Excellus

Excellus BluePPO Signature Deduct 3

Drug Coverage Excluded

Benefit Time Period: 01/01/2025 - 12/31/2025

UTICA COLLEGE

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$1,800	$3,600	
Deductible - Two Person	$3,600	$7,200	
Deductible - Family	$3,600	$7,200	
Services that Apply to Deductible			Medical plus drug
Deductible Aggregation - Single and Family			The entire family annual deductible must be met before copay or coinsurance is applied for any individual family member. If the family deductible amount exceeds the out of pocket maximum per person cap, the individual cannot contribute more than the out of pocket maximum per person cap amount for the plan year. Family
Deductible Aggregation - In Network and Out of Network			In Network and Out of Network aggregate separately
Deductible Carryover Months	No	No	
History Credit	No	No	
Coinsurance	10%	20%	
Annual Out of Pocket Maximum - Single	$3,600	$7,200	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 - Two Person	$7,200	$14,400	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	$7,200	$14,400	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	$6,650	$14,400	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 Only
Annual Out of Pocket Maximum Aggregation - Single and Family			The entire Family Annual Out-of-Pocket Maximum must be met before family members receive covered services processed at 100% of the allowable amount for the remainder of the plan year. An individual member covered under a family plan may not exceed the Out-of-Pocket Maximum per person cap amount for that plan year, should the family Out-of-Pocket Maximum level exceed the Out-of-Pocket Maximum Per Person Cap. Family
Annual Out of Pocket Maximum Aggregation - In Network and Out of Network			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	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Cost Share - Specialist	10% Coinsurance Subject to Deductible	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			N/A
Referrals Required			No
HSA Funding for Single Tier			$0
HRA Funding for Single Tier			$0
Plan/Calendar Year			Calendar Year Benefits
Coordination of Benefits			Made Whole
Prior Authorization			Applies
Preauthorization - Vendor Managed			This plan requires prior authorization for Radiology, Cardiac Services & Devices, and Radiation Therapy services through eviCore healthcare. All
Diabetic Preauthorization and Step Therapy			Applies

Benefit Name	In Network	Out of Network	Limits and Additional Information
Patient Assurance Program			Does Not Apply
Prior Authorization - Medical Specialty Drugs			Does Not Apply
Medical Preventive Services Prior to Deductible			No

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			4 Tier (EE, 2P, EE/Children, FAM)
Dependent Coverage			Age to which all dependents (excluding spouse) are covered. 26
Dependent Age End Period			Age to which all dependents (excluding spouse) are covered. End of Month
Domestic Partner Coverage			Covered

Additional Group Characteristics

Benefit Name	In Network	Out of Network	Limits and Additional Information
Total Employees			
Total Eligible			
Group Size			
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 the Charge if Lower than the Negotiated Amount.	We allow the lesser of 80 Percent of the Medicare Prospective Payment System or 100 Percent of Charge. If the service is not listed on the Medicare Prospective Payment System, we allow 80 Percent of average Negotiated Participating Amounts of like facilities or 100 Percent of Charge.	
Facility Out of Area	Negotiated Amount or Blue Card Allowance. Member's cost share is based on the Charge if Lower than the Negotiated Amount or Blue Card Allowance.	We allow the lesser of 100 Percent of Negotiated Amount, 100 Percent of Blue Card Allowance, 100 Percent of average Negotiated Participating Amounts of like facilities or 100 Percent of Charge.	
Professional Healthcare Provider In Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 80 Percent of the Medicare Provider fee schedule or 100 Percent of Charge. If the service is not listed on the Medicare Provider fee schedule, we allow 75 Percent of Charge.	
Professional Healthcare Provider Out of Area	Negotiated Amount or Blue Card Allowance. Member's cost share is based on the Charge if Lower than the Negotiated Amount or Blue Card Allowance.	We allow the lesser of 150 Percent of the Medicare Provider fee schedule, 100 Percent of Blue Card allowance or 100 Percent of Charge. If the service is not listed on the Medicare Provider fee schedule, we allow 75 Percent of Charge.	
Emergency Facility in Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 100 Percent of Qualified Payment Amount or 100 Percent of Charge.	
Emergency Facility Out of Area	Negotiated Amount or Blue Card Allowance. Member's cost share is based on the Charge if Lower than the Negotiated Amount or Blue Card Allowance.	We allow the lesser of 100 Percent of Qualified Payment Amount or 100 Percent of Charge.	
Emergency Professional Healthcare Provider In Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 100 Percent of Qualified Payment Amount or 100 Percent of Charge.	
Emergency Professional Healthcare Provider Out of Area	Negotiated Amount or Blue Card Allowance. Member's cost share is based on the Charge if Lower than the Negotiated Amount or Blue Card Allowance.	We allow the lesser of 100 Percent of Qualified Payment Amount or 100 Percent of Charge.	
Prehospital Emergency Services and Transport - Ground Ambulance including Interfacility Transfer In Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow 100 Percent of Charge.	
Prehospital Emergency Services and Transport - Ground Ambulance including Interfacility Transfer Out of Area Within NYS	Negotiated Amount or Blue Card Allowance. Member's cost share is based on the Charge if Lower than the Negotiated Amount or Blue Card Allowance.	We allow 100 Percent of Charge.	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency Services and Transport - Ground Ambulance Out of Area Outside of NYS	Negotiated Amount or Blue Card Allowance. Member's cost share is based on the Charge if Lower than the Negotiated Amount or Blue Card Allowance.	We allow 100 Percent of Charge.	
Air Ambulance In Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 100 Percent of Qualified Payment Amount or 100 Percent of Charge.	
Air Ambulance Out of Area	Negotiated Amount or Blue Card Allowance. Member's cost share is based on the Charge if Lower than the Negotiated Amount or Blue Card Allowance.	We allow the lesser of 100 Percent of Qualified Payment Amount or 100 Percent of Charge.	
Dialysis Facility in Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 80 Percent of the Medicare Prospective Payment System or 100 Percent of Charge. If the service is not listed on the Medicare Prospective Payment System, we allow 80 Percent of average Negotiated Participating Amounts of like facilities or 100 Percent of Charge.	
Dialysis Facility Out of Area	Negotiated Amount or Blue Card Allowance. Member's cost share is based on the Charge if Lower than the Negotiated Amount or Blue Card Allowance.	We allow the lesser of 100 Percent of Negotiated Amount, 100 Percent of Blue Card Allowance, 100 Percent of average Negotiated Participating Amounts of like facilities or 100 Percent of Charge.	
Dialysis Professional Healthcare Provider In Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 80 Percent of the Medicare Provider fee schedule or 100 Percent of Charge. If the service is not listed on the Medicare Provider fee schedule, we allow 75 Percent of Charge.	
Dialysis Professional Healthcare Provider Out of Area	Negotiated Amount or Blue Card Allowance. Member's cost share is based on the Charge if Lower than the Negotiated Amount or Blue Card Allowance.	We allow the lesser of 150 Percent of the Medicare Provider fee schedule, 100 Percent of Blue Card allowance or 100 Percent of Charge. If the service is not listed on the Medicare Provider fee schedule, we allow 75 Percent of Charge.	

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Mental Health Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Mental Health Residential Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Substance Use Detoxification	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Substance Use Rehabilitation	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Substance Use Residential Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Skilled Nursing Facility	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Days per year Limits are combined INN and OON.
Physical Rehabilitation	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	60 Days per plan year Limits are combined INN and OON.
Maternity Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Routine Newborn Nursery Care	10% Coinsurance	20% Coinsurance Subject to Deductible	
Prosthetic - Implanted Devices	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Mastectomy	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Observation Stay	10% Coinsurance Subject to Deductible	10% Coinsurance Subject to $1,800 Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - 10% Coinsurance Subject to Deductible	10% Coinsurance Subject to $1,800 Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.
In Hospital Physician Visits and Consults	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Colonoscopy Facility Diagnostic	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Preadmission Pre-Operative Testing	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Routine X-ray	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Advanced Imaging Services	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans.
Mammography Facility Diagnostic	Covered in Full	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Routine Laboratory and Pathology	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Diagnostic Testing	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Radiation Therapy	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Chemotherapy	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Infusion Therapy Outpatient	Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	10% Coinsurance Subject to Deductible	20% 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	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Opioid Treatment Program			
Autism Applied Behavior Analysis	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Substance Use Family Counseling	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Pulmonary Rehabilitation	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Cardiac Rehabilitation	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Home Infusion Therapy	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Services must be ordered by a Physician/ authorized Health Care Professional and provided by an agency or office licensed/ certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care).

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Hospice Care Outpatient	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Family Bereavement	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	5 Visits per plan 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 - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Office Surgery	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - 10% Coinsurance Subject to Deductible	10% Coinsurance Subject to Deductible	
Colonoscopy Professional Diagnostic	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Routine X-ray	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Advanced Imaging Services	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and Cat Scans.
Mammography Professional Diagnostic	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Routine Laboratory and Pathology	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diagnostic Testing	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Infusion Therapy Services	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 - 10% Coinsurance Subject to Deductible	20% 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 - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Substance Use Treatment	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Opioid Treatment Program	PCP/Specialist - 10% Coinsurance		
Maternity Care	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Autism Applied Behavior Analysis	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Additional Surgical Opinion	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Second Medical Opinion for Cancer	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Pulmonary Rehabilitation	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Cardiac Rehabilitation	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Office Visits - Diagnostic	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Covered for the diagnosis and treatment of injury, disease and medical conditions. All professional provider specialties e.g. GYN, cardiac, orthopedists, etc. are included. This also includes eye exams or hearing exams for the diagnosis or treatment of illness or injury. Office visits may include house calls.
Telehealth	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - 10% Coinsurance Subject to Deductible	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 - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Hearing Evaluations Diagnostic	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Chiropractic Care	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Allergy Testing	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	1 Exam per plan year Limits are combined INN and OON.
Adult Hearing Aids	PCP/Specialist - Not Covered	Not Covered	Not Covered
Pediatric Hearing Aid Age Limit			19
Pediatric Hearing Aids	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	1 Purchase every 3 years
Cochlear Implants	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Physical Habilitation	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Habilitation	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Habilitation	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract 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 - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract 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 - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract 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 - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract 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 - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract 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 - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract 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 - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract 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	20% Coinsurance Subject to Deductible	1 Exam per plan year
Adult Immunizations	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	0% Coinsurance	
Routine GYN Visit	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Family Planning	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

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

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

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

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

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Preventive	N/A	N/A	
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Treatment of Diabetes - Insulin	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Education	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diabetic Retail Max Day Supply	90		
Diabetic Retail Copay for Max Day Supply	10% Coinsurance		
Diabetic Mail Order Max Day Supply	90		
Diabetic Mail Order Copay for Max Day Supply	10% Coinsurance		
Autism Assistive Communication Device	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Autologous Blood Banking	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	
Durable Medical Equipment (DME)	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Mastectomy Prosthesis	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Orthotics	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Foot Orthotics	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Prosthetic - External Benefit	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Prosthetic - Wigs External Benefit	PCP/Specialist - Not Covered	Not Covered	Not Covered
Medical Supplies	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Breast Pump Purchase or Rental	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	1 Rental or Purchase per pregnancy
Acupuncture	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	10 Visits per year
Reproductive Services	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered
PUVA Treatment	PCP/Specialist - Not Covered	Not Covered	Not Covered
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 Subject to Deductible	Included Subject to Deductible	
Dental Oral Surgery	PCP/Specialist - Included	Included	
Temporomandibular Joint (TMJ)	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	
Nutritional Counseling	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	
Inherited Metabolic Disorder - PKU	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	
Infertility Care	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	Coverage for the diagnosis and treatment (surgical and medical) of infertility. Effective 1/1/2020. upon group renewal there are no age restrictions and the benefit now includes fertility preservation when a medical treatment will directly or indirectly lead to iatrogenic infertility and 3 cycles of in-vitro fertilization.
Organ and Bone Marrow Transplants	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	
Elective Sterilization - Female	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	
Elective Sterilization - Male	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	
Interruption of Pregnancy	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	
Reimbursement for Travel and Lodging Expenses	PCP/Specialist - Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	10% Coinsurance Subject to Deductible	10% Coinsurance Subject to $1,800 Deductible	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

ER Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physician Emergency Room Visit	PCP/Specialist - 10% Coinsurance Subject to Deductible	10% Coinsurance Subject to $1,800 Deductible	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	10% Coinsurance Subject to Deductible	10% Coinsurance Subject to $1,800 Deductible	
Air Ambulance	10% Coinsurance Subject to Deductible	10% Coinsurance Subject to $1,800 Deductible	
Ambulance - Inter Hospital Transportation	10% Coinsurance Subject to Deductible	10% Coinsurance Subject to $1,800 Deductible	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	10% Coinsurance Subject to Deductible	20% 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 - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Physician Office Visit for Urgent Care	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% 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
Surgery Decision Program			N/A

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Vision Age Limit			Does Not Apply
Pediatric Eye Exams - Routine	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	1 Exam per contract year
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	1 Exam per contract year
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered

Rx Benefits

Rx Plan

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

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
$0 Generics for Kids	Not Covered		
Generics for Kids Age Limit	Does not apply		
MAC Penalty	Not Covered		
Step Therapy	Not Covered		
Prior Authorization	Not Covered		
Oral Contraceptives	Not Covered		
Mandatory MO for Maintenance Drugs	Not Covered		
Days Supply Per Retail Order	N/A		
Days Supply Per Mail Order	N/A		
Copays Per Mail Order Supply	N/A		
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

The group has reviewed the benefit grid 2298745-1 and accepts the benefits as indicated.

Signature of Group Administrator: _____

Date: _____

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

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