General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$0	$300	
Deductible - Two Person	$0	$600	
Deductible - Family	$0	$600	Each individual does not exceed the single deductible.
Services that Apply to Deductible			Medical Only
Deductible Aggregation - Single and Family			Each family member is only subject to the single Deductible and any combination of family members can satisfy the family Deductible as long as one individual does not meet more than the single deductible. Individual
Deductible Aggregation - In Network and Out of Network			In Network and Out of Network aggregate separately
Deductible Carryover Months	No	No	
History Credit	No	No	
Coinsurance	0%	20%	
Annual Out of Pocket Maximum - Single	$5,125	$2,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Two Person	$10,250	$4,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Family	$10,250	$4,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Services that Apply to Out of Pocket Maximum			Medical Only
Annual Out of Pocket Maximum Aggregation - Single and Family			Each family member is only subject to the single Annual Out of Pocket Maximum any combination of family members can satisfy the family Annual Out of Pocket Maximum. Individual
Annual Out of Pocket Maximum Aggregation - In Network and Out of Network			In Network and Out of Network aggregate separately

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$8 Copayment	20% Coinsurance Subject to Deductible	
Cost Share - Specialist	$8 Copayment	20% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Limits Aggregation - In-network and Out of Network			In Network and Out of Network aggregate together
Annual Maximum			Unlimited
Lifetime Benefit Maximum			Unlimited
Kids Copay Age Limit			Does Not Apply
Kids Copay Age Applies To			Does Not Apply
Kids Copay Network			None
Referrals Required			No
HSA Funding for Single Tier			$0
HRA Funding for Single Tier			$0
Plan/Calendar Year			Calendar Year Benefits
Coordination of Benefits			Made Whole
Prior Authorization			Applies
Preauthorization - Vendor Managed			This plan requires prior authorization for Musculoskeletal (MSK), Radiology, Cardiac Services & Devices, and Radiation Therapy Services through eviCore healthcare. All plus MSK
Diabetic Preauthorization and Step Therapy			No
Patient Assurance Program			Does Not Apply
Medication Assurance Program			Does Not Apply
Prior Authorization - Medical Specialty Drugs			Applies

Precertification

Benefit Name	In Network	Out of Network	Limits and Additional Information
PreCertification			Does Not Apply
PreCertification Penalty			Does Not Apply

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Type of Tiers			2 Tier (EE / FAM)
Dependent Coverage			Age to which all dependents (excluding spouse) are covered 26
Dependent Age End Period			Age to which all dependents (excluding spouse) are covered End of Month
Domestic Partner Coverage			Not Covered

Additional Group Characteristics

Benefit Name	In Network	Out of Network	Limits and Additional Information
Total Employees			
Total Eligible			
Group Size			
Funding Arrangement			Minimum Premium
FMHP Exempt			No
Retiree Only			No
Sovereign Nation			No
Religious Group			No
Grandfathered			No

Allowable Expense

Allowable Expense

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility in Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 80 Percent of the Medicare Prospective Payment System or 100 Percent of Charge. If the service is not listed on the Medicare Prospective Payment System, we allow 80 Percent of average Negotiated Participating Amounts of like facilities or 100 Percent of Charge.	
Facility Out of Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 100 Percent of Negotiated Amount, 100 Percent of Multiplan, 100 Percent of average Negotiated Participating Amounts of like facilities or 100 Percent of Charge.	
Professional Healthcare Provider In Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 80 Percent of the Medicare Provider fee schedule or 100 Percent of Charge. If the service is not listed on the Medicare Provider fee schedule, we allow 75 Percent of Charge.	
Professional Healthcare Provider Out of Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 100 Percent of the Medicare Provider fee schedule or 100 Percent of Charge. If the service is not listed on the Medicare Provider fee schedule, we allow 75 Percent of Charge.	
Emergency Facility in Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 100 Percent of Qualified Payment Amount or 100 Percent of Charge.	
Emergency Facility Out of Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 100 Percent of Qualified Payment Amount or 100 Percent of Charge.	
Emergency Professional Healthcare Provider In Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 100 Percent of Qualified Payment Amount or 100 Percent of Charge.	
Emergency Professional Healthcare Provider Out of Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 100 Percent of Qualified Payment Amount or 100 Percent of Charge.	
Prehospital Emergency Services and Transport - Ground Ambulance including Interfacility Transfer In Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 80th Percentile of Fair Health or 100 Percent of Charge.	
Prehospital Emergency Services and Transport - Ground Ambulance including Interfacility Transfer Out of Area Within NYS	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 80th Percentile of Fair Health or 100 Percent of Charge.	
Prehospital Emergency Services and Transport - Ground Ambulance Out of Area Outside of NYS	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow 100 Percent of Charge.	
Air Ambulance In Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 100 Percent of Qualified Payment Amount or 100 Percent of Charge.	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Air Ambulance Out of Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 100 Percent of Qualified Payment Amount or 100 Percent of Charge.	
Dialysis Facility in Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 80 Percent of the Medicare Prospective Payment System or 100 Percent of Charge. If the service is not listed on the Medicare Prospective Payment System, we allow 80 Percent of average Negotiated Participating Amounts of like facilities or 100 Percent of Charge.	
Dialysis Facility Out of Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 100 Percent of Negotiated Amount, 100 Percent of Multiplan, 100 Percent of average Negotiated Participating Amounts of like facilities or 100 Percent of Charge.	
Dialysis Professional Healthcare Provider In Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 80 Percent of the Medicare Provider fee schedule or 100 Percent of Charge. If the service is not listed on the Medicare Provider fee schedule, we allow 75 Percent of Charge.	
Dialysis Professional Healthcare Provider Out of Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 100 Percent of the Medicare Provider fee schedule or 100 Percent of Charge. If the service is not listed on the Medicare Provider fee schedule, we allow 75 Percent of Charge.	

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Residential Care	Covered in Full	20% Coinsurance Subject to Deductible	
Substance Use Detoxification	Covered in Full	20% Coinsurance Subject to Deductible	
Substance Use Rehabilitation	Covered in Full	20% Coinsurance Subject to Deductible	
Substance Use Residential Care	Covered in Full	20% Coinsurance Subject to Deductible	
Skilled Nursing Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Physical Rehabilitation	Covered in Full	20% Coinsurance Subject to Deductible	
Maternity Care	Covered in Full	20% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Routine Newborn Nursery Care	Covered in Full	20% Coinsurance Subject to Deductible	
Prosthetic - Implanted Devices	Covered in Full	20% Coinsurance Subject to Deductible	
Mastectomy	Covered in Full	20% Coinsurance Subject to Deductible	
Observation Stay	$35 Copayment	$35 Copayment	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.Out-of-Network is payable at the in-network level if procedure is associated with an in-network hospital or provider.
In Hospital Physician Visits and Consults	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	$8 Copayment	20% Coinsurance Subject to Deductible	
Colonoscopy Facility Diagnostic	$8 Copayment	20% Coinsurance Subject to Deductible	
Preadmission Pre-Operative Testing	Covered in Full	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	$8 Copayment	20% Coinsurance Subject to Deductible	
Routine X-ray	$8 Copayment	20% Coinsurance Subject to Deductible	
Advanced Imaging Services	$8 Copayment	20% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans.
Mammography Facility Diagnostic	Covered in Full	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible	
Routine Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible	
Diagnostic Testing	$8 Copayment	20% Coinsurance Subject to Deductible	
Radiation Therapy	$8 Copayment	20% Coinsurance Subject to Deductible	
Chemotherapy	$8 Copayment	20% Coinsurance Subject to Deductible	
Infusion Therapy	$8 Copayment	20% Coinsurance Subject to Deductible	
Dialysis	Covered in Full	20% Coinsurance Subject to Deductible	
Injectable Drugs	$8 Copayment	20% Coinsurance Subject to Deductible	Excludes vaccines, allergy injections & treatment of diabetes.

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mental Health Care	$8 Copayment	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	$8 Copayment	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Opioid Treatment Program	Covered in Full	20% Coinsurance Subject to Deductible	
Autism Applied Behavior Analysis	$8 Copayment	20% Coinsurance Subject to Deductible	
Substance Use Family Counseling	$8 Copayment	20% Coinsurance Subject to Deductible	
Pulmonary Rehabilitation	$8 Copayment	20% Coinsurance Subject to Deductible	
Cardiac Rehabilitation	$8 Copayment	20% Coinsurance Subject to Deductible	

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	Covered in Full	20% Coinsurance Subject to Deductible	
Home Infusion Therapy	Covered in Full	20% Coinsurance Subject to Deductible	Services must be ordered by a Physician/ authorized Health Care Professional and provided by an agency or office licensed/ certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care).

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	20% Coinsurance Subject to Deductible	
Hospice Care Outpatient	Covered in Full	20% Coinsurance Subject to Deductible	
Family Bereavement	Covered in Full	20% Coinsurance Subject to Deductible	5 Visits per calendar year

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Outpatient Hospital and Ambulatory Surgery	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Office Surgery	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.Out-of-Network is payable at the in-network level if procedure is associated with an in-network hospital or provider.
Colonoscopy Professional Diagnostic	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Routine X-ray	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
Advanced Imaging Services	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans
Mammography Professional Diagnostic	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Routine Laboratory and Pathology	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Diagnostic Testing	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
Dialysis	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Injectable Drugs	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	Excludes vaccines, allergy injections & treatment of diabetes.
Mental Health Care	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
Substance Use Treatment	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
Opioid Treatment Program	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	Covered in full after the initial visit
Autism Applied Behavior Analysis	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
Additional Surgical Opinion	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
Second Medical Opinion for Cancer	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
Pulmonary Rehabilitation	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
Cardiac Rehabilitation	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
Office Visits - Diagnostic	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	Covered for the diagnosis and treatment of injury, disease and medical conditions. All professional provider specialties e.g. GYN, cardiac, orthopedists, etc. are included. This also includes eye exams or hearing exams for the diagnosis or treatment of illness or injury. Office visits may include house calls.
Telehealth	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - $8 Copayment	Not Covered	Covers online internet consultations between the member and the providers who participate in our Telemedicine MDLive and, if applicable, Vori Health Program for medical, behavioral health, and physical therapy conditions that are not emergency conditions.
Medications Administered in Office	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	Excludes injections for vaccines, allergy injections & treatment of diabetes.
Eye Exams Diagnostic	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
Hearing Evaluations Diagnostic	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Chiropractic Care	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	Maintenance Chiropractic Care covered with a limit of 8 visits per calendar year
Allergy Testing	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums). Allergy Serum INN Covered in Full
Hearing Evaluations Routine	PCP/Specialist - Not Covered	Not Covered	Not Covered
Adult Hearing Aids	PCP/Specialist - Not Covered	Not Covered	Not Covered
Pediatric Hearing Aid Age Limit			Does Not Apply
Pediatric Hearing Aids	PCP/Specialist - Not Covered	Not Covered	Not Covered
Cochlear Implants	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$8 Copayment	20% Coinsurance Subject to Deductible	30 Visits per calendar year
Occupational Rehabilitation	$8 Copayment	20% Coinsurance Subject to Deductible	30 Visits per calendar year
Speech Rehabilitation	$8 Copayment	20% Coinsurance Subject to Deductible	30 Visits per calendar year
Physical Habilitation	$8 Copayment	20% Coinsurance Subject to Deductible	30 Visits per calendar year
Occupational Habilitation	$8 Copayment	20% Coinsurance Subject to Deductible	30 Visits per calendar year
Speech Habilitation	$8 Copayment	20% Coinsurance Subject to Deductible	30 Visits per calendar year

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	30 Visits per calendar year
Occupational Rehabilitation	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	30 Visits per calendar year
Speech Rehabilitation	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	30 Visits per calendar year
Physical Habilitation	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	30 Visits per calendar year
Occupational Habilitation	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	30 Visits per calendar year
Speech Habilitation	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	30 Visits per calendar year

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	Not Covered	1 Exam per calendar year
Adult Immunizations	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Routine GYN Visit	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Family Planning	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Pre/Post-Natal Care 2nd Tier	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Preventive	N/A	N/A	
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
Treatment of Diabetes - Insulin	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Diabetic Education	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
Diabetic Retail Max Day Supply	N/A		
Diabetic Retail Copay for Max Day Supply	N/A		
Diabetic Mail Order Max Day Supply	N/A		
Diabetic Mail Order Copay for Max Day Supply	N/A		
Autism Assistive Communication Device	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
Autologous Blood Banking	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance	50% Coinsurance Subject to Deductible	
Mastectomy Prosthesis	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Orthotics	PCP/Specialist - 20% Coinsurance	Not Covered	
Foot Orthotics	PCP/Specialist - 20% Coinsurance	Not Covered	
Prosthetic - External Benefit	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Prosthetic - Wigs External Benefit	PCP/Specialist - Not Covered	Not Covered	Not Covered
Medical Supplies	PCP/Specialist - 20% Coinsurance	50% Coinsurance Subject to Deductible	
Breast Pump Purchase or Rental	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	1 Rental or Purchase per pregnancy
Acupuncture	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	6 Visits per calendar year
Reproductive Services	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered
PUVA Treatment	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
Nutritional Therapy	PCP/Specialist - Not Covered	Not Covered	Not Covered
Biofeedback	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	

Diagnoses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Accidental Dental	PCP/Specialist - Included	Included Subject to Deductible	
Dental Oral Surgery	PCP/Specialist - Included	Included Subject to Deductible	
Temporomandibular Joint (TMJ)	PCP/Specialist - Included	Included Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Nutritional Counseling	PCP/Specialist - Included	Included Subject to Deductible	
Inherited Metabolic Disorder - PKU	PCP/Specialist - Included	Included Subject to Deductible	
Infertility Care	PCP/Specialist - Included	Included Subject to Deductible	Coverage for the diagnosis and treatment (surgical and medical) of infertility. Effective 1/1/2020. upon group renewal there are no age restrictions and the benefit now includes fertility preservation when a medical treatment will directly or indirectly lead to iatrogenic infertility and 3 cycles of in-vitro fertilization.
Organ and Bone Marrow Transplants	PCP/Specialist - Included	Included Subject to Deductible	
Elective Sterilization - Female	PCP/Specialist - Included	Included Subject to Deductible	
Elective Sterilization - Male	PCP/Specialist - Included	Included Subject to Deductible	
Interruption of Pregnancy	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Reimbursement for Travel and Lodging Expenses	PCP/Specialist - Not Covered	Not Covered	Not Covered

Custom Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Respiratory Therapy	$8 Copayment	20% Coinsurance Subject to Deductible	

Custom Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Massage Therapy	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	12 Visits per calendar year
Routine Podiatry Care	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	
Respiratory Therapy	PCP/Specialist - $8 Copayment	20% Coinsurance Subject to Deductible	

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	$35 Copayment	$35 Copayment	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

ER Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physician Emergency Room Visit	PCP/Specialist - Covered in Full	Covered in Full	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	$35 Copayment	$35 Copayment	
Air Ambulance	$35 Copayment	$35 Copayment	
Ambulance - Inter Hospital Transportation	$35 Copayment	$35 Copayment	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$8 Copayment	$8 Copayment	

Urgent Care - Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physician Urgent Care Center Visit	PCP/Specialist - Covered in Full	Covered in Full	
Physician Office Visit for Urgent Care	PCP/Specialist - $8 Copayment	$8 Copayment	

Total Health Management Programs

Medical Management Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Case Management Program			Applies Yes
Case Management Behavioral Health Program			Applies Yes
Disease Management Program			Applies Yes
Health Promotion			Applies Yes

Wellness Programs

Benefit Name	In Network	Out of Network	Limits and Additional Information
Certified Partners			N/A
Surgery Decision Program			N/A

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Vision Age Limit			Does Not Apply
Pediatric Eye Exams - Routine	Not Covered	Not Covered	
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	Not Covered	Not Covered	
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			Drug Coverage Excluded

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
$0 Generics for Kids	Not Covered		
Generics for Kids Age Limit	Does not apply		
MAC Penalty	Not Covered		
Step Therapy	Not Covered		
Prior Authorization	Not Covered		
Oral Contraceptives	Not Covered		
Mandatory MO for Maintenance Drugs	Not Covered		
Days Supply Per Retail Order	Not Covered		
Days Supply Per Mail Order	Not Covered		
Copays Per Mail Order Supply	Not Covered		
Deductible	Not Covered		
Family Deductible	Not Covered		
Deductible applies to	Not Covered		
Embedded Rx	No		
Annual benefit maximum	Not Covered		
Benefit maximum applies to	Not Covered		
OOP Maximum	Not Covered		
OOP Maximum Applies to	Not Covered		

Exclusions

Exclusions

Benefit Name	Excluded
Convalescent and Custodial Care	Yes
Cosmetic Services	Yes
Dental Services	Yes
Experimental or Investigational Treatment	Yes
Felony Participation	Yes

Benefit Name	Excluded
Government Facility	Yes
Medicare or Other Governmental Program	Yes
Military Service	Yes
No-Fault Automobile Insurance	Yes
Services Not Listed	Yes
Services with No Charge	Yes
War	Yes
Workers Compensation	Yes

The group has reviewed the benefit grid 2171925-1 and accepts the benefits as indicated.

Signature of Group Administrator: _____

Date: _____

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.