Excellus

Excellus BluePPO Signature Deduct 4

$10/$35/$70 Integrated Rx

Benefit Time Period: 01/01/2023 - 12/31/2023

CAYUGA MEDICAL ASSOCIATES

General Information

Cost Sharing Expenses

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$1,500	$2,800	$5,600	
Deductible - Two Person	$3,000	$5,600	$11,200	
Deductible - Family	$3,000	$5,600	$11,200	
Services that Apply to Deductible				Medical plus drug
Deductible Aggregation - Single and Family				The entire family annual deductible must be met before copay or coinsurance is applied for any individual family member. If the family deductible amount exceeds the out of pocket maximum per person cap, the individual cannot contribute more than the out of pocket maximum per person cap amount for the plan year. Family
Deductible Aggregation - In Network and Out of Network				Domestic and In Network aggregate together; Out of Network aggregates separately
Deductible Carryover Months	No	No	No	
History Credit	No	No	No	
Coinsurance	0%	0%	40%	
Annual Out of Pocket Maximum - Single	$2,800	$5,500	$11,000	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	$5,600	$11,000	$22,000	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	$5,600	$11,000	$22,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Annual Out of Pocket Maximum - Per Person Cap	$6,650	$6,650	$22,000	The Out-of-Pocket Maximum Per Person Cap includes deductible, coinsurance, copays and prescription drugs. If a member under a family contract meets the Out-Of-Pocket Maximum Per Person Cap amount, the individual will no longer pay for covered services and claims will be paid at 100% of the allowable amount by the Health Plan for the remainder of the plan year. The remaining annual out-of-pocket maximum still needs to be met by any combination of family members on the contract before claims are paid at 100% for the whole family.
Services that Apply to Out of Pocket Maximum				Medical plus drug
Annual Out of Pocket Maximum Aggregation - Single and Family				The entire Family Annual Out-of-Pocket Maximum must be met before family members receive covered services processed at 100% of the allowable amount for the remainder of the plan year. An individual member covered under a family plan may not exceed the Out-of-Pocket Maximum per person cap amount for that plan year, should the family Out-of-Pocket Maximum level exceed the Out-of-Pocket Maximum Per Person Cap. Family
Annual Out of Pocket Maximum Aggregation - In Network and Out of Network				Domestic and In Network aggregate together; Out of Network aggregates separately

Office Visit Cost Shares

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$25 Copayment Subject to Deductible	$25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Cost Share - Specialist	$40 Copayment Subject to Deductible	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	Domestic	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				19
Kids Copay Age Applies To				PCP only
Kids Copay Network				In
Referrals Required				No
HSA Funding for Single Tier				$0

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
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 Radiology, Cardiac Services & Devices, and Radiation Therapy services through eviCore healthcare. All
Diabetic Preauthorization and Step Therapy				Applies
Patient Assurance Program				Does Not Apply
Prior Authorization - Medical Specialty Drugs				Does Not Apply
Medical Preventive Services Prior to Deductible				No

Precertification

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

Who is Covered

Benefit Name	Domestic	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				Covered

Additional Group Characteristics

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Total Employees				253
Total Eligible				0
Group Size				Large Group
Funding Arrangement				ASC

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
FMHP Exempt				No
Retiree Only				No
Sovereign Nation				No
Religious Group				No
Grandfathered				No

Allowable Expense

Allowable Expense

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Facility in Area		Negotiated Amount. Member's cost share is based on Charge if Lower than Negotiated Rate	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 75 Percent of Charge.	
Facility Out of Area		Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 150 Percent of the Medicare Prospective Payment System, 100 Percent of Blue Card allowance or 100 Percent of Charge. If the service is not listed on the Medicare Prospective Payment System, we allow 75 Percent of Charge.	
Professional Healthcare Provider In Area		Lower of Negotiated Amount or Charge	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		Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 150 Percent of the Medicare Provider fee schedule, 100 Percent of Blue Card allowance 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 Charge if Lower than Negotiated Rate	We allow the lesser of 100 Percent of the Negotiated Amount or 100 Percent of Charge.	

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Emergency Facility Out of Area		Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 100 Percent of the Negotiated Amount, 100 Percent of Blue Card allowance or 100 Percent of Charge.	
Emergency Professional Healthcare Provider In Area		Lower of Negotiated Amount or Charge	We allow the lesser of 100 Percent of the Negotiated Amount or 100 Percent of Charge.	
Emergency Professional Healthcare Provider Out of Area		Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 100 Percent of the Negotiated Amount, 100 Percent of Blue Card allowance or 100 Percent of Charge.	
Prehospital Emergency Services and Transport - Ground Ambulance Out of Area		Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 100 Percent of the Negotiated Amount, 100 Percent of Blue Card allowance or 100 Percent of Charge.	
Dialysis Facility in Area		Negotiated Amount. Member's cost share is based on Charge if Lower than Negotiated Rate	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 75 Percent of Charge.	
Dialysis Facility Out of Area		Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 150 Percent of the Medicare Prospective Payment System, 100 Percent of Blue Card allowance or 100 Percent of Charge. If the service is not listed on the Medicare Prospective Payment System, we allow 75 Percent of Charge.	
Dialysis Professional Healthcare Provider In Area		Lower of Negotiated Amount or Charge	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		Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 150 Percent of the Medicare Provider fee schedule, 100 Percent of Blue Card allowance 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	Domestic	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	$1,000 Copayment Subject to Deductible	$1,000 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	$1,000 Copayment Subject to Deductible	$1,000 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Residential Care	$1,000 Copayment Subject to Deductible	$1,000 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Substance Use Detoxification	$1,000 Copayment Subject to Deductible	$1,000 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Substance Use Rehabilitation	$1,000 Copayment Subject to Deductible	$1,000 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Substance Use Residential Care	$1,000 Copayment Subject to Deductible	$1,000 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Skilled Nursing Facility	$1,000 Copayment Subject to Deductible	$1,000 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	45 Days per plan year Limits are combined INN and OON.
Physical Rehabilitation	$1,000 Copayment Subject to Deductible	$1,000 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per plan year Limits are combined INN and OON.
Maternity Care	$1,000 Copayment Subject to Deductible	$1,000 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Routine Newborn Nursery Care	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	
Prosthetic - Implanted Devices	$0 Copayment Subject to Deductible	$0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Mastectomy	$1,000 Copayment Subject to Deductible	$1,000 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Observation Stay	$250 Copayment Subject to Deductible	$250 Copayment Subject to Deductible	$250 Copayment Subject to $2,800 Deductible	

Inpatient Professional Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - $0 Copayment Subject to Deductible	PCP/Specialist - $0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - $0 Copayment Subject to Deductible	PCP/Specialist - $0 Copayment Subject to Deductible	$0 Copayment Subject to $2,800 Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.
In Hospital Physician Visits and Consults	PCP/Specialist - $0 Copayment Subject to Deductible	PCP/Specialist - $0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	$250 Copayment Subject to Deductible	$250 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Colonoscopy Facility Diagnostic	$250 Copayment Subject to Deductible	$250 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Preadmission Pre-Operative Testing	$0 Copayment Subject to Deductible	$0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Diagnostic X-ray	$40 Copayment Subject to Deductible	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Routine X-ray	$40 Copayment Subject to Deductible	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Advanced Imaging Services	$40 Copayment Subject to Deductible	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans.
Mammography Facility Diagnostic	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	$0 Copayment Subject to Deductible	$0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Routine Laboratory and Pathology	$0 Copayment Subject to Deductible	$0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Testing	$0 Copayment Subject to Deductible	$0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	$40 Copayment Subject to Deductible	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	$25 Copayment Subject to Deductible	$25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	$0 Copayment Subject to Deductible	$0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Injectable Drugs	Inclusive of Primary Service	Inclusive of Primary Service	Inclusive of Primary Service	Excludes vaccines, allergy injections & treatment of diabetes. Cost share is inclusive of services in which the injection is rendered with.
Mental Health Care	$25 Copayment Subject to Deductible	$25 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	$0 PCP Copay for members to age 19 for Domestic and In-Network. Includes Partial Hospitalization
Substance Use Care	$25 Copayment Subject to Deductible	$25 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	$0 PCP Copay for members to age 19 for Domestic and In-Network. Includes Partial Hospitalization
Autism Applied Behavior Analysis	$25 Copayment Subject to Deductible	$25 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	$0 PCP Copay for members to age 19 for Domestic and In-Network.
Substance Use Family Counseling	$25 Copayment Subject to Deductible	$25 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	$0 PCP Copay for members to age 19 for Domestic and In-Network.
Pulmonary Rehabilitation	$40 Copayment Subject to Deductible	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Cardiac Rehabilitation	$40 Copayment Subject to Deductible	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	

Home and Hospice Care

Home Care

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Home Care	$0 Copayment Subject to Deductible	$0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Home Infusion Therapy	$0 Copayment Subject to Deductible	$0 Copayment Subject to Deductible	40% 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	Domestic	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	$0 Copayment Subject to Deductible	$0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Hospice Care Outpatient	$0 Copayment Subject to Deductible	$0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Family Bereavement	$0 Copayment Subject to Deductible	$0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	5 Visits per plan year

Outpatient and Office Professional Services

Professional Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Outpatient Hospital and Ambulatory Surgery	PCP/Specialist - $0 Copayment Subject to Deductible	PCP/Specialist - $0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Office Surgery	PCP -$25 Copayment Specialist -$40 Copayment Subject to Deductible	PCP - $25 Copayment Specialist - $40 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	$0 PCP Copay for members to age 19 for Domestic and In-Network.
Anesthesia	PCP/Specialist - $0 Copayment Subject to Deductible	PCP/Specialist - $0 Copayment Subject to Deductible	$0 Copayment Subject to $2,800 Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.
Colonoscopy Professional Diagnostic	PCP/Specialist - $0 Copayment Subject to Deductible	PCP/Specialist - $0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - $40 Copayment Subject to Deductible	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Routine X-ray	PCP/Specialist - $40 Copayment Subject to Deductible	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Advanced Imaging Services	PCP/Specialist - $40 Copayment Subject to Deductible	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans.
Mammography Professional Diagnostic	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - $0 Copayment Subject to Deductible	PCP/Specialist - $0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Routine Laboratory and Pathology	PCP/Specialist - $0 Copayment Subject to Deductible	PCP/Specialist - $0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Diagnostic Testing	PCP/Specialist - $0 Copayment Subject to Deductible	PCP/Specialist - $0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - $40 Copayment Subject to Deductible	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - $25 Copayment Subject to Deductible	PCP/Specialist - $25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - Inclusive of Primary Service	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP/Specialist - $0 Copayment Subject to Deductible	PCP/Specialist - $0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Injectable Drugs	PCP/Specialist - Inclusive of Primary Service	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	Excludes vaccines, allergy injections & treatment of diabetes. Cost share is inclusive of services in which the injection is rendered with.
Mental Health Care	PCP/Specialist - $25 Copayment Subject to Deductible	PCP/Specialist - $25 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	$0 PCP Copay for members to age 19 for Domestic and In-Network.
Substance Use Treatment	PCP/Specialist - $25 Copayment Subject to Deductible	PCP/Specialist - $25 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	$0 PCP Copay for members to age 19 for Domestic and In-Network.
Maternity Care	PCP/Specialist - $0 Copayment Subject to Deductible	PCP/Specialist - $0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Autism Applied Behavior Analysis	PCP/Specialist - $25 Copayment Subject to Deductible	PCP/Specialist - $25 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	$0 PCP Copay for members to age 19 for Domestic and In-Network.
Additional Surgical Opinion	PCP -$25 Copayment Specialist -$40 Copayment Subject to Deductible	PCP - $25 Copayment Specialist - $40 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	$0 PCP Copay for members to age 19 for Domestic and In-Network.
Second Medical Opinion for Cancer	PCP -$25 Copayment Specialist -$40 Copayment Subject to Deductible	PCP - $25 Copayment Specialist - $40 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	$0 PCP Copay for members to age 19 for Domestic and In-Network.
Pulmonary Rehabilitation	PCP/Specialist - $40 Copayment Subject to Deductible	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Cardiac Rehabilitation	PCP/Specialist - $40 Copayment Subject to Deductible	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Office Visits - Diagnostic	PCP -$25 Copayment Specialist -$40 Copayment Subject to Deductible	PCP - $25 Copayment Specialist - $40 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	$0 PCP Copay for members to age 19 for Domestic and In-Network. 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 - $0 Copayment Subject to Deductible	PCP/Specialist - $0 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	$0 PCP Copay for members to age 19 for Domestic and In-Network.
TeleMedicine Program	PCP/Specialist - Not Covered	PCP/Specialist - $0 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	Not Covered	Covers online internet consultations between the member and the providers who participate in our TeleMedicine MDLive Program for medical and behavioral health conditions that are not emergency conditions.
Medications Administered in Office	PCP/Specialist - Inclusive of Primary Service	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	Excludes injections for vaccines, allergy injections & treatment of diabetes.
Eye Exams Diagnostic	PCP/Specialist - $40 Copayment Subject to Deductible	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Hearing Evaluations Diagnostic	PCP/Specialist - $40 Copayment Subject to Deductible	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Chiropractic Care	PCP/Specialist - $25 Copayment Subject to Deductible	PCP/Specialist - $25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Allergy Testing	PCP -$25 Copayment Specialist -$40 Copayment Subject to Deductible	PCP - $25 Copayment Specialist - $40 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	$0 PCP Copay for members to age 19 for Domestic and In-Network. Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - $0 Copayment Subject to Deductible	PCP/Specialist - $0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - $40 Copayment Subject to Deductible	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	1 Exam per plan year Limits are combined INN and OON.
Adult Hearing Aids	PCP/Specialist - $0 Copayment Subject to Deductible	PCP/Specialist - $0 Copayment Subject to Deductible	0% Coinsurance Subject to Deductible	1 Purchase every 3 years
Pediatric Hearing Aid Age Limit				19
Pediatric Hearing Aids	PCP/Specialist - $0 Copayment Subject to Deductible	PCP/Specialist - $0 Copayment Subject to Deductible	0% Coinsurance Subject to Deductible	1 Purchase every 3 years
Cochlear Implants	PCP/Specialist - $0 Copayment Subject to Deductible	PCP/Specialist - $0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	

Rehab and Habilitation

Outpatient Facility

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$40 Copayment Subject to Deductible	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	$40 Copayment Subject to Deductible	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	$40 Copayment Subject to Deductible	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Physical Habilitation	$40 Copayment Subject to Deductible	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Habilitation	$40 Copayment Subject to Deductible	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Habilitation	$40 Copayment Subject to Deductible	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Outpatient Professional Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - $40 Copayment Subject to Deductible	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	PCP/Specialist - $40 Copayment Subject to Deductible	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	PCP/Specialist - $40 Copayment Subject to Deductible	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Physical Habilitation	PCP/Specialist - $40 Copayment Subject to Deductible	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Habilitation	PCP/Specialist - $40 Copayment Subject to Deductible	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Habilitation	PCP/Specialist - $40 Copayment Subject to Deductible	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	1 Exam per plan year
Adult Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Family Planning	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	

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

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - $40 Copayment Subject to Deductible	PCP/Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	

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

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	$40 Copayment Subject to Deductible	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Preventive	N/A	N/A	N/A	
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - $25 Copayment Subject to Deductible	PCP/Specialist - $25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Education	PCP/Specialist - $25 Copayment Subject to Deductible	PCP/Specialist - $25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP/Specialist - $25 Copayment Subject to Deductible	PCP/Specialist - $25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Diabetic Retail Max Day Supply	90	90		
Diabetic Retail Copay for Max Day Supply	$75 Copayment	$75 Copayment		
Diabetic Mail Order Max Day Supply	90	90		
Diabetic Mail Order Copay for Max Day Supply	$50 Copayment	$50 Copayment		
Autism Assistive Communication Device	PCP/Specialist - $25 Copayment Subject to Deductible	PCP/Specialist - $25 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	$0 PCP Copay for members to age 19 for Domestic and In-Network.
Autologous Blood Banking	PCP/Specialist - Inclusive of Primary Service	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Mastectomy Prosthesis	PCP/Specialist - $0 Copayment Subject to Deductible	PCP/Specialist - $0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Orthotics	PCP/Specialist - 20% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Foot Orthotics	PCP/Specialist - 20% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Prosthetic - External Benefit	PCP/Specialist - 20% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Prosthetic - Wigs External Benefit	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered
Medical Supplies	PCP/Specialist - 20% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Breast Pump Purchase or Rental	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	1 Rental or Purchase per pregnancy
Acupuncture	PCP/Specialist - 50% Coinsurance Subject to Deductible	PCP/Specialist - 50% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	10 Visits per year
Reproductive Services	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered
PUVA Treatment	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered
Nutritional Therapy	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered
Biofeedback	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered

Diagnoses

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Accidental Dental	PCP/Specialist - Included Subject to Deductible	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	
Dental Oral Surgery	PCP/Specialist - Included Subject to Deductible	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	
Temporomandibular Joint (TMJ)	PCP/Specialist - Included Subject to Deductible	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	
Nutritional Counseling	PCP/Specialist - Included Subject to Deductible	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	
Inherited Metabolic Disorder - PKU	PCP/Specialist - Included Subject to Deductible	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	
Infertility Care	PCP/Specialist - Included Subject to Deductible	PCP/Specialist - Included Subject to Deductible	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.

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Organ and Bone Marrow Transplants	PCP/Specialist - Included Subject to Deductible	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	
Elective Sterilization - Female	PCP/Specialist - Included Subject to Deductible	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	
Elective Sterilization - Male	PCP/Specialist - Included Subject to Deductible	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	
Interruption of Pregnancy	PCP/Specialist - Included Subject to Deductible	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	
Reimbursement for Travel and Lodging Expenses	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered

Custom Facility

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Gene Therapy, CAR-T Therapy & Anti-Amyloid Agents	Not Covered	Not Covered	Not Covered	Note: Only the drugs will be excluded. Routine services associated with treatment (such as lab testing) may be covered.

Emergency Services

ER Facility

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	$250 Copayment Subject to Deductible	$250 Copayment Subject to Deductible	$250 Copayment Subject to $2,800 Deductible	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	Domestic	In Network	Out of Network	Limits and Additional Information
Physician Emergency Room Visit	PCP/Specialist - $0 Copayment Subject to Deductible	PCP/Specialist - $0 Copayment Subject to Deductible	$0 Copayment Subject to $2,800 Deductible	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

Transportation

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	$250 Copayment Subject to Deductible	$250 Copayment Subject to Deductible	$250 Copayment Subject to $2,800 Deductible	
Air Ambulance	$250 Copayment Subject to Deductible	$250 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	
Intra Hospital Transportation	$250 Copayment Subject to Deductible	$250 Copayment Subject to Deductible	$250 Copayment Subject to $2,800 Deductible	

Urgent Care

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$40 Copayment Subject to Deductible	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	

Urgent Care - Professional

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Physician Urgent Care Center Visit	PCP/Specialist - 0% Coinsurance Subject to Deductible	PCP/Specialist - 0% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Physician Office Visit for Urgent Care	PCP -$25 Copayment Specialist -$40 Copayment Subject to Deductible	PCP - $25 Copayment Specialist - $40 Copayment Subject to Deductible $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	$0 PCP Copay for members to age 19 for Domestic and In-Network.

Total Health Management Programs

Medical Management Services

Benefit Name	Domestic	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	Domestic	In Network	Out of Network	Limits and Additional Information
Stress Management				N/A
Surgery Decision Program				N/A

Ancillary Benefits

Vision

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Pediatric Vision Age Limit				Does Not Apply
Pediatric Eye Exams - Routine	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	1 Exam per plan year
Pediatric Eyewear - Routine	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	1 Pair per plan year
Adult Eye Exams - Routine	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	1 Exam per plan year
Adult Eyewear - Routine	Covered	Covered	Covered	$60 Reimbursement per plan year

Dental

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Adult Dental - Emergency Care	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental - Preventive	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental - Routine	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental - Endodontic	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental - Prosthodontics	Not Covered	Not Covered	Not Covered	Not Covered
Adult Dental - Orthodontics	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental Age Limit				Does Not Apply
Pediatric Dental - Emergency Care	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental - Preventive	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental - Routine	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental - Endodontic	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental - Prosthodontics	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental - Orthodontics	Not Covered	Not Covered	Not Covered	Not Covered

Rx Benefits

Rx Plan

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Rx Plan				$10/$35/$70 Integrated Rx

Rx Benefits

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
$0 Generics for Kids	No	No		
Generics for Kids Age Limit	Does Not Apply	Does not apply		
MAC Penalty	Yes	Yes		
Step Therapy	Yes	Yes		
Prior Authorization	Yes	Yes		
Oral Contraceptives		Included - Generics CIF		
Mandatory MO for Maintenance Drugs	No	No		
Days Supply Per Retail Order	30	30		
Days Supply Per Mail Order	90	90		

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Copays Per Mail Order Supply	2	2		
Deductible	Integrated with Medical	Integrated with Medical		
Family Deductible	Integrated with Medical	Integrated with Medical		
Deductible applies to	All	All		
Embedded Rx	Yes	Yes		
Annual benefit maximum	Integrated with Medical	Integrated with Medical		
Benefit maximum applies to	All	All		
OOP Maximum	Integrated with Medical	Integrated with Medical		
OOP Maximum Applies to	All	All		

Exclusions

Exclusions

Benefit Name	Excluded
Convalescent and Custodial Care	Yes
Cosmetic Services	Yes
Dental Services	Yes
Experimental or Investigational Treatment	Yes
Felony Participation	Yes
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 2036261-1 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.