Excellus BluePPO Signature Copay 1

Drug Coverage Excluded

Benefit Time Period: 01/01/2022 - 12/31/2022

ST LAWRENCE COUNTY - Over 65

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$0	$200	
Deductible - Two Person	$0	$400	
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%	40%	
Annual Out of Pocket Maximum - Single	$1,000	$1,100	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	$2,000	$2,200	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	$3,000	$3,300	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	$20 Copayment	40% Coinsurance Subject to Deductible	
Cost Share - Specialist	$20 Copayment	40% 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 separately
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 N/A
HRA Funding for Single Tier			$0 N/A
Plan/Calendar Year			Calendar Year Benefits
Coordination of Benefits			Made Whole
Prior Authorization			Applies
Diabetic Preauthorization and Step Therapy			No
Patient Assurance Program (Diabetic Medication Cost-Sharing Reduction)			Does Not Apply

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			3 Tier (EE, 2P, FAM)
Dependent Coverage			Age to which all dependents (excluding spouse) are covered Dependent To Age 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			1305
Total Eligible			0
Group Size			Large Group
Funding Arrangement			ASC
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 Charge if Lower than Negotiated Rate	We allow the lesser of 100 Percent In-Network Negotiated Regional Rate or 100 Percent of Charge.	
Facility Out of Area	Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 100 Percent In-Network Negotiated Regional Rate or 100 Percent of Charge.	
Professional Healthcare Provider In Area	Lower of Negotiated Amount or Charge	We allow the lesser of 75th Percentile of Fair Health or 100 Percent of Charge.	
Professional Healthcare Provider Out of Area	Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 75th Percentile of Fair Health or 100 Percent of Charge.	
Emergency Facility In Area	Negotiated Amount. Member's cost share is based on Charge if Lower than Negotiated Rate	We allow 100 Percent of Charge.	
Emergency Facility Out of Area	Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow 100 Percent of Charge.	
Emergency Professional Healthcare Provider In Area	Lower of Negotiated Amount or Charge	We allow 100 Percent of Charge.	
Emergency Professional Healthcare Provider Out of Area	Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow 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 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 100 Percent In-Network Negotiated Regional Rate or 100 Percent of Charge.	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Dialysis Facility Out of Area	Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 100 Percent In-Network Negotiated Regional Rate or 100 Percent of Charge.	
Dialysis Professional Healthcare Provider In Area	Lower of Negotiated Amount or Charge	We allow the lesser of 75th Percentile of Fair Health or 100 Percent of Charge.	
Dialysis Professional Healthcare Provider Out of Area	Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 75th Percentile of Fair Health or 100 Percent of Charge.	

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	Covered in Full	40% Coinsurance Subject to Deductible	
Mental Health Care	Covered in Full	40% Coinsurance Subject to Deductible	
Mental Health Residential Care	Covered in Full	40% Coinsurance Subject to Deductible	
Substance Use Detoxification	Covered in Full	40% Coinsurance Subject to Deductible	
Substance Use Rehabilitation	Covered in Full	40% Coinsurance Subject to Deductible	
Substance Use Residential Care	Covered in Full	40% Coinsurance Subject to Deductible	
Skilled Nursing Facility	$100 Copayment	40% Coinsurance Subject to Deductible	
Physical Rehabilitation	Covered in Full	Subject to Deductible	60 Days per year Limits are combined INN and OON.
Maternity Care	Covered in Full	40% Coinsurance Subject to Deductible	
Routine Newborn Nursery Care	Covered in Full	40% Coinsurance Subject to Deductible	
Prosthetic - Implanted Devices	Covered in Full	40% Coinsurance Subject to Deductible	
Mastectomy	Covered in Full	40% Coinsurance Subject to Deductible	
Observation Stay	Covered in Full	40% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	40% Coinsurance Subject to 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 - Covered in Full	40% 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	$20 Copayment	40% Coinsurance Subject to Deductible	
Colonoscopy Facility Diagnostic	Covered in Full	40% Coinsurance Subject to Deductible	
Preadmission Pre-Operative Testing	Covered in Full	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	Covered in Full	40% Coinsurance Subject to Deductible	
Routine X-ray	Covered in Full	40% Coinsurance Subject to Deductible	
Advanced Imaging Services	Covered in Full	40% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans.
Mammography Facility Diagnostic	Covered in Full	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	40% Coinsurance Subject to Deductible	
Routine Laboratory and Pathology	Covered in Full	40% Coinsurance Subject to Deductible	
Diagnostic Testing	Covered in Full	40% Coinsurance Subject to Deductible	
Radiation Therapy	Covered in Full	40% Coinsurance Subject to Deductible	
Chemotherapy	Covered in Full	40% Coinsurance Subject to Deductible	
Infusion Therapy	Covered in Full	40% Coinsurance Subject to Deductible	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	Covered in Full	40% Coinsurance Subject to Deductible	
Injectable Drugs	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	$20 Copayment	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization. No coverage for Hypnosis
Substance Use Care	$20 Copayment	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Autism Applied Behavior Analysis	Not Covered	Not Covered	Not Covered
Substance Use Family Counseling	$20 Copayment	40% Coinsurance Subject to Deductible	
Pulmonary Rehabilitation	Covered in Full	40% Coinsurance Subject to Deductible	
Cardiac Rehabilitation	Covered in Full	40% Coinsurance Subject to Deductible	

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	$20 Copayment	40% Coinsurance Subject to Deductible	60 visits per year combined INN and OON services
Home Infusion Therapy	$20 Copayment	40% Coinsurance Subject to Deductible	

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	40% Coinsurance Subject to Deductible	210 days per lifetime
Hospice Care Outpatient	Covered in Full	40% Coinsurance Subject to Deductible	210 days per lifetime
Family Bereavement	Covered in Full	40% Coinsurance Subject to Deductible	5 Visits per 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	40% Coinsurance Subject to Deductible	
Office Surgery	PCP/Specialist - $20 Copayment	40% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	40% Coinsurance Subject to 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 - Covered in Full	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Routine X-ray	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Advanced Imaging Services	PCP/Specialist - Covered in Full	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	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Routine Laboratory and Pathology	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Diagnostic Testing	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Injectable Drugs	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 - $20 Copayment	40% Coinsurance Subject to Deductible	No Coverage for Hypnosis
Substance Use Treatment	PCP/Specialist - $20 Copayment	40% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	Inital visit $20 Copayment
Autism Applied Behavior Analysis	PCP/Specialist - Not Covered	Not Covered	Not Covered
Additional Surgical Opinion	PCP/Specialist - $20 Copayment	40% Coinsurance Subject to Deductible	
Second Medical Opinion for Cancer	PCP/Specialist - $20 Copayment	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pulmonary Rehabilitation	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Cardiac Rehabilitation	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Office Visits - Diagnostic	PCP/Specialist - $20 Copayment	40% 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 - $20 Copayment	40% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - Covered in Full	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	Inclusive of Primary Service	Excludes injections for vaccines, allergy injections & treatment of diabetes.
Eye Exams Diagnostic	PCP/Specialist - $20 Copayment	40% Coinsurance Subject to Deductible	
Hearing Evaluations Diagnostic	PCP/Specialist - $20 Copayment	40% Coinsurance Subject to Deductible	
Chiropractic Care	PCP/Specialist - $20 Copayment	40% Coinsurance Subject to Deductible	20 visits per year
Allergy Testing	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
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	40% Coinsurance Subject to Deductible	

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$20 Copayment	40% Coinsurance Subject to Deductible	32 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility.
Occupational Rehabilitation	Not Covered	Not Covered	
Speech Rehabilitation	Not Covered	Not Covered	
Physical Habilitation	$20 Copayment	40% Coinsurance Subject to Deductible	32 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility.
Occupational Habilitation	Not Covered	Not Covered	
Speech Habilitation	Not Covered	Not Covered	

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - $20 Copayment	40% Coinsurance Subject to Deductible	32 Visits per contract year Includes aggregate of visits for INN and OON, professional and facility services.
Occupational Rehabilitation	PCP/Specialist - Not Covered	Not Covered	
Speech Rehabilitation	PCP/Specialist - Not Covered	Not Covered	
Physical Habilitation	PCP/Specialist - $20 Copayment	40% Coinsurance Subject to Deductible	32 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility.
Occupational Habilitation	PCP/Specialist - Not Covered	Not Covered	
Speech Habilitation	PCP/Specialist - Not Covered	Not Covered	

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	40% Coinsurance Subject to Deductible	1 Exam per year
Adult Immunizations	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Routine GYN Visit	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Family Planning	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	40% 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	40% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	40% 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	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	40% 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	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	40% 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 Insulin and Supplies	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	Any cost shares under part B or supplies not covered under Part B payable "in full".
Diabetic Education	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP/Specialist - Covered in Full	40% 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 - Not Covered	Not Covered	Not Covered
Autologous Blood Banking	PCP/Specialist - Not Covered	Not Covered	Not Covered
Durable Medical Equipment (DME)	PCP/Specialist - $20 Copayment	40% Coinsurance Subject to Deductible	For rental of DME, the co-pay will be applied once per year, or per course of treatment, per member whichever is less. DME Supplies; In-network Covered in full; OON 40% coinsurance subject to deductible.
Mastectomy Prosthesis	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Orthotics	PCP/Specialist - $20 Copayment	40% Coinsurance Subject to Deductible	
Foot Orthotics	PCP/Specialist - $20 Copayment	40% Coinsurance Subject to Deductible	
Prosthetic - External Benefit	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Prosthetic - Wigs External Benefit	PCP/Specialist - Not Covered	Not Covered	Not Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Medical Supplies	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Breast Pump Purchase or Rental	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	1 Rental or Purchase per pregnancy
Acupuncture	PCP/Specialist - Not Covered	Not Covered	Not Covered
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 - $20 Copayment	40% Coinsurance Subject to Deductible	
Nutritional Therapy	PCP/Specialist - Not Covered	Not Covered	Not Covered
Biofeedback	PCP/Specialist - Not Covered	Not Covered	Not Covered

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 - $20 Copayment	40% Coinsurance Subject to Deductible	Oral Surgery services are covered for the removal of bony impacted or soft tissue impacted teeth.
Temporomandibular Joint (TMJ)	PCP/Specialist - Included	Included Subject to Deductible	
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	Artificial Insemination Not Covered
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 - Included	Included Subject to Deductible	Elective Termination Not Covered

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	$50 Copayment	$50 Copayment	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility. Non emergent copay $100 for In/Out of Network

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	$20 Copayment	40% Coinsurance Subject to Deductible	
Air Ambulance	$20 Copayment	40% Coinsurance Subject to Deductible	
Intra Hospital Transportation	$20 Copayment	40% Coinsurance Subject to Deductible	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$20 Copayment	40% Coinsurance Subject to Deductible	

Urgent Care - Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physician Urgent Care Center Visit	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Physician Office Visit for Urgent Care	PCP/Specialist - $20 Copayment	40% Coinsurance Subject to Deductible	

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
Stress Management			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	Not Covered
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	Not Covered	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	N/A		
Generics for Kids Age Limit	Does not apply		
MAC Penalty	N/A		
Step Therapy	N/A		
Prior Authorization	N/A		
Oral Contraceptives	N/A		
Mandatory MO for Maintenance Drugs	No		
Days Supply Per Retail Order	N/A		
Days Supply Per Mail Order	N/A		
Copays Per Mail Order Supply	N/A		
Deductible	$0		
Family Deductible	N/A		
Deductible applies to	N/A		
Embedded Rx	No		
Annual benefit maximum	N/A		
Benefit maximum applies to	N/A		
OOP Maximum	N/A		
OOP Maximum Applies to	N/A		

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 1774870-1 and accepts the benefits as indicated.

Signature of Group Administrator:

Date: 10-29-21

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.