Public Partnerships Home Care LLC
Employee Benefit Summary – SecureHealth Plus Plan
Network: National PPO (BlueCard PPO) Network
Effective Date: 01/01/2026

Benefit	In-Network	Out-Of-Network
Plan Deductible	$2,000 Individual $4,000 Family	$12,700 Individual $25,400 Family
Any Other Deductible	N/A	N/A
Deductible – Accumulation	Embedded	Embedded
Deductible – INN and OON integration	In-Network and Out-of-Network accumulate separately	
Member Coinsurance	20%	0%
Out of Pocket Maximum	$9,450 Individual $18,900 Family	$12,700 Individual $25,400 Family
Out of Pocket – Accumulation	Embedded	Embedded
Out of Pocket – INN and OON integration	In-Network and Out-of-Network accumulate separately	
Annual Benefit Maximum	Unlimited	Unlimited
Benefit Period	Calendar Year	1/1 – 12/31

Prescription Drug Benefits
Carelon Rx 1-833-271-2374 www.anthem.com

Plan Deductible does not apply. No Charge for Preventive PPACA mandated medications. If a prescription is filled with a non-generic drug when a generic equivalent exists, member will be responsible for the cost difference between the non-generic drug and the generic equivalent.

Generic (Tier 1)	**No cost for Preventive Rx Drugs** **30-day supply:** $15 Copay per drug **Mail Order up to 90-day supply:** $37.50 Copay per drug	Not Covered
Preferred (Tier 2)	**30-day supply:** $60 Copay per drug **Mail Order up to 90-day supply:** $150 Copay per drug	Not Covered
Non-Limited/Non-Preferred (Tier 3)	**30-day supply:** $120 Copay per drug **Mail Order up to 90-day supply:** $300 Copay per drug	Not Covered
Specialty (Tier 4)	**30-day supply:** $150 Copay per drug **Retail 30-day supply:** $150 Copay per drug **Mail Order:** Not Covered **Prescription cost limitation** of $12,500 per drug/per fill applies. Drugs that cost over $12,500 per 30 day supply per prescription are excluded from coverage.	Not Covered

Preventive Medical Services

Benefit	In-Network	Out-Of-Network
Primary Care Physician Office: Adult Routine Physical - 1 visit per benefit period.	No Charge (Deductible Waived)	Not Covered
Pediatrician - Well Child Care: Up to age 2 - 9 visits per benefit period Age 2 – 2 visits per benefit period Age 3 and more – 1 visit per benefit period	No Charge (Deductible Waived)	Not Covered
Children Eye Exam	No Charge (Deductible Waived)	Not Covered
Gynecological - Adult Routine Physical - 1 visit per benefit period.	No Charge (Deductible Waived)	Not Covered

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Maternity (ACA Required Prenatal /Postnatal Testing/Services only)	No Charge (Deductible Waived)	Not Covered
Routine Immunizations (Child & Adult)	No Charge (Deductible Waived)	Not Covered
Flu Shot (Routine)	No Charge (Deductible Waived)	Not Covered
X-Rays and Lab tests (Routine)	No Charge (Deductible Waived)	Not Covered
Mammography (Routine) – 1 per benefit period; Age 40 and more	No Charge (Deductible Waived)	Not Covered
Pap-smear (Routine) – 1 per benefit period	No Charge (Deductible Waived)	Not Covered
Prostate Cancer Screening PSA (Routine) - 1 per benefit period	No Charge (Deductible Waived)	Not Covered
Colon Cancer Screening (Routine) - age 45-75 Colonoscopy – 1 in 10 years Sigmoidoscopy – 1 in 3 years	No Charge (Deductible Waived)	Not Covered

Non-Preventive Medical Services			
Benefit	**In-Network**		**Out-Of-Network**
Primary Care Physician Visits	**Professional Non-Facility based Services:** $35 Copay/per visit	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Specialist Physician Visits	**Professional Non-Facility based Services:** $70 Copay/per visit	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Maternity Professional – Maternity care for a dependent child is excluded.	**Professional Non-Facility based Services:** $35 Copay/per visit	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Second Opinion – Surgical	**Professional Non-Facility based Services:** **PCP:** $35 Copay/per visit **Specialist:** $70 Copay/per visit	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Chiropractic Care – Limited to 30 visits per benefit period	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Telemedicine via Live Health Online at www.livehealthonline.com or 1-888-548-3432 Coverage includes Primary Care, Specialist Care, and Mental Health & Substance Use.	**PCP:** $35 Copay/per visit **Specialist:** $70 Copay/per visit **Mental Health:** $35 Copay/per visit		Not Covered

Non-Preventive Lab and Radiology			
Benefit	**In-Network**		**Out-Of-Network**
Lab and Pathology	**Office Setting or Independent Lab:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible

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X-Rays / Radiology	**Office Setting or Independent Lab:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
MRI / MRA; CT / CTA / PET Scan; Genetic testing and counseling beyond ACA mandated is covered. Preauthorization is required.	**Office Setting or Independent Lab:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Sleep Studies/Sleep Management Services	**Office Setting, Home, or Independent Lab** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Inpatient Services			
Benefit	**In-Network**		**Out-Of-Network**
Pre-Surgical / Pre-Admission Testing	20% Coinsurance after Deductible		No Charge after Plan Deductible
Hospital Stay: Includes Room and Board; Drugs and Medication; Anesthesia and ICU; Maternity Stay, Inpatient Lab; Maternity – newborn under mother for well-baby Preauthorization is required.	20% Coinsurance after Deductible		No Charge after Plan Deductible
Inpatient Physician Services	20% Coinsurance after Deductible		No Charge after Plan Deductible
Inpatient Maternity Professional	20% Coinsurance after Deductible		No Charge after Plan Deductible
Anesthesia	20% Coinsurance after Deductible		No Charge after Plan Deductible
Inpatient Surgery- Surgeon/ Assistant Surgeon Charges	20% Coinsurance after Deductible		No Charge after Plan Deductible
Inpatient Behavioral / Mental Health & Chemical/Substance / Alcohol Abuse. Preauthorization is required.	20% Coinsurance after Deductible		No Charge after Plan Deductible
Inpatient Detoxification Preauthorization is required.	20% Coinsurance after Deductible		No Charge after Plan Deductible
Inpatient Physical Medical Rehabilitation – Limited to 120 days per benefit period. (Combined limit with Skilled Nursing Facility) Limit is combined INN/OON. Preauthorization is required.	20% Coinsurance after Deductible		No Charge after Plan Deductible
Skilled Nursing Facility - Limited to 120 days per benefit period. (Combined limit with Inpatient Physical Medical Rehabilitation) Limit is combined INN/OON. Preauthorization is required.	20% Coinsurance after Deductible		No Charge after Plan Deductible

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Outpatient Services			
Benefit	**In-Network**		**Out-Of-Network**
Outpatient Surgery Facility Preauthorization is required.	20% Coinsurance after Deductible		No Charge after Plan Deductible
Outpatient Surgery -Physician / Surgeon / Assistant Surgeon	20% Coinsurance after Deductible		No Charge after Plan Deductible
Anesthesia	20% Coinsurance after Deductible		No Charge after Plan Deductible
Home Health Care – Limited to 120 visits per benefit period. Combined limit with Home Infusion. Limit is combined INN/OON. Patient not required to be homebound. Home Health Aides are covered. Preauthorization is required.	20% Coinsurance after Deductible		No Charge after Plan Deductible
Hospice – Facility or Home Preauthorization is required.	**Home Setting:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Behavioral/Mental Health & Chemical / Substance or Alcohol Abuse: Medication Management, Psych testing, Eating disorders, Bereavement counseling, Partial Hospitalization, Intensive Out-patient Therapy, and Methadone clinics are covered. Halfway Homes are not covered. Preauthorization is required for certain services.	**Professional Non-Facility based Services:** $35 Copay/per visit	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Therapy Services			
Benefit	**In-Network**		**Out-Of-Network**
Aural Therapy	Not Covered		Not Covered
Autism Spectrum Disorder – ABA Therapy is included Developmental delays included	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Cardiac Rehabilitation	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Chemotherapy	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Gene / Cellular Therapy	Not Covered		Not Covered
Dialysis / Hemodialysis Home Dialysis is covered	**All Settings including Outpatient Facility, Office, and Home:** 20% Coinsurance after Deductible		No Charge after Plan Deductible

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Home Infusion – Limited to 120 visits per benefit period. Combined limit with Home Health Care. Limit is combined INN/OON. Patient not required to be homebound.	20% Coinsurance after Deductible		No Charge after Plan Deductible
Home visits – Professional	20% Coinsurance after Deductible		No Charge after Plan Deductible
Infusion Therapy	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Medical Nutrition Therapy	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Occupational Therapy - Limited to 30 visits per benefit period. Combined limit with Physical and Speech Therapy. Limit is combined INN/OON. Preauthorization is required.	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Orthoptic / Pleoptic Therapy Limited to 8 visits per lifetime. Limit is combined INN/OON.	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Physical Therapy - Limited to 30 visits per benefit period. Combined limit with Occupational and Speech Therapy. Limit is combined INN/OON. Preauthorization is required.	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Pulmonary/Respiratory Therapy	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Radiation Therapy	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Speech Therapy - Limited to 30 visits per benefit period. Combined limit with Occupational and Physical Therapy. Limit is combined INN/OON. Preauthorization is required.	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible

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Emergency Services			
Benefit	**In-Network & Out-Of-Network**		
Emergency Care	$750 Copay after Plan Deductible		
Emergency Medical Transportation: Ground, Air, and Water Ambulance are covered.	20% Coinsurance after Deductible		
Urgent Care	$75 Copay/per visit		No Charge after Plan Deductible
Other Services			
Benefit	**In-Network**		**Out-Of-Network**
Abortion - Therapeutic Only (Elective not covered) maternity care for a dependent child is excluded. Complications from elective abortion is covered.	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Outpatient / Inpatient Facility:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Acupuncture - Limited to 15 visits per benefit period.	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Allergy Services / Injections – Copay is only for the office visit. Injections and serums are subject to plan deductible and coinsurance.	**Professional Non-Facility based Services:** **PCP:** $35 Copay/per visit **Specialist:** $70 Copay/per visit Injections and serums are covered at 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Allergy Testing	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Alternative Medicine	Not Covered		Not Covered
Ambulance Service – Non-Emergency Transport Ground Ambulance only.	20% Coinsurance after Deductible		No Charge after Plan Deductible
Bariatric Surgery	Not Covered		Not Covered
Biofeedback	Not Covered		Not Covered
Blood Processing / Blood Storage; Includes autologous donation and storage up to 30 days.	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Dental – Accident to sound teeth only. Treatment must be started within 3 months of injury. Routine Dental is excluded. Dental Anesthesia for those 7 and under is covered.	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible

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Durable Medical Equipment (Includes Diabetic Supplies) – includes repairs, and rentals. Breast Pumps are covered INN only at 100% per PPACA Guidelines; Electric pumps – limited to 1 every 36 months. Manual pumps – limited to 1 every pregnancy; Preauthorization is required on certain items.	20% Coinsurance after Deductible		No Charge after Plan Deductible
Foot Care (routine) – Diabetic/Circulatory disease only.	**Professional Non-Facility based Services:** **PCP:** $35 Copay/per visit **Specialist:** $70 Copay/per visit	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Gender Affirmation Surgery	20% Coinsurance after Deductible		No Charge after Plan Deductible
Hearing Aids Hearing Aids - (exams, fittings, and device) Limited to 1 device per ear every 3 years.	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Immunization (non-routine) Copay is only for the office visit. Injections are subject to plan deductible and coinsurance. Vaccinations for travel are excluded	**Professional Non-Facility based Services:** **PCP:** $35 Copay/per visit **Specialist:** $70 Copay/per visit Injections are covered at 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Infertility Services - Basic Testing Only. Infertility treatment is excluded	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Infertility Services – Comprehensive (AI) & Advanced (ZIFT/GIFT/IVF)	Not Covered		Not Covered
Injections - Copay is only for the office visit. Injections are subject to plan deductible and coinsurance.	**Professional Non-Facility based Services:** **PCP:** $35 Copay/per visit **Specialist:** $70 Copay/per visit Injections are covered at 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Medical Nutrition Products – PKU formulas and enteral feeding supplies. Over the counter formula, even with a prescription, is excluded.	20% Coinsurance after Deductible		No Charge after Plan Deductible
Medical Supplies	20% Coinsurance after Deductible		No Charge after Plan Deductible

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Nutritional Counseling – Diabetic; Limited to 6 visit per benefit period. Limit is combined INN/OON.	**Professional Non-Facility based Services:** **PCP:** $35 Copay/per visit **Specialist:** $70 Copay/per visit	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Nutritional Counseling – Nondiabetics Limited to 6 visit per benefit period. Limit is combined INN/OON.	**Professional Non-Facility based Services:** **PCP:** $35 Copay/per visit **Specialist:** $70 Copay/per visit	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Online visits - Telephone consultations are covered.	**PCP:** $35 Copay/per visit **Specialist:** $70 Copay/per visit **Mental Health:** $35 Copay/per visit		No Charge after Plan Deductible
Oral Surgery – Includes removal of impacted wisdom teeth.	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Orthotics and Prosthetic Devices – Diabetic shoes are covered.	20% Coinsurance after Deductible		No Charge after Plan Deductible
Private Duty Nursing	Not Covered		Not Covered
Respite Care	Not Covered		Not Covered
Retail Health Clinics	$75 Copay/per visit		No Charge after Plan Deductible
Sterilization – Men are covered at Deductible and coinsurance. Woman are covered INN only at 100% per PPACA guidelines.	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Sterilization Reversals	Not Covered		Not Covered
TMJ Treatment & Appliances	Not Covered		Not Covered
Vision Exams (Routine) and Hardware	Not Covered		Not Covered
Vision surgery – Post Cataract and Glaucoma surgeries coverage is provided for initial frames, lenses, or contacts.	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible	No Charge after Plan Deductible
Wigs – After Chemotherapy or Radiation	20% Coinsurance after Deductible		No Charge after Plan Deductible

Transplant Services
Centers of Excellence Locations Only

Benefit	**In-Network**	**Out-Of-Network**
Live Donor Health Services	20% Coinsurance after Deductible	Not Covered
Bone Marrow Donor Search – Limited to $10,000 Per Benefit period	20% Coinsurance after Deductible	Not Covered
Organ Transplant – Facility	20% Coinsurance after Deductible	Not Covered
Organ Transplant – Physician & anesthesiologist	20% Coinsurance after Deductible	Not Covered

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Travel and lodging for Organ Transplant	Maximum of $25,000 per Transplant	
Travel and lodging for Bone Marrow Donor Search	Maximum of $5,000 per Benefit period	
Preauthorization: Omni Advantage 1-866-794-6664 The following services require Preauthorization, or benefit will be reduced by 50%.		
Inpatient Services:	**Outpatient Services:**	**Other Services:**
Cervical Spine Surgery	Cartilage Transplant Knee	Bone Stimulator
Computer Navigation for Orthopedic Surgery	Cervical Spine Surgery	Cardio/External Defibrillator
Elective Admissions	Cochlear Implant	Cooling Devices
Emergency Admissions	Computer Navigation for Orthopedic Surgery	CPAP/BIPAP
Hospice	Lumbar Spine Surgery	Electric Scooters
Lumbar Spine Surgery	Mandibular/Maxillary Surgery (Orthognathic)	Infusion Pumps
Rehabilitation Facility Admissions	Mastectomy for Gynecomastia	Insulin Pumps
Sacroiliac Joint Fusion	Nasal Septoplasty	Limb Prosthetics
Skilled Nursing Facility Admissions	Reduction Mammoplasty	Myoelectric prosthetics
Transplants	Rhinoplasty	Neuromuscular Stimulators
	Sacroiliac Joint Fusion	TENS Unit
	Sclerotherapy (Lower Extremities)	Wheelchairs
Managed Care Services:	Sleep Apnea Surgery - LAUP/UPPP, Nasal, and Uvulopalatoplasty	Wound Vacs
Inpatient BH/SA	Botulinum Toxin – Review for Migraine Use Only	Azacitidine (Vidaza)
Electric Convulsive Therapy (ECT)	Home Health Services	Bevacizumab (Avastin) – Review for Non-Eye Only
Intensive Outpatient Therapy	Home Hospice	Bortezomib (Velcade)
Partial Hospitalization (PHO)	Hyperbaric Oxygen Therapy (Systemic/Topical)	Etanercept (Enbrel)
Residential Care (RTC)	Coronary CT Angiography (CCTA)	Fulvestrant (Faslodex)
Psychological testing	Coronary MRA	Immune Globulin (Intravenous)
Genetic Counseling	Cardiac MRI	Infliximab (Remicade)
	MRA of the Head and/or Neck	Ipilimumab (Yervoy)
	MRI of the Brain	Nivolumab (Opdivo)
	MRI of the Spine – Cervical, Thoracic, Lumbar, Sacral	Paclitaxel (Abraxane Only)
	PET Scan	Panitumubab (Vectibix)
	Physical/Occupational/Speech Therapy	Pembrolizumab (Keytruda)
		Pemetrexed (Alimta)

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		Rituximab (Rituxan) – Review for Non-Oncology Diagnosis/Treatment Only

Exclusions In addition to exclusions listed in the document, the following services are excluded from coverage under the Plan	
Abortion - Elective	Massage Therapy
Alternative Medicine/homeopathy	Maternity Care for a Dependent Child
Aquatic Therapy	Non-Emergency Care outside the U.S.
Arch supports (supportive shoe inserts)	Orthopedic Shoes/ orthopedic inserts – Non-diabetic
Bariatric Surgery	Private-duty Nursing
Biofeedback	Respite Care
Cosmetic Surgery (exclusion does not apply to breast reconstruction post-mastectomy)	Routine Eye Care (Adult) and Child except ACA allowed
Custodial Care	Routine Foot Care (non-diabetic/circulatory disease)
Dental Care (Routine) Adult and Child except ACA allowed	Self-Inflicted unless result of medical condition
Gene & Cellular Therapy	Sterilization Reversals
Growth Hormone Therapy	TMJ Treatment and Appliances
Halfway house/home – non-healthcare residential facility	Vision Exam and Hardware
Infertility Services (Comprehensive (AI) & Advanced (ZIFT/GIFT/IVF)	Weight Loss Programs
Long-Term Care	