

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	\$0	\$750	
Deductible - Two Person	\$0	\$1,500	
Deductible - Family	\$0	\$2,250	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	20%	30%	
Annual Out of Pocket Maximum - Single	\$1,400	\$1,775	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	\$2,800	\$3,550	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	\$2,800	\$5,300	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 plus drug
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% Coinsurance	30% Coinsurance Subject to Deductible	
Cost Share - Specialist	20% Coinsurance	30% 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
Employer Deductible Funding Percentage			0%
HSA vs HRA			Does Not Apply
Plan/Calendar Year			Calendar Year Benefits
Coordination of Benefits			Made Whole
Prior Authorization			Prior Authorization applies to In Network Inpatient Excluding Maternity and Emergency Admission Only. When no prior authorization is called in, members will be held harmless for any in-network only non-notification penalties. 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			Applies
PreCertification Penalty			50% of Coinsurance up to \$500
All Inpatient Excluding Maternity and Emergency Admission			Applies OON Only
Organ Transplants			Applies
Autism Assistive Communication Devices			Does Not Apply
Home Care			Applies
Outpatient Surgery			Does not apply
Outpatient Mental Health Care and Substance Use Treatment			Does not apply

Benefit Name	In Network	Out of Network	Limits and Additional Information
Air Ambulance			Does not apply
Cardiac Rehabilitation			Does not apply
Covered Therapies			Does not apply
Physical Therapy			Does not apply
Sleep Apnea and Pain Management			Does not apply
Services by a Specialist			Does not apply
DME			Does Not Apply
External Prosthetics			Does not apply
Advanced Imaging Services			Does not apply
Magnetic Resonance Imaging (MRI) Services			Applies
CAT Scans			Applies
PET Scans			Applies
Hospice Care			Does not apply
Reproductive Services			Does not apply

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Type of Tiers			4 Tier (EE, EE/SP, EE/Child(ren), 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			Covered

Additional Group Characteristics

Benefit Name	In Network	Out of Network	Limits and Additional Information
Total Employees			1545
Total Eligible			0
Group Size			Large Group
Funding Arrangement			ASC
FMHP Exempt			No
Retiree Only			No

Benefit Name	In Network	Out of Network	Limits and Additional Information
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, 100 Percent of Blue Card allowance or 100 Percent of Charge.	
Professional Healthcare Provider In Area	Lower of Negotiated Amount or Charge	We allow the lesser of 100 Percent In-Network Negotiated Regional Rate 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 90th Percentile of Fair Health, 100 Percent of Blue Card allowance or 100 Percent of Charge. If the service is not listed in the Fair Health System, we allow 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.	OON Air Ambulance Reimbursement: 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, 100 Percent of Blue Card allowance or 100 Percent of Charge.	
Dialysis Professional Healthcare Provider In Area	Lower of Negotiated Amount or Charge	We allow the lesser of 100 Percent In-Network Negotiated Regional Rate 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 90th Percentile of Fair Health, 100 Percent of Blue Card allowance or 100 Percent of Charge. If the service is not listed in the Fair Health System, we allow 100 Percent of Charge.	

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	20% Coinsurance	30% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance	30% Coinsurance Subject to Deductible	
Mental Health Residential Care	20% Coinsurance	30% Coinsurance Subject to Deductible	
Substance Use Detoxification	20% Coinsurance	30% Coinsurance Subject to Deductible	
Substance Use Rehabilitation	20% Coinsurance	30% Coinsurance Subject to Deductible	
Substance Use Residential Care	20% Coinsurance	30% Coinsurance Subject to Deductible	
Skilled Nursing Facility	20% Coinsurance	30% Coinsurance Subject to Deductible	45 Days per year Limits are combined INN and OON.
Physical Rehabilitation	20% Coinsurance	30% Coinsurance Subject to Deductible	60 Days per year
Maternity Care	20% Coinsurance	30% Coinsurance Subject to Deductible	Maternity Inpatient INN: 20% with \$600 max cap. Maternity Office Visits and diagnostic testing will be CIF.
Routine Newborn Nursery Care	Covered in Full	30% Coinsurance Subject to Deductible	
Prosthetic - Implanted Devices	Covered in Full	30% Coinsurance Subject to Deductible	
Mastectomy	20% Coinsurance	30% Coinsurance Subject to Deductible	
Observation Stay	20% Coinsurance	30% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - 20% Coinsurance	30% 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	30% 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% Coinsurance	30% Coinsurance Subject to Deductible	
Colonoscopy Facility Diagnostic	20% Coinsurance	30% Coinsurance Subject to Deductible	
Preadmission Pre-Operative Testing	20% Coinsurance	30% Coinsurance Subject to Deductible	
Diagnostic X-ray	20% Coinsurance	30% Coinsurance Subject to Deductible	
Routine X-ray	20% Coinsurance	30% Coinsurance Subject to Deductible	INN: Maternity radiological services are CIF
Advanced Imaging Services	20% Coinsurance	30% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans. INN: Maternity radiological services are CIF
Mammography Facility Diagnostic	Covered in Full	30% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	20% Coinsurance	30% Coinsurance Subject to Deductible	INN: Maternity lab and pathology services are CIF.
Routine Laboratory and Pathology	20% Coinsurance	30% Coinsurance Subject to Deductible	INN: Maternity lab and pathology services are CIF.
Diagnostic Testing	20% Coinsurance	30% Coinsurance Subject to Deductible	INN: Maternity testing services are CIF.
Radiation Therapy	20% Coinsurance	30% Coinsurance Subject to Deductible	
Chemotherapy	20% Coinsurance	30% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	20% Coinsurance	30% 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% Coinsurance	30% Coinsurance Subject to Deductible	Includes Partial Hospitalization. NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Substance Use Care	20% Coinsurance	30% Coinsurance Subject to Deductible	Includes Partial Hospitalization. NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Autism Applied Behavior Analysis	20% Coinsurance	30% Coinsurance Subject to Deductible	NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Substance Use Family Counseling	20% Coinsurance	30% Coinsurance Subject to Deductible	NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Pulmonary Rehabilitation	20% Coinsurance	30% Coinsurance Subject to Deductible	
Cardiac Rehabilitation	20% Coinsurance	30% Coinsurance Subject to Deductible	

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	20% Coinsurance	25% Coinsurance Subject to \$50 Deductible	
Home Infusion Therapy	20% Coinsurance	25% Coinsurance Subject to \$50 Deductible	

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	30% Coinsurance Subject to Deductible	
Hospice Care Outpatient	Covered in Full	30% Coinsurance Subject to Deductible	
Family Bereavement	Covered in Full	30% 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 - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Office Surgery	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Colonoscopy Professional Diagnostic	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	INN: Maternity radiological services are CIF.
Routine X-ray	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	INN: Maternity radiological services are CIF.
Advanced Imaging Services	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans. INN: Maternity radiological services are CIF.
Mammography Professional Diagnostic	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	INN: Maternity lab and pathology services are CIF.
Routine Laboratory and Pathology	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	INN: Maternity lab and pathology services are CIF.
Diagnostic Testing	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	INN: Maternity testing services are CIF.
Radiation Therapy	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Infusion Therapy	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 - 20% Coinsurance	30% 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% Coinsurance	30% Coinsurance Subject to Deductible	NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.

Benefit Name	In Network	Out of Network	Limits and Additional Information
Substance Use Treatment	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Maternity Care	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	NYS Maternal Depression Screening Mandate Applies.
Autism Applied Behavior Analysis	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Additional Surgical Opinion	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Second Medical Opinion for Cancer	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Pulmonary Rehabilitation	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Cardiac Rehabilitation	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Office Visits - Diagnostic	PCP/Specialist - 20% Coinsurance	30% 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 - Covered in Full	30% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - \$0 Copayment	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% Coinsurance	30% Coinsurance Subject to Deductible	
Hearing Evaluations Diagnostic	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Chiropractic Care	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Allergy Testing	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - Covered in Full	30% 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	30% Coinsurance Subject to Deductible	

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Physical Habilitation	20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Habilitation	20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Habilitation	20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per 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	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per 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 - 20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per 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 - 20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Physical Habilitation	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per 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 - 20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per 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 - 20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per 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	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	1 Exam per year
Adult Immunizations	PCP/Specialist - Covered in Full	Not Covered	Travel vaccinations covered for Polio, Rabies, Encephalitis, Typhoid, malaria, Hep A&B and Yellow Fever covered in full in and out-of-network.
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Family Planning	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	30% 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	30% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	30% 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	30% Coinsurance Subject to Deductible	NYS Prostate Cancer Testing Mandate applies.
Mammography Screening Professional	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	Applies to Diagnostic Services.
Bone Density Screening Professional	PCP/Specialist - 20% Coinsurance	30% 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	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	20% Coinsurance	30% Coinsurance Subject to Deductible	Applies to Diagnostic Services.
Bone Density Screening Facility	20% Coinsurance	30% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Preventive	\$20 Copayment	30% Coinsurance Subject to Deductible	
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - \$20 Copayment	30% Coinsurance Subject to Deductible	No coverage for insulin and supplies through a retail pharmacy. Covered through Carve-out Rx vendor or Diabetic DME vendor
Diabetic Education	PCP/Specialist - \$20 Copayment	30% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP/Specialist - \$20 Copayment	30% Coinsurance Subject to Deductible	No coverage for insulin and supplies through a retail pharmacy. Covered through Carve-out Rx vendor or Diabetic DME vendor
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 - 20% Coinsurance	30% Coinsurance Subject to Deductible	NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Autologous Blood Banking	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Mastectomy Prosthesis	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Orthotics	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Foot Orthotics	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Prosthetic - External Benefit	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Prosthetic - Wigs External Benefit	PCP/Specialist - Not Covered	Not Covered	Not Covered
Medical Supplies	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Breast Pump Purchase or Rental	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	1 Rental or Purchase per pregnancy
Acupuncture	PCP/Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits Per Contract Year OON: Deductible, then 50% Coinsurance
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% Coinsurance	30% Coinsurance Subject to Deductible	Only covered if medically necessary
Nutritional Therapy	PCP/Specialist - Not Covered	Not Covered	Not Covered
Biofeedback	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	Only covered if medically necessary

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	
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	

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	20% Coinsurance	20% Coinsurance	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	20% Coinsurance	20% Coinsurance	
Air Ambulance	20% Coinsurance	20% Coinsurance	
Intra Hospital Transportation	20% Coinsurance	20% Coinsurance	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	20% Coinsurance	30% 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	30% Coinsurance Subject to Deductible	
Physician Office Visit for Urgent Care	PCP/Specialist - 20% Coinsurance	30% 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

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	\$40 Copayment	30% Coinsurance Subject to Deductible	1 Exam per year Limits are combined INN and OON.
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	\$40 Copayment	30% Coinsurance Subject to Deductible	1 Exam per year Limits are combined INN and OON.
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	N/A		
Days Supply Per Retail Order	30		
Days Supply Per Mail Order	90		
Copays Per Mail Order Supply	N/A		
Deductible	N/A		

Benefit Name	In Network	Out of Network	Limits and Additional Information
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 1695700-1 and accepts the benefits as indicated.

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.