GRANITE CONSTRUCTION (Post 65 Retiree)
2025 BC PPO $3,000/90/70

PPO Benefits

This summary of benefits has been updated to comply with federal requirements, including applicable provisions of the federal health care reform laws. As we receive additional guidance and clarification on the health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

In addition to dollar and percentage copays, enrolled persons are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. Members are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:

PPO Providers—PPO negotiated rates. Members are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-PPO Providers—For non-emergency services, the scheduled amount. For emergency services, same as other health care providers

Other Health Care Providers *(includes those not represented in the PPO provider network)*—

The maximum allowable charge for professional or institutional services. You are responsible for any amount billed in excess of the maximum allowable charge and any expense not covered under this Plan.

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible	
➢ **For All Providers**	$3,000 The applicable deductible for each insured person; a maximum of three separate deductibles for each family.
Deductible for emergency room services	$50/visit *(waived if admitted directly from ER)*
Annual Out-of-Pocket Maximums	
PPO Providers & Other Health Care Providers	$ 5,250/member/year or $11,200/family/year
Non-PPO Providers	$ 7,500/member/year or $11,200/family/year

The following do not apply to out-of-pocket maximums: non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for non-PPO providers & other health care providers, costs in excess of the covered expense; amounts related to a transplant unrelated donor search.

Lifetime Maximum	Unlimited	
Covered Services	**PPO: Per Member Copay**	**Non-PPO: Per Member Copay[1]**
Hospital Medical Services *(subject to utilization review for inpatient services; a $500 penalty will be applied for lack of pre-certification; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	10%	30%
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	10%	30%
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	10%	30%
Hemodialysis		
➢ Outpatient hemodialysis services & supplies	10%	30%
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	10%	30%
Hospice Care		
➢ Inpatient or outpatient services; family bereavement services	10%	30%

[1]The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	10%	30%
Home Infusion Therapy *(subject to utilization review)*		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%	30% *(benefit limited to $600/day)*
Physician Medical Services		
➢ Office & home visits	$25/visit[2] *(deductible waived)*	30%
➢ Hospital & skilled nursing facility visits	10%	30%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	30%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	10%	30%
➢ Other diagnostic x-ray & lab	10%	30%
Preventive Care Services *Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits*		
➢ Routine physical examinations *(birth through age six)*	No copay/exam *(deductible waived)*	30%
➢ Immunizations *(birth through age six)*	No copay *(deductible waived)*	30%
➢ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam *(members 7 years old and older)*	No copay/exam *(deductible waived)*	30%
➢ Adult preventive services *(including mammograms, Pap smears, prostate cancer screenings & colorectal cancer screenings)*	No copay *(deductible waived)*	30%
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(limited to 24 visits/calendar year; additional visits may be authorized)*	10%	30%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	10%	30%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 12 visits/calendar year)*	10%[3]	30%[3]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	10%[4]	
Pregnancy & Maternity Care		
➢ Physician office visits	$25/visit[2] *(deductible waived)*	30%
➢ Prescription drug for elective abortion *(mifepristone)*	10%	30%
Normal delivery, cesarean section, complications of pregnancy & abortion *(newborn routine nursery care covered when natural mother is subscriber or spouse/domestic partner)*		
➢ Inpatient physician services	10%	30%
➢ Hospital & ancillary services	10%	30%

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

[3] Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

[4] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Organ & Tissue Transplants *(subject to utilization review: a $500 penalty will be applied for lack of pre-certification; specified organ transplants covered only when performed at Centers of Medical Excellence [CME])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	10%	Not covered
➢ Transplant travel expense for an authorized, specified transplant at a *CME* *(recipient & companion transportation limited to $10,000 per transplant)*	No copay deductible waived	
➢ Unrelated donor search, limited to $30,000 per transplant		
Bariatric Surgery *(subject to utilization review; a $500 penalty will be applied for lack of pre-certification; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at Centers of Medical Excellence [CME])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	10%	No copay deductible waived
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric *CME* *(member's transportation to & from CME limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from CME limited to $130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*		
Cardiac Surgery, Orthopedic Surgery (includes Spine Surgery, Knee and Hip Replacement) *(subject to utilization review; a $500 penalty will be applied for lack of pre-certification. Covered only when performed at a Blue Distinction Center+ (BDC+) Center of Medical Excellence)*		
➢ Inpatient services provided in connection with medically necessary surgery	100%	Not covered
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach enrolled persons & their families about the disease process, the daily management of diabetic therapy & self-management training	10%	30%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts for members with diabetes	10%	30%
	20% for prosthetic devices billed by suppliers	
(no limitation for prostheses following a mastectomy or prosthetic devices following laryngectomy)		
Durable Medical Equipment		
➢ Rental or purchase of DME including hearing aids, dialysis equipment & supplies *(hearing aids benefit available for one hearing aid per ear every three years)*	10%	30%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	20%[2]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%[2]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	20%[2]	

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Emergency Care		
➢ Emergency room services & supplies *($50 deductible waived if admitted)*	10%	10%
➢ Inpatient hospital services & supplies	10%	10%
➢ Physician services	10%	10%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; a $500 penalty will be applied for lack of pre-certification; waived for emergency admissions)*	10%	30%
➢ Inpatient physician visits	10%	30%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10% (deductible waived)	10% (deductible waived)
➢ Outpatient physician visits	10% (deductible waived)	10% (deductible waived)

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Summary Plan Description, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

PPO Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Summary Plan Description.

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the Summary Plan Description.

Excess Amounts. Any amounts in excess of covered expense or any Medical Benefit Maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the member claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the Summary Plan Description.

Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the Summary Plan Description.

Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the Summary Plan Description.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the Summary Plan Description. Cosmetic dental surgery or other dental services for beautification.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the Summary Plan Description.
Eyeglasses or contact lenses, except as specified as covered in the Summary Plan Description.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the Summary Plan Description.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the Summary Plan Description.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this *plan*.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Summary Plan Description.

Sterilization Reversal.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic Supplies. Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related feet complications as specified as covered in the Summary Plan Description.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the Summary Plan Description.

Chronic Pain. Treatment of chronic pain, except as specified as covered in the Summary Plan Description.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a *physician*. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the Summary Plan Description. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not requirement either a written prescription or dispensing by a licensed pharmacist.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the Summary Plan Description.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the Summary Plan Description.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the Summary Plan Description. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the Summary Plan Description.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the Summary Plan Description.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Third Party Liability — Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Coordination of Benefits — The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.