

## Summary of PPOBlue \$1,500 High-Deductible Value Benefits

With your PPO, or Preferred Provider Organization, if you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. Below are specific benefit levels that apply during your benefit period.

### Municipal Employers Insurance Trust (MEIT)

Benefit	Network	Out-of-Network
<b>Benefit Period</b> <sup>(1)</sup>	Contract Year	
<b>Deductible</b> (per benefit period)		
Individual	\$1,500	\$3,000
Family	\$3,000	\$6,000
<b>Plan Payment Level</b> – Based on the provider's reasonable charge (PRC)	100% after deductible	80% after deductible
<b>Autism Spectrum Disorders Maximum</b> (per person) <sup>(2)</sup>	\$36,000/benefit period	
<b>Out-of-Pocket Maximums</b> (Once met, plan payment level becomes 100%)		
Individual	None	\$5,000
Family	None	\$10,000
<b>Lifetime Maximum</b> (per person)	\$5,000,000 Combined	
<b>Primary Care Physician Office Visits</b>	100% after \$10 copayment	80% after deductible
<b>Specialist Office Visits</b>	100% after \$25 copayment	80% after deductible
<b>Preventive Care</b>		
<i>Adult</i>		
Routine physical exams	100% after \$10 copayment	Not Covered
Adult Immunizations	100% after deductible	80% after deductible
Colorectal Cancer Screening		
Diagnostic Services	100% after deductible	80% after deductible
Medical Surgical	100% after deductible	80% after deductible
Routine gynecological exams, including a Pap Test	100% after \$25 copayment	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	80% after deductible
<i>Pediatric</i>		
Routine physical exams	100% after \$10 copayment	Not Covered
Pediatric immunizations	100% (deductible does not apply)	80% (deductible does not apply)
<b>Emergency Room Services</b>	100% after \$100 copayment (waived if admitted)	
<b>Spinal Manipulations</b>	100% after \$25 copayment	80% after deductible
	Limit: 20 visits/benefit period	
<b>Physical Medicine</b>	100% after \$25 copayment	80% after deductible
	Limit: 20 visits/benefit period	
<b>Speech Therapy</b>	100% after \$25 copayment	80% after deductible
	Limit: 20 visits/benefit period	
<b>Occupational Therapy</b>	100% after \$25 copayment	80% after deductible
	Limit: 20 visits/benefit period	
<b>Allergy Extracts and Injections</b>	100% after deductible	80% after deductible
<b>Applied Behavior Analysis for Autism Spectrum Disorders</b> <sup>(2)</sup>	100% after deductible	80% after deductible
<b>Ambulance</b>	100% after network deductible	
<b>Assisted Fertilization Procedures</b>	Not Covered	
<b>Dental Services Related to Accidental Injury</b>	100% after deductible	80% after deductible
<b>Diabetes Treatment</b>	100% after deductible	80% after deductible
<b>Diagnostic Services</b> (including routine)		
<i>Advanced Imaging</i> (MRI, CAT Scan, PET scan, etc.)	100% after deductible	80% after deductible
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible

