## Livingston County / Premium Plan

# General Information

### Cost Sharing Expenses

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Deductible - Single | $0 | $300 | |
| Deductible - Two Person | $0 | $600 | |
| Deductible - Family | $0 | $750 | 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.<br>Individual |
| Deductible Aggregation - In Network and Out of Network | | | In Network and Out of Network aggregate separately |
| Deductible Carryover Months | No | No | |
| History Credit | No | No | |
| Coinsurance | 0% | 20% | |
| Annual Out of Pocket Maximum - Single | $6,850 | $3,000 | 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 | $13,700 | $6,000 | 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 | $13,700 | $7,500 | 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 - Per Person Cap | $6,850 | $3,000 | 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. |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| 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 | $15 Copayment | 20% Coinsurance Subject to Deductible | |
| Cost Share - Specialist | $15 Copayment | 20% Coinsurance Subject to Deductible | |

## Plan Limits

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Limits Aggregation - In-network and Out of Network | | | In Network and Out of Network aggregate together |
| Annual Maximum | | | Unlimited |
| Lifetime Benefit Maximum | | | Unlimited |
| Kids Copay Age Limit | | | Does Not Apply |
| Kids Copay Age Applies To | | | Does Not Apply |
| Kids Copay Network | | | None |
| Referrals Required | | | No |
| Employer Deductible Funding Percentage | | | 0% |
| HSA vs HRA | | | Does Not Apply |
| Plan/Calendar Year | | | Calendar Year Benefits |
| Coordination of Benefits | | | Custom |
| Prior Authorization | | | Does Not Apply |
| Diabetic Preauthorization and Step Therapy | | | Yes |

## Precertification

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| PreCertification | | | Pre-Certification is required for out of network only except for transplant and transplant related services where Pre-Certification is required for both in and out of network. Applies |
| PreCertification Penalty | | | 50% of Coinsurance up to $500 |
| All Inpatient Excluding Maternity and Emergency Admission | | | Applies |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Organ Transplants | | | Applies |
| Autism Assistive Communication Devices | | | Applies over $200 only |
| Home Care | | | Applies |
| Outpatient Surgery | | | Does not apply |
| Outpatient Mental Health Care and Substance Use Treatment | | | Does not apply |
| Air Ambulance | | | Non-Emergent Air Ambulance |
| 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 | | | Applies over $200 only |
| External Prosthetics | | | Includes Prosthetic and Orthotics<br>Applies over $200 |
| Advanced Imaging Services | | | Does not apply |
| Magnetic Resonance Imaging (MRI) Services | | | Does not apply |
| CAT Scans | | | Does not apply |
| PET Scans | | | Does not apply |
| 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, 2P, EE/Children, FAM) |
| Dependent Coverage | | | Age to which all dependents (excluding spouse) are covered<br>Dependent To Age 26 |
| Dependent Age End Period | | | Age to which all dependents (excluding spouse) are covered<br>End of Month |
| Domestic Partner Coverage | | | Not Covered |

## Additional Group Characteristics

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Total Employees | | | |
| Total Eligible | | | |
| Group Size | | | |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| 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 150 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 50 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 50 Percent of Charge. | |
| Professional Healthcare Provider In Area | Lower of Negotiated Amount or Charge | We allow the lesser of 150 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 50 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 50 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. | |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Emergency Professional Healthcare Provider 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 150 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 50 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 50 Percent of Charge. | |
| Dialysis Professional Healthcare Provider In Area | Lower of Negotiated Amount or Charge | We allow the lesser of 150 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 50 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 50 Percent of Charge. | |

# Inpatient Services

## Inpatient Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Inpatient Hospital Services | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Mental Health Residential Care | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Substance Use Detoxification | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Substance Use Rehabilitation | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Substance Use Residential Care | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Skilled Nursing Facility | Covered in Full | 20% Coinsurance<br>Subject to Deductible | 45 Days per year<br>Limits are combined INN and OON. |
| Physical Rehabilitation | Covered in Full | 20% Coinsurance<br>Subject to Deductible | 45 Days per year<br>Limits are combined INN and OON. |
| Maternity Care | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Routine Newborn Nursery Care | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Prosthetic - Implanted Devices | Covered in Full | 50% Coinsurance<br>Subject to Deductible | |
| Mastectomy | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Observation Stay | Covered in Full | 20% Coinsurance<br>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 | 20% Coinsurance<br>Subject to Deductible | Out of Network services performed in an In Network Facility covered at the In Network benefit. |
| Anesthesia | PCP/Specialist - Covered in Full | 20% Coinsurance<br>Subject to Deductible | Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral. Out of Network services performed in an In Network Facility covered at the In Network benefit. |
| In Hospital Physician Visits and Consults | PCP/Specialist - Covered in Full | 20% Coinsurance<br>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 | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Colonoscopy Facility Diagnostic | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Preadmission Pre-Operative Testing | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Diagnostic X-ray | $15 Copayment | 20% Coinsurance<br>Subject to Deductible | |
| Routine X-ray | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Advanced Imaging Services | Covered in Full | 20% Coinsurance<br>Subject to Deductible | Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans. |
| Mammography Facility Diagnostic | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Diagnostic Laboratory and Pathology | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Routine Laboratory and Pathology | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Diagnostic Testing | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Radiation Therapy | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Chemotherapy | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Infusion Therapy | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Dialysis | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Injectable Drugs | $15 Copayment | 20% Coinsurance<br>Subject to Deductible | Excludes vaccines, allergy injections & treatment of diabetes. |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Mental Health Care | Covered in Full | 20% Coinsurance<br>Subject to Deductible | Includes Partial Hospitalization |
| Substance Use Care | Covered in Full | 20% Coinsurance<br>Subject to Deductible | Includes Partial Hospitalization |
| Autism Applied Behavior Analysis | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Substance Use Family Counseling | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Pulmonary Rehabilitation | $15 Copayment | 20% Coinsurance<br>Subject to Deductible | 36 Visits Per Lifetime |
| Cardiac Rehabilitation | $15 Copayment | 20% Coinsurance<br>Subject to Deductible | 54 Visits per calendar year |

## Home and Hospice Care

### Home Care

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Home Care | Covered in Full | 20% Coinsurance<br>Subject to $50 Deductible | |
| Home Infusion Therapy | Covered in Full | 20% Coinsurance<br>Subject to $50 Deductible | Services must be ordered by a Physician/ authorized Health Care Professional and provided by an agency or office licensed/ certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care). |

### Hospice Care

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Hospice Care Inpatient | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Hospice Care Outpatient | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Family Bereavement | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |

## 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 - $15 Copayment | 20% Coinsurance<br>Subject to Deductible | Out of Network services performed in an In Network Facility covered at the In Network benefit. |
| Office Surgery | PCP/Specialist - Covered in Full | 20% Coinsurance<br>Subject to Deductible | Includes colonoscopy performed in an office setting. Out of Network services performed in an In Network Facility covered at the In Network benefit. |
| Colonoscopy Professional Diagnostic | PCP/Specialist - $15 Copayment | 20% Coinsurance<br>Subject to Deductible | |
| Diagnostic X-ray | PCP/Specialist - $15 Copayment | 20% Coinsurance<br>Subject to Deductible | Out of Network services performed in an In Network Facility covered at the In Network benefit. In-network professional interpretation is $15 copay. |
| Routine X-ray | PCP/Specialist - Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Advanced Imaging Services | PCP/Specialist - Covered in Full | 20% Coinsurance<br>Subject to Deductible | Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Mammography Professional Diagnostic | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Diagnostic Laboratory and Pathology | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | Out of Network services performed in an In Network Facility covered at the In Network benefit. |
| Routine Laboratory and Pathology | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Diagnostic Testing | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Radiation Therapy | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Chemotherapy | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Infusion Therapy | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Dialysis | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Injectable Drugs | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | Excludes vaccines, allergy injections & treatment of diabetes. |
| Mental Health Care | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | |
| Substance Use Treatment | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | |
| Maternity Care | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | Coverage only for Employee and Spouse. NYS Maternal Depression Screening Mandate Applies. |
| Autism Applied Behavior Analysis | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | |
| Additional Surgical Opinion | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | |
| Second Medical Opinion for Cancer | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | |
| Pulmonary Rehabilitation | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | 36 Visits Per Lifetime |
| Cardiac Rehabilitation | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | 54 Visits per calendar year |
| Office Visits - Diagnostic | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | Covered for the diagnosis and treatment of injury, disease and medical conditions. All professional provider specialties e.g. GYN, cardiac, orthopedists, etc. are included. This also includes eye exams or hearing exams for the diagnosis or treatment of illness or injury. Office visits may include house calls. |
| TeleMedicine Program | PCP/Specialist - Covered in Full | Not Covered | Covers online internet consultations between the member and the providers who participate in our telemedicine program for medical conditions that are not an emergency condition. Behavioral Health Telemedicine is not covered. |
| Medications Administered in Office | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | Excludes injections for vaccines, allergy injections & treatment of diabetes. |
| Eye Exams Diagnostic | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | |
| Hearing Evaluations Diagnostic | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Chiropractic Care | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | |
| Allergy Testing | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | Allergy Testing includes injections and scratch and prick tests. |
| Allergy Treatment Including Serum | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | Includes desensitization treatments (injections & serums). |
| Hearing Evaluations Routine | PCP/Specialist - $15 Copayment | Not Covered | 1 Exam per Year |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Adult Hearing Aids | PCP/Specialist - Not Covered | Not Covered | Not Covered |
| Pediatric Hearing Aid Age Limit | | | 19 |
| Pediatric Hearing Aids | PCP/Specialist - Covered in Full | Not Covered | 1 Hearing Aid every 3 years<br>Limited to $600 Every 3 Years. |
| Cochlear Implants | PCP/Specialist - Covered in Full | 50% Coinsurance<br>Subject to Deductible | |

# Rehab and Habilitation

## Outpatient Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Physical Rehabilitation | $15 Copayment | 20% Coinsurance<br>Subject to Deductible | 45 Visits per year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, occupational and respiratory therapy. |
| Occupational Rehabilitation | $15 Copayment | 20% Coinsurance<br>Subject to Deductible | 45 Visits per year |
| Speech Rehabilitation | $15 Copayment | 20% Coinsurance<br>Subject to Deductible | 45 Visits per year |
| Physical Habilitation | $15 Copayment | 20% Coinsurance<br>Subject to Deductible | 45 Visits per year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, occupational and respiratory therapy. |
| Occupational Habilitation | $15 Copayment | 20% Coinsurance<br>Subject to Deductible | 45 Visits per year |
| Speech Habilitation | $15 Copayment | 20% Coinsurance<br>Subject to Deductible | 45 Visits per year |

## Outpatient Professional Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Physical Rehabilitation | PCP/Specialist - $15 Copayment | 20% Coinsurance<br>Subject to Deductible | 45 Visits per year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, occupational and respiratory therapy. |
| Occupational Rehabilitation | PCP/Specialist - $15 Copayment | 20% Coinsurance<br>Subject to Deductible | 45 Visits per year |
| Speech Rehabilitation | PCP/Specialist - $15 Copayment | 20% Coinsurance<br>Subject to Deductible | 45 Visits per year |
| Physical Habilitation | PCP/Specialist - $15 Copayment | 20% Coinsurance<br>Subject to Deductible | 45 Visits per year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, occupational and respiratory therapy. |
| Occupational Habilitation | PCP/Specialist - $15 Copayment | 20% Coinsurance<br>Subject to Deductible | 45 Visits per year |
| Speech Habilitation | PCP/Specialist - $15 Copayment | 20% Coinsurance<br>Subject to Deductible | 45 Visits per year |

# Preventive Services

## Preventive Professional Services Meeting Federal Guidelines*

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Adult Physical Examination | PCP/Specialist - Covered in Full | Not Covered | 1 Exam per year |
| Adult Immunizations | PCP/Specialist - Covered in Full | Not Covered | |
| Well Child Visits and Immunizations | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Routine GYN Visit | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | 2 Exams per year |
| Family Planning | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Pre/Post-Natal Care | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | One Post-Partum Care Home visit covered in full for both In and Out of network |
| Mammography Screening Professional | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | 1 Exam per year<br>Age 40 and older. Includes 3D imaging. |
| Colonoscopy Screening Professional | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | 1 Exam per year<br>Age 50 and older |
| Bone Density Screening Professional | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |

### Preventive Facility Services Meeting Federal Guidelines*

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Cervical Cytology Preventative | Covered in Full | 20% Coinsurance Subject to Deductible | 2 Exams per year |
| Mammography Screening Facility | Covered in Full | 20% Coinsurance Subject to Deductible | 1 Exam per year<br>Age 40 and older. Includes 3D imaging. |
| Colonoscopy Screening Facility | Covered in Full | 20% Coinsurance Subject to Deductible | 1 Exam per year<br>Age 50 and older. |
| Bone Density Screening Facility | Covered in Full | 20% Coinsurance Subject to Deductible | |

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

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Prostate Cancer Screening | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | Covered at age 50. High Risk covered at age 40. One exam per calendar year. |
| Mammography Screening Professional | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | 1 Exam per year<br>Includes 3D imaging. |
| Colonoscopy Screening Professional | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | 1 Exam per year |
| Bone Density Screening Professional | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |

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

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Mammography Screening Facility | Covered in Full | 20% Coinsurance Subject to Deductible | 1 Exam per year<br>Includes 3D imaging. |
| Colonoscopy Screening Facility | Covered in Full | 20% Coinsurance Subject to Deductible | 1 Exam per year |
| Bone Density Screening Facility | Covered in Full | 20% Coinsurance Subject to Deductible | |

## Other Benefits

### Additional Benefits

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Treatment of Diabetes Preventive | N/A | N/A | |
| Treatment of Diabetes Insulin and Supplies | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy. |
| Diabetic Education | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | |
| Diabetic Equipment | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | |
| Diabetic Retail Max Day Supply | 30 | | |
| Diabetic Retail Copay for Max Day Supply | $15 Copayment | | |
| Diabetic Mail Order Max Day Supply | 90 | | |
| Diabetic Mail Order Copay for Max Day Supply | $45 Copayment | | |
| Autism Assistive Communication Device | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | |
| Autologous Blood Banking | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Durable Medical Equipment (DME) | PCP/Specialist - 20% Coinsurance | 50% Coinsurance Subject to Deductible | |
| Mastectomy Prosthesis | PCP/Specialist - 20% Coinsurance | 50% Coinsurance Subject to Deductible | |
| Orthotics | PCP/Specialist - 20% Coinsurance | 50% Coinsurance Subject to Deductible | |
| Foot Orthotics | PCP/Specialist - Not Covered | Not Covered | Not Covered |
| Prosthetic - External Benefit | PCP/Specialist - 20% Coinsurance | 50% Coinsurance Subject to Deductible | $15,000 calendar year maximum for Non-Essential Prosthetics. Blood Pressure Cuff/ Monitors not covered. |
| Prosthetic - Wigs External Benefit | PCP/Specialist - Not Covered | Not Covered | Not Covered |
| Medical Supplies | PCP/Specialist - 20% Coinsurance | 50% Coinsurance Subject to Deductible | |
| Breast Pump Purchase or Rental | PCP/Specialist - Covered in Full | 50% Coinsurance Subject to Deductible | |
| Acupuncture | PCP/Specialist - 50% Coinsurance | 50% Coinsurance Subject to Deductible | 10 Visits every year<br>Limits combined INN and OON. Out of Network services does not apply to Out of Pocket maximums |
| 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 - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Nutritional Therapy | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | 4 Visits per Year |
| 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 - $15 Copayment | 20% Coinsurance Subject to Deductible | |
| Dental Oral Surgery | PCP/Specialist - $15 Copayment | 20% Coinsurance Subject to Deductible | |
| Temporomandibular Joint (TMJ) | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | Includes TMJ Appliances |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Nutritional Counseling | PCP/Specialist - Covered in Full | Not Covered | 1 Visit per year |
| Inherited Metabolic Disorder - PKU | PCP/Specialist - Included | Included<br>Subject to Deductible | |
| Infertility Care | PCP/Specialist - Included | Included<br>Subject to Deductible | Coverage for the diagnosis and treatment (surgical and medical) of infertility. Effective 1/1/2020 upon group renewal there are no age restrictions and the benefit now includes fertility preservation when a medical treatment will directly or indirectly lead to iatrogenic infertility and 3 cycles of in-vitro fertilization. |
| Organ and Bone Marrow Transplants | PCP/Specialist - Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Elective Sterilization - Female | PCP/Specialist - Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Elective Sterilization - Male | PCP/Specialist - $15 Copayment | 20% Coinsurance<br>Subject to Deductible | |
| Interruption of Pregnancy | PCP/Specialist - Covered in Full | 20% Coinsurance<br>Subject to Deductible | |

### Custom Professional

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Intraocular Lenses following Cataract Surgery | PCP/Specialist - $15 Copayment | 20% Coinsurance<br>Subject to Deductible | 1 pair of glasses covered after cataract surgery. |

## 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. Copay waived if admitted. Non-Emergent not covered. |

### 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. Non-Emergent not covered. |

### Transportation

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Prehospital Emergency and Transportation - Ground or Water | Covered in Full | Covered in Full | |
| Air Ambulance | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Intra Hospital Transportation | Covered in Full | Covered in Full | |

### Urgent Care

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Urgent Care Center Facility Visit | $25 Copayment | 20% Coinsurance<br>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 | 20% Coinsurance<br>Subject to Deductible | |
| Physician Office Visit for Urgent Care | PCP/Specialist - $15 Copayment | 20% Coinsurance<br>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<br>Yes |
| Case Management Behavioral Health Program | | | Applies<br>Yes |
| Disease Management Program | | | Applies<br>Yes |
| Health Promotion | | | Applies<br>Yes |

## Ancillary Benefits

### Vision

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Adult Eye Exams - Routine | $15 Copayment | Not Covered | 1 Exams every 2 years |
| Adult Eyewear - Routine | Covered in Full | Covered in Full | $60 Allowance every year<br>Includes Frames/Lenses or Contact Lenses |
| Pediatric Vision Age Limit | | | 19 |
| Pediatric Eye Exams - Routine | $15 Copayment | Not Covered | 1 Exam every year |
| Pediatric Eyewear - Routine | Covered in Full | 20% Coinsurance | 1 Pair per plan year<br>Includes Frames/Lenses or Contact Lenses |

## Rx Benefits

### Rx Plan

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Rx Plan | | | DRUG COVERAGE EXCLUDED |

### Rx Benefits

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| $0 Generics for Kids | Not Covered | | |
| Generics for Kids Age Limit | Does not apply | | |
| MAC Penalty | Not Covered | | |
| Step Therapy | Not Covered | | |
| Prior Authorization | Not Covered | | |
| Oral Contraceptives | Not Covered | | |
| Mandatory MO for Maintenance Drugs | Not Covered | | |
| Days Supply Per Retail Order | 30 | | |
| Days Supply Per Mail Order | 90 | | |
| Copays Per Mail Order Supply | 1 | | |
| Deductible | Not Covered | | |
| Family Deductible | Not Covered | | |
| Deductible applies to | Not Covered | | |
| Embedded Rx | No | | |
| Annual benefit maximum | Not Covered | | |
| Benefit maximum applies to | Not Covered | | |
| OOP Maximum | Not Covered | | |
| OOP Maximum Applies to | Not Covered | | |

# Exclusions

## Exclusions

| Benefit Name | Excluded |
|---|---|
| Convalescent and Custodial Care | Yes |
| Cosmetic Services | Yes |
| Dental Services | Yes |
| Experimental or Investigational Treatment | Yes |
| Felony Participation | Yes |
| Government Facility | Yes |
| Medicare or Other Governmental Program | Yes |
| Military Service | Yes |
| No-Fault Automobile Insurance | Yes |
| Services Not Listed | Yes |

| Benefit Name | Excluded |
| --- | --- |
| Services with No Charge | Yes |
| War | Yes |
| Workers Compensation | Yes |