employer PPO
Contract-Plan Benefit Package	H5434-801/802	H5434-801/802
Service Area/Counties	Nationwide	Nationwide
Year	2020	2021
Home Health Services		
In-Network	$0 Copayment	$0 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Hospice - Medicare-Covered Initial Consultation		
In-Network	$0 Copayment	$0 Copay
Out-of-Network	$0 Copayment	$0 Copay
Chiropractic		
In-Network	$20 Copayment	$20 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Occupational Therapy Rehab		
Freestanding or Office		
In-Network	$40 Copayment	$35 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Outpatient Hospital		
In-Network	$40 Copayment	$35 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Mental Health Specialty - Non Physician Level		
Group Sessions - All Locations		
In-Network	$40 Copayment	$40 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Individual Sessions - All Locations		
In-Network	$40 Copayment	$40 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Podiatry		
Medicare-Covered		
In-Network	$50 Copayment	$45 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Routine Supplemental Benefit Max: 6 visits per year		
In-Network	$50 Copayment	N/A
Out-of-Network	DED & 40% Coinsurance	N/A
Other Professional Services		
In-Network	$0 Copayment	$20 Copay for Acupuncture $0 Copay All Other
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Psychiatric Services - Physician Level		
Group Sessions - All Locations		
In-Network	$40 Copayment	$40 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Individual Sessions - All Locations		
In-Network	$40 Copayment	$40 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Physical and Speech Therapy Rehab		
Freestanding or Office		
In-Network	$40 Copayment	$35 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Outpatient Hospital		
In-Network	$40 Copayment	$35 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance

Plan Name	EGWP PPO2	BlueMedicare Group PPO Advanced (Employer PPO)
Plan Type	Employer PPO	Employer PPO
Contract-Plan Benefit Package	H5434-801/802	H5434-801/802
Service Area/Counties	Nationwide	Nationwide
Year	2020	2021
Additional Telehealth Services		
In-Network	Additional Telehealth Programs not offered. For Medicare Part B covered Telehealth Services: PCP $35 Copayment Specialist $50 Copayment See the CMS list of telehealth services for more info.	$30 Copay for Urgently Needed Services $25 Copay for Primary Care Services $30 Copay for OT/PT/ST at a freestanding location $30 Copay OT/PT/ST at an outpatient hospital $45 Copay for Dermatology Services $40 Copay for individual sessions for outpatient Mental Health Specialty Services $40 Copay for individual sessions for outpatient Psychiatry Specialty Services $40 Copay for Opioid Treatment Program Services $40 Copay for individual sessions for outpatient Substance Abuse Specialty Services $0 Copay for Diabetes Self-Management Training $0 Copay for Dietician Services
Out-of-Network	Medicare Part B covered services: DED & 40% Coinsurance	DED & 40% Coinsurance
Opioid Treatment Programs		
In-Network	$40 Copayment	$40 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Laboratory		
Independent Laboratory (Quest)		
In-Network	$0 Copayment	$0 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Outpatient Hospital		
In-Network	$30 Copayment	$30 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Diagnostic Procedures and Tests (Ultrasound, etc.)		
Allergy Testing - All Locations		
In-Network	$0 Copayment	$0 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Independent Diagnostic Testing Facility		
In-Network	$100 Copayment	$30 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Outpatient Hospital		
In-Network	$250 Copayment	$100 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Advanced Imaging Services		
Physician Office		
In-Network	$175 Copayment	$75 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Independent Diagnostic Testing Facility		
In-Network	$175 Copayment	$100 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Outpatient Hospital Facility		
In-Network	$250 Copayment	$150 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
X-Rays		
Independent Diagnostic Testing Facility		
In-Network	$100 Copayment	$50 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Outpatient Hospital		
In-Network	$250 Copayment	$150 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Therapeutic Radiological Services (Radiation Therapy)		
All Locations		
In-Network	$50 Copayment	20% Coinsurance
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance

Plan Name	EGWP PPO2	BlueMedicare Group PPO Advanced (Employer PPO)
Plan Type	Employer PPO	Employer PPO
Contract-Plan Benefit Package	H5434-801/802	H5434-801/802
Service Area/Counties	Nationwide	Nationwide
Year	2020	2021
Outpatient Hospital Services		
Outpatient Hospital Surgery		
In-Network	$250 Copayment	**$250 Copay**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
Observation		
In-Network	$75 Copayment	**$75 Copay**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
All Other Services not specified in another benefit category		
In-Network	$250 Copayment	**$250 Copay**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
Ambulatory Surgical Center		
In-Network	$175 Copayment	**$200 Copay**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
Outpatient Substance Abuse Services		
Group Sessions - All Locations		
In-Network	$40 Copayment	**$40 Copay**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
Individual Sessions - All Locations		
In-Network	$40 Copayment	**$40 Copay**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
Blood Services (3 pint deductible waived)		
In-Network	$0 Copayment	**$0 Copay**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
Ambulance Services (included mileage)		
Ground Ambulance Emergency/Non-Emergency		
In-Network	$150 Copayment	**$200 Copay**
Out-of-Network	$150 Copayment	**$200 Copay**
Air Ambulance (Rotary and Fixed Wing)		
In-Network	$150 Copayment	**$200 Copay**
Out-of-Network	$150 Copayment	**$200 Copay**
Routine Transportation Services (Non-emergency without mileage)		
In-Network	N/A	**N/A**
Out-of-Network	N/A	**N/A**
Durable Medical Equipment		
Motorized Wheelchairs and Electric Scooters		
In-Network	20% Coinsurance	**20% Coinsurance**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
Drugs Administered Through DME		
In-Network	20% Coinsurance	**20% Coinsurance**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
All Other Medicare-Covered Equipment and Related Supplies		
In-Network	0% Coinsurance	**0% Coinsurance**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
Prosthetic and Orthotics and Related Supplies		
In-Network	$0 Copayment	**20% Coinsurance**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
Diabetic Supplies		
In-Network	$0 Copayment	**$0 Copay**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
Diabetic Therapeutic Shoes		
In-Network	$0 Copayment	**$0 Copay**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**

Plan Name	EGWP PPO2	BlueMedicare Group PPO Advanced (Employer PPO)
Plan Type	Employer PPO	Employer PPO
Contract-Plan Benefit Package	H5434-801/802	H5434-801/802
Service Area/Counties	Nationwide	Nationwide
Year	2020	2021
Renal Dialysis		
All Locations		
In-Network	20% Coinsurance	**20% Coinsurance**
Out-of-Network	20% Coinsurance	**20% Coinsurance**
Acupuncture		
In-Network	**N/A** *See Other Professional Services category for Medicare-covered Part B Acupuncture*	**N/A** *See Other Professional Services category for Medicare-covered Part B Acupuncture*
Out-of-Network	**N/A**	**N/A**
Over-the-Counter Items		
Navarro	**N/A**	**N/A**
Out-of-Network	**N/A**	**N/A**
Meal Benefit		
In-Network	**N/A**	**N/A**
Out-of-Network	**N/A**	**N/A**
Preventive Services: Alcohol Misuse Screening and Counseling , Annual Wellness Visits (AWV), Barium Enemas, Bone Mass Measurements, Cardiovascular Disease Screening Tests, Colorectal Cancer Screening, Counseling to Prevent Tobacco Use, Depression Screening, Diabetes Screening, Diabetes Self-Management Training, Digital Rectal Exams, EKG following Welcome Visit (IPPE), Glaucoma Screening, Hepatitis B Virus Screening, Hepatitis B Vaccine and Administration, Hepatitis C Virus Screening, HIV Screening, Influenza Virus Vaccine and Administration, Initial Preventive Physical Exam (IPPE), IBT for Cardiovascular Disease, IBT for Obesity, Lung Cancer Screening (LDCT), Medical Nutrition Therapy, Pneumococcal Vaccine and Administration, Prostate Cancer Screening, Screening for Cervical Cancer with HPV Tests, STI/STD Screening with HIBC, Screening Mammography, Screening Pap Tests, Screening Pelvic Exam and Clinical Breast Exam, Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)		
In-Network	$0 Copayment	**$0 Copay**
Out-of-Network	40% Coinsurance	**40% Coinsurance**
Diabetes Prevention Program		
In-Network	**$0 Copay**	**$0 Copay**
Out-of-Network	**40% Coinsurance**	**40% Coinsurance**
Fitness Gym Membership		
SilverSneakers Locations	$0 Copayment	**$0 Copay**
Out-of-Network	N/A	**N/A**
Food as Pharmacy		
In-Network	**N/A**	**N/A**
Out-of-Network	**N/A**	**N/A**
Caregiver Support Program		
In-Network	**N/A**	**N/A**
Out-of-Network	**N/A**	**N/A**
At-Home Care - Papa		
In-Network	**N/A**	**N/A**
Out-of-Network	**N/A**	**N/A**
Kidney Disease Education Services		
In-Network	$0 Copayment	**$0 Copay**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
Medicare Part B Drugs		
Chemotherapy Drugs		
In-Network	20% Coinsurance	**20% Coinsurance**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
All Other Medicare Part B Drugs		
In-Network	20% Coinsurance	**20% Coinsurance**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**
Allergy Injectable Antigen Serum		
In-Network	$10 Copayment	**$5 Copay**
Out-of-Network	DED & 40% Coinsurance	**DED & 40% Coinsurance**

Plan Name	EGWP PPO2	BlueMedicare Group PPO Advanced (Employer PPO)
Plan Type	Employer PPO	Employer PPO
Contract-Plan Benefit Package	H5434-801/802	H5434-801/802
Service Area/Counties	Nationwide	Nationwide
Year	2020	2021
Dental Services - Medical		
Medicare-Covered Services		
In-Network	$50 Copayment	$45 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Vision Services - Medical		
Medicare-Covered Services		
In-Network	$50 Copayment	$45 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Diabetic Retinal Eye Exam		
In-Network	$0 Copayment	$0 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Medicare-Covered Eyewear following Cataract Surgery		
In-Network	$0 Copayment	$0 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
Hearing Services - Medical		
Medicare-Covered Services		
In-Network	$50 Copayment	$45 Copay
Out-of-Network	DED & 40% Coinsurance	DED & 40% Coinsurance
HealthyBlue Rewards		
	Members receive gift cards and other rewards for receiving preventive care screenings, or participating in wellness programs.	Members receive gift cards and other rewards for receiving preventive care screenings, or participating in wellness programs.

		CURRENT PLAN 2020-2021	Rx2 2021-2022
Plan Name		EGWP Rx Option 1	BlueMedicare Group Rx Platinum (Employer PDP)
Plan Type		Part D	Part D
Contract-Plan Benefit Package		S5904-801/802	S5904-801/802
Service Area/Counties		Nationwide	Nationwide
Year		2020	2021
Annual Deductible		$0	$0
Initial Coverage Limit (Gap Begins)		$4,020	$4,130
True Out-of-Pocket (Catastrophic Begins)		$6,350	$6,550
Excluded Drug Tiers		N/A	N/A
Preferred Pharmacies		N/A	Walgreens, Walmart, PillPack
Initial Coverage Stage			
Tier 1 - Preferred Generic Drugs			
Preferred In-Network	31 day supply	N/A	$3
	90 day supply	N/A	$9
Standard In-Network	31 day supply	$10	$10
	90 day supply	$30	$30
Mail Order In-Network	31 day supply	$0	$0
	90 day supply	$0	$0
Out-of-Network	31 day supply	$10	$10
Long Term Care	31 day supply	$10	$3
Tier 2 - Generic Drugs			
Preferred In-Network	31 day supply	N/A	$8
	90 day supply	N/A	$24
Standard In-Network	31 day supply	$10	$15
	90 day supply	$30	$45
Mail Order In-Network	31 day supply	$0	$8
	90 day supply	$0	$8
Out-of-Network	31 day supply	$10	$15
Long Term Care	31 day supply	$10	$8
Tier 3 - Preferred Brand Drugs			
Preferred In-Network	31 day supply	N/A	$35
	90 day supply	N/A	$105
Standard In-Network	31 day supply	$40	$40
	90 day supply	$120	$120
Mail Order In-Network	31 day supply	$40	$35
	90 day supply	$80	$70
Out-of-Network	31 day supply	$40	$40
Long Term Care	31 day supply	$40	$35
Tier 4 - Non-Prferred Drugs			
Preferred In-Network	31 day supply	N/A	$65
	90 day supply	N/A	$195
Standard In-Network	31 day supply	$70	$85
	90 day supply	$210	$255
Mail Order In-Network	31 day supply	$70	$65
	90 day supply	$140	$195
Out-of-Network	31 day supply	$70	$85
Long Term Care	31 day supply	$70	$65

Plan Name		EGWP Rx Option 1	BlueMedicare Group Rx Platinum (Employer PDP)
Plan Type		Part D	Part D
Contract-Plan Benefit Package		S5904-801/802	S5904-801/802
Service Area/Counties		Nationwide	Nationwide
Year		2020	2021
Tier 5 - Specialty Drugs			
Preferred In-Network	31 day supply	N/A	33%
	90 day supply	N/A	N/A
Standard In-Network	31 day supply	25%	33%
	90 day supply	N/A	N/A
Mail Order In-Network	31 day supply	25%	33%
	90 day supply	N/A	N/A
Out-of-Network	31 day supply	25%	33%
Long Term Care	31 day supply	25%	33%
Coverage Gap			
		All Tiers (No Gap)	All Tiers (No Gap)
Tier 1 - Preferred Generics			
Preferred In-Network	31 day supply	N/A	$3
	90 day supply	N/A	$9
Standard In-Network	31 day supply	$10	$10
	90 day supply	$30	$30
Mail Order In-Network	31 day supply	$0	$0
	90 day supply	$0	$0
Out-of-Network	31 day supply	$10	$10
Long Term Care	31 day supply	$10	$3
Tier 2 - Generics			
Preferred In-Network	31 day supply	N/A	$8
	90 day supply	N/A	$24
Standard In-Network	31 day supply	$10	$15
	90 day supply	$30	$45
Mail Order In-Network	31 day supply	$0	$8
	90 day supply	$0	$8
Out-of-Network	31 day supply	$10	$15
Long Term Care	31 day supply	$10	$8
Tier 3 - Preferred Brands			
Preferred In-Network	31 day supply	N/A	$35
	90 day supply	N/A	$105
Standard In-Network	31 day supply	$40	$40
	90 day supply	$120	$120
Mail Order In-Network	31 day supply	$40	$35
	90 day supply	$80	$70
Out-of-Network	31 day supply	$40	$40
Long Term Care	31 day supply	$40	$35
Tier 4 - Non-Preferred Brands			
Preferred In-Network	31 day supply	N/A	$65
	90 day supply	N/A	$195
Standard In-Network	31 day supply	$70	$85
	90 day supply	$210	$255
Mail Order In-Network	31 day supply	$70	$65
	90 day supply	$140	$195
Out-of-Network	31 day supply	$70	$85
Long Term Care	31 day supply	$70	$65
Tier 5 - Specialty Drugs			

Plan Name		EGWP Rx Option 1	BlueMedicare Group Rx Platinum (Employer PDP)
Plan Type		Part D	Part D
Contract-Plan Benefit Package		S5904-801/802	S5904-801/802
Service Area/Counties		Nationwide	Nationwide
Year		2020	2021
Preferred In-Network	31 day supply	N/A	33%
	90 day supply	N/A	N/A
Standard In-Network	31 day supply	25%	33%
	90 day supply	N/A	N/A
Mail Order In-Network	31 day supply	25%	33%
	90 day supply	N/A	N/A
Out-of-Network	31 day supply	25%	33%
Long Term Care	31 day supply	25%	33%
Catastrophic Stage			
Tier 1 - Preferred Generics			
All Locations	31/90 day supply	$3.60	Greater of $3.70 or 5%
Tier 2 - Generics			
All Locations	31/90 day supply	$3.60	Greater of $3.70 or 5%
Tier 3 - Preferred Brands			
All Locations	31/90 day supply	$8.95	Greater of $9.20 or 5%
Tier 4 - Non-Preferred Drugs			
All Locations	31/90 day supply	$8.95	Greater of $9.20 or 5%
Tier 5 - Specialty Generics			
All Locations	31 day supply	$3.60	Greater of $3.70 or 5%
Tier 5 - Specialty Brands			
All Locations	31 day supply	$8.95	Greater of $9.20 or 5%

	CURRENT PLAN 2020-2021	2021-2022
Plan Name	**EGWP PPO2**	**BlueMedicare Group PPO Advanced (Employer PPO)**
Plan Type	**Employer PPO**	**Employer PPO**
Contract-Plan Benefit Package	**H5434-801/802**	**H5434-801/802**
Service Area/Counties	**Nationwide**	**Nationwide**
Year	**2020**	**2021**
Fitness Gym Membership		
SilverSneakers Locations	$0 Copay	**$0 Copay**
Out-of-Network	N/A	**N/A**
Additional Dental Services	**FCL Dental Plan PPO 10**	**FCL Dental Plan PPO 10**
Total Preventive/Comprehensive Benefit Maximum	N/A	**N/A**
Periodic Oral Exam (D0120)		
Benefit Limit	2 per year	**2 per year**
In-Network	$0 Copay	**$0 Copay**
Out-of-Network	Member pays up front and is reimbursed 50% of non-participating rates	**Member pays up front and is reimbursed 50% of non-participating rates**
Comprehensive Oral Exam (D0150)		
Benefit Limit	1 Per Lifetime, Per Dentist Counts against exams limit	**1 Per Lifetime, Per Dentist Counts against exams limit**
In-Network	$0 Copay	**$0 Copay**
Out-of-Network	Member pays up front and is reimbursed 50% of non-participating rates	**Member pays up front and is reimbursed 50% of non-participating rates**
Cleaning (D1110)		
Benefit Limit	1 Per 6 Months	**1 Per 6 Months**
In-Network	$0 Copay	**$0 Copay**
Out-of-Network	Member pays up front and is reimbursed 50% of non-participating rates	**Member pays up front and is reimbursed 50% of non-participating rates**
Full-Mouth Series X-rays (D0210, D0330)		
Benefit Limit	1 Every 36 Months	**1 Every 36 Months**
In-Network	$0 Copay	**$0 Copay**
Out-of-Network	Member pays up front and is reimbursed 50% of non-participating rates	**Member pays up front and is reimbursed 50% of non-participating rates**
Bitewing X-rays (D0270, D0272, D0273, D0274, D0277)		
Benefit Limit	1 Every 12 Months	**1 Every 12 Months**
In-Network	$0 Copay	**$0 Copay**
Out-of-Network	Member pays up front and is reimbursed 50% of non-participating rates	**Member pays up front and is reimbursed 50% of non-participating rates**
Endodontics/Periodontics/Extractions (Extraction (D7140)		
Benefit Limit	2 per Year	**Up To 2 Per Year**
In-Network	$0 Copay	**$0 Copay**
Out-of-Network	Member pays up front and is reimbursed 50% of non-participating rates	**Member pays up front and is reimbursed 50% of non-participating rates**
Denture Adjustment - Complete or Partial (D5410, D5411, D5421, or D5422)		
Benefit Limit	2 per Year	**Up To 2 Per Year**
In-Network	$0 Copay	**$0 Copay**
Out-of-Network	Member pays up front and is reimbursed 50% of non-participating rates	**Member pays up front and is reimbursed 50% of non-participating rates**

Plan Name	EGWP PPO2	BlueMedicare Group PPO Advanced (Employer PPO)
Plan Type	Employer PPO	Employer PPO
Contract-Plan Benefit Package	H5434-801/802	H5434-801/802
Service Area/Counties	Nationwide	Nationwide
Year	2020	2021
Additional Vision Services		
Routine Eye Exams (1 Every 12 Months)		
In-Network	$0 Copay	**$0 Copay**
Out-of-Network	Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 50% of the in-network allowed amount.	**Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 50% of the in-network allowed amount.**
Eyewear (Lenses, Frames, Contacts)		
Benefit Maximum	$100 Allowance per year towards the purchase of lenses, frames or contacts.	**$100 Allowance per year towards the purchase of lenses, frames or contacts.**
In-Network	$0 Copay Subject to the annual maximum plan benefit allowance. Member responsible for any amounts in excess of the annual maximum plan benefit allowance.	**$0 Copay** **Subject to the annual maximum plan benefit allowance.** **Member responsible for any amounts in excess of the annual maximum plan benefit allowance.**
Out-of-Network	Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 50% of the in-network allowed amount. Member is responsible for all amounts in excess of the 50% in-network allowed amount and/or any amounts in excess of the annual maximum plan benefit allowance. Total reimbursement is subject to the annual maximum plan benefit allowance.	**Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 50% of the in-network allowed amount.** **Member is responsible for all amounts in excess of the 50% in-network allowed amount and/or any amounts in excess of the annual maximum plan benefit allowance.** **Total reimbursement is subject to the annual maximum plan benefit allowance.**
Additional Hearing Services		
Routine Hearing Exams (1 every year)		
Benefit Maximum	1 every 12 months	**1 every 12 months**
In-Network	$0 Copay	**$0 Copay**
Out-of-Network	Member must submit receipts for reimbursement at 50% of maximum allowed.	**Member must submit receipts for reimbursement at 50% of maximum allowed.**
Hearing Aid Evaluation and Fitting		
In-Network	$0 Copay	**$0 Copay**
Out-of-Network	Member must submit receipts for reimbursement at 50% of maximum allowed.	**Member must submit receipts for reimbursement at 50% of maximum allowed.**
Hearing Aids		
Benefit Maximum	$350 maximum allowance for each hearing aid. Up to 2 hearing aids every year. Hearing aids must be purchased through NationsHearing to receive in-network benefits.	**$350 maximum allowance for each hearing aid.** **Up to 2 hearing aids every year.** **Hearing aids must be purchased through NationsHearing to receive in-network benefits.**
In-Network	$0 Copay Subject to Benefit Maximum. Member is responsible for any amount after the benefit allowance has been applied.	**$0 Copay** **Subject to Benefit Maximum.** **Member is responsible for any amount after the benefit allowance has been applied.**
Out-of-Network	Member must submit receipts for reimbursement at 50% of maximum allowed. Subject to Benefit Maximum. Member is responsible for any amount after the benefit allowance has been applied.	**Member must submit receipts for reimbursement at 50% of maximum allowed.** **Subject to Benefit Maximum.** **Member is responsible for any amount after the benefit allowance has been applied.**