General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$1,000	$2,000	
Deductible - Two Person	$2,000	$4,000	
Deductible - Family	$3,000	$6,000	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	30%	50%	
Annual Out of Pocket Maximum - Single	$3,000	$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 - Two Person	$6,000	$12,000	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	$9,000	$18,000	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	$40 Copayment	50% Coinsurance Subject to Deductible	
Cost Share - Specialist	$60 Copayment	50% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Limits Aggregation - In-network and Out of Network			In Network and Out of Network aggregate separately
Annual Maximum			Unlimited
Lifetime Benefit Maximum			Unlimited
Kids Copay Age Limit			19
Kids Copay Age Applies To			PCP only
Kids Copay Network			In
Referrals Required			No
Employer Deductible Funding Percentage			0%
HSA vs HRA			Does Not Apply
Plan/Calendar Year			Plan Year Benefits
Coordination of Benefits			Made Whole
Prior Authorization			Applies
Diabetic Preauthorization and Step Therapy			Applies

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

Additional Group Characteristics

Benefit Name	In Network	Out of Network	Limits and Additional Information
Total Employees			46
Total Eligible			110
Group Size			Large Group
Funding Arrangement			Prospective
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 80 Percent of the Medicare Prospective Payment System or 100 Percent of Charge. If the service is not listed on the Medicare Prospective Payment System, we allow 75 Percent of Charge.	
Facility Out of Area	Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 150 Percent of the Medicare Prospective Payment System, 100 Percent of Blue Card allowance or 100 Percent of Charge. If the service is not listed on the Medicare Prospective Payment System, we allow 75 Percent of Charge.	
Professional Healthcare Provider In Area	Lower of Negotiated Amount or Charge	We allow the lesser of 80 Percent of the Medicare Provider fee schedule or 100 Percent of Charge. If the service is not listed on the Medicare Provider fee schedule, we allow 75 Percent of Charge.	
Professional Healthcare Provider Out of Area	Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 150 Percent of the Medicare Provider fee schedule, 100 Percent of Blue Card allowance or 100 Percent of Charge. If the service is not listed on the Medicare Provider fee schedule, we allow 75 Percent of Charge.	
Emergency Facility in Area	Negotiated Amount. Member's cost share is based on Charge if Lower than Negotiated Rate	We allow the lesser of 100 Percent of the Negotiated Amount or 100 Percent of Charge.	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Emergency Facility Out of Area	Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 100 Percent of the Negotiated Amount, 100 Percent of Blue Card allowance or 100 Percent of Charge.	
Emergency Professional Healthcare Provider In Area	Lower of Negotiated Amount or Charge	We allow the lesser of 100 Percent of the Negotiated Amount or 100 Percent of Charge.	
Emergency Professional Healthcare Provider Out of Area	Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 100 Percent of the Negotiated Amount, 100 Percent of Blue Card allowance or 100 Percent of Charge.	
Dialysis Facility in Area	Negotiated Amount. Member's cost share is based on Charge if Lower than Negotiated Rate	We allow the lesser of 80 Percent of the Medicare Prospective Payment System or 100 Percent of Charge. If the service is not listed on the Medicare Prospective Payment System, we allow 75 Percent of Charge.	
Dialysis Facility Out of Area	Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 150 Percent of the Medicare Prospective Payment System, 100 Percent of Blue Card allowance or 100 Percent of Charge. If the service is not listed on the Medicare Prospective Payment System, we allow 75 Percent of Charge.	
Dialysis Professional Healthcare Provider In Area	Lower of Negotiated Amount or Charge	We allow the lesser of 80 Percent of the Medicare Provider fee schedule or 100 Percent of Charge. If the service is not listed on the Medicare Provider fee schedule, we allow 75 Percent of Charge.	
Dialysis Professional Healthcare Provider Out of Area	Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 150 Percent of the Medicare Provider fee schedule, 100 Percent of Blue Card allowance or 100 Percent of Charge. If the service is not listed on the Medicare Provider fee schedule, we allow 75 Percent of Charge.	

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Mental Health Care	30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Mental Health Residential Care	30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Substance Use Detoxification	30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Substance Use Rehabilitation	30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Substance Use Residential Care	30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Skilled Nursing Facility	30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	45 Days per plan year Limits are combined INN and OON.
Physical Rehabilitation	30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	60 Days per plan year Limits are combined INN and OON.
Maternity Care	30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Routine Newborn Nursery Care	30% Coinsurance	50% Coinsurance Subject to Deductible	
Prosthetic - Implanted Devices	30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Mastectomy	30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Observation Stay	$300 Copayment	50% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - 30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - 30% Coinsurance Subject to Deductible	30% Coinsurance Subject to $1,000 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 - 30% Coinsurance Subject to Deductible	50% 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	30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Colonoscopy Facility Diagnostic	30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Preadmission Pre-Operative Testing	Covered in Full	50% Coinsurance Subject to Deductible	
Diagnostic X-ray	$60 Copayment	50% Coinsurance Subject to Deductible	
Routine X-ray	$60 Copayment	50% Coinsurance Subject to Deductible	
Advanced Imaging Services	$60 Copayment	50% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans.
Mammography Facility Diagnostic	Covered in Full	50% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	50% Coinsurance Subject to Deductible	
Routine Laboratory and Pathology	Covered in Full	50% Coinsurance Subject to Deductible	
Diagnostic Testing	Covered in Full	50% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Radiation Therapy	$60 Copayment	50% Coinsurance Subject to Deductible	
Chemotherapy	$40 Copayment	50% 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	Covered in Full	50% 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	$60 Copayment	50% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	$60 Copayment	50% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Autism Applied Behavior Analysis	$60 Copayment	50% Coinsurance Subject to Deductible	
Substance Use Family Counseling	$60 Copayment	50% Coinsurance Subject to Deductible	
Pulmonary Rehabilitation	$60 Copayment	50% Coinsurance Subject to Deductible	
Cardiac Rehabilitation	$60 Copayment	50% Coinsurance Subject to Deductible	

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	Covered in Full	25% Coinsurance Subject to $50 Deductible	
Home Infusion Therapy	Covered in Full	25% Coinsurance 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	50% Coinsurance Subject to Deductible	
Hospice Care Outpatient	Covered in Full	50% Coinsurance Subject to Deductible	
Family Bereavement	Covered in Full	50% 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 - 30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Office Surgery	PCP - $40 Copayment Specialist - $60 Copayment $0 PCP Copay for members to age 19.	50% Coinsurance Subject to Deductible	
Colonoscopy Professional Diagnostic	PCP/Specialist - 30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - $60 Copayment	50% Coinsurance Subject to Deductible	
Routine X-ray	PCP/Specialist - $60 Copayment	50% Coinsurance Subject to Deductible	
Advanced Imaging Services	PCP/Specialist - $60 Copayment	50% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans
Mammography Professional Diagnostic	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Routine Laboratory and Pathology	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Diagnostic Testing	PCP - $40 Copayment Specialist - $60 Copayment	50% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - $60 Copayment	50% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - $40 Copayment	50% 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 - Covered in Full	50% 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 - $60 Copayment	50% Coinsurance Subject to Deductible	
Substance Use Treatment	PCP/Specialist - $60 Copayment	50% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - 30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Autism Applied Behavior Analysis	PCP/Specialist - $60 Copayment	50% Coinsurance Subject to Deductible	
Additional Surgical Opinion	PCP - $40 Copayment Specialist - $60 Copayment $0 PCP Copay for members to age 19.	50% Coinsurance Subject to Deductible	
Second Medical Opinion for Cancer	PCP - $40 Copayment Specialist - $60 Copayment $0 PCP Copay for members to age 19.	50% Coinsurance Subject to Deductible	
Pulmonary Rehabilitation	PCP/Specialist - $60 Copayment	50% Coinsurance Subject to Deductible	
Cardiac Rehabilitation	PCP/Specialist - $60 Copayment	50% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Visits - Diagnostic	PCP - $40 Copayment Specialist - $60 Copayment $0 PCP Copay for members to age 19.	50% 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 - $10 Copayment $0 PCP Copay for members to age 19.	Not Covered	Covers online internet consultations between the member and the providers who participate in our telemedicine program for medical conditions that are not an emergency condition.
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 - $60 Copayment	50% Coinsurance Subject to Deductible	
Hearing Evaluations Diagnostic	PCP/Specialist - $60 Copayment	50% Coinsurance Subject to Deductible	
Chiropractic Care	PCP/Specialist - $40 Copayment	50% Coinsurance Subject to Deductible	
Allergy Testing	PCP - $40 Copayment Specialist - $60 Copayment $0 PCP Copay for members to age 19.	50% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - $60 Copayment	50% 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 - Covered in Full	0% Coinsurance	1 Purchase every 3 years
Cochlear Implants	PCP/Specialist - 30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	1 Purchase every 3 years

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$60 Copayment	50% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	$60 Copayment	50% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	$60 Copayment	50% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Habilitation	$60 Copayment	50% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Habilitation	$60 Copayment	50% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Habilitation	$60 Copayment	50% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - $60 Copayment	50% Coinsurance Subject to Deductible	30 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	PCP/Specialist - $60 Copayment	50% Coinsurance Subject to Deductible	30 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	PCP/Specialist - $60 Copayment	50% Coinsurance Subject to Deductible	30 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Physical Habilitation	PCP/Specialist - $60 Copayment	50% Coinsurance Subject to Deductible	30 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Habilitation	PCP/Specialist - $60 Copayment	50% Coinsurance Subject to Deductible	30 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Habilitation	PCP/Specialist - $60 Copayment	50% Coinsurance Subject to Deductible	30 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	1 Exam per plan year
Adult Immunizations	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	0% Coinsurance	
Routine GYN Visit	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Family Planning	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Professional	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	50% 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	50% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	50% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	50% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	50% 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	50% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - $60 Copayment	50% 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	50% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	50% Coinsurance Subject to Deductible	
Bone Density Screening Facility	$60 Copayment	50% 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 - $40 Copayment	50% 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 - $40 Copayment	50% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP/Specialist - $40 Copayment	50% Coinsurance Subject to Deductible	
Diabetic Retail Max Day Supply	90		
Diabetic Retail Copay for Max Day Supply	$120 Copayment		

Benefit Name	In Network	Out of Network	Limits and Additional Information
Diabetic Mail Order Max Day Supply	90		
Diabetic Mail Order Copay for Max Day Supply	$80 Copayment		
Autism Assistive Communication Device	PCP/Specialist - $60 Copayment	50% Coinsurance Subject to Deductible	
Autologous Blood Banking	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	
Durable Medical Equipment (DME)	PCP/Specialist - 30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Mastectomy Prosthesis	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Orthotics	PCP/Specialist - 30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Foot Orthotics	PCP/Specialist - 30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Prosthetic - External Benefit	PCP/Specialist - 30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Prosthetic - Wigs External Benefit	PCP/Specialist - Not Covered	Not Covered	Not Covered
Medical Supplies	PCP/Specialist - 30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Breast Pump Purchase or Rental	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	1 Rental or Purchase per pregnancy
Acupuncture	PCP/Specialist - $60 Copayment	50% Coinsurance Subject to Deductible	10 Visits per contract 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 Subject to Deductible	Included Subject to Deductible	
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	
Organ and Bone Marrow Transplants	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
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	

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	$300 Copayment	$300 Copayment	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	$300 Copayment	$300 Copayment	
Air Ambulance	$300 Copayment	50% Coinsurance Subject to Deductible	
Intra Hospital Transportation	$300 Copayment	$300 Copayment	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$75 Copayment	50% 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	50% Coinsurance Subject to Deductible	
Physician Office Visit for Urgent Care	PCP - $40 Copayment Specialist - $60 Copayment $0 PCP Copay for members to age 19.	50% 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
Adult Eye Exams - Routine	$60 Copayment	50% Coinsurance Subject to Deductible	1 Exam per contract year
Adult Eyewear - Routine	Covered	Covered	$60 Reimbursement per plan year
Pediatric Vision Age Limit			Does Not Apply
Pediatric Eye Exams - Routine	$60 Copayment	50% Coinsurance Subject to Deductible	1 Exam per contract year
Pediatric Eyewear - Routine	30% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	1 Pair per plan year

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			$7 GENERIC

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
$0 Generics for Kids	Yes		
Generics for Kids Age Limit	Does not apply		
MAC Penalty	Yes		
Step Therapy	Yes		
Prior Authorization	Yes		
Oral Contraceptives	Included - Generics CIF		
Mandatory MO for Maintenance Drugs	No		
Days Supply Per Retail Order	30		
Days Supply Per Mail Order	90		
Copays Per Mail Order Supply	2		
Deductible	$0		
Family Deductible	$0		

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible applies to	N/A		
Embedded Rx	No		
Annual benefit maximum	Integrated with Medical		
Benefit maximum applies to	All		
OOP Maximum	Integrated with Medical		
OOP Maximum Applies to	All		

Exclusions

Exclusions

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

The group has reviewed the benefit grid 1481797-1 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.