

Iron Workers District Council of WNY

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	\$400	\$800	
Deductible - Two Person	\$800	\$1,600	
Deductible - Family	\$800	\$1,600	Each individual does not exceed the single deductible.
Services that Apply to Deductible			Medical Only
Deductible Aggregation - Single and Family			Each family member is only subject to the single Deductible and any combination of family members can satisfy the family Deductible as long as one individual does not meet more than the single deductible. Individual
Deductible Aggregation - In Network and Out of Network			In Network and Out of Network aggregate separately
Deductible Carryover Months	No	No	
History Credit	No	No	
Coinsurance	20%	40%	
Annual Out of Pocket Maximum - Single	\$3,000	No Limit	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	No Limit	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	\$6,000	No Limit	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Services that Apply to Out of Pocket Maximum			Medical Only
Annual Out of Pocket Maximum Aggregation - Single and Family			Each family member is only subject to the single Annual Out of Pocket Maximum. Individual
Annual Out of Pocket Maximum Aggregation - In Network and Out of Network			In Network and Out of Network aggregate separately

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Cost Share - Specialist	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Limits Aggregation - In-network and Out of Network			In Network and Out of Network aggregate 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			This policy requires prior authorization for Radiology, Cardiac Services & Devices, and Radiation Therapy services through eviCore healthcare. 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			No
Patient Assurance Program			Does Not Apply
Medication Assurance Program			Does Not Apply
Prior Authorization - Medical Specialty Drugs			Does Not Apply

Precertification

Benefit Name	In Network	Out of Network	Limits and Additional Information
PreCertification			Does Not Apply
PreCertification Penalty			Does Not Apply

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Type of Tiers			2 Tier (EE / FAM)
Dependent Coverage			Age to which all dependents (excluding spouse) are covered Dependent To Age 26
Dependent Age End Period			Age to which all dependents (excluding spouse) are covered End of Month
Domestic Partner Coverage			Not Covered

Additional Group Characteristics

Benefit Name	In Network	Out of Network	Limits and Additional Information
Total Employees			296
Total Eligible			0
Group Size			Large Group
Funding Arrangement			ASC
FMHP Exempt			No
Retiree Only			No
Sovereign Nation			No
Religious Group			No
Grandfathered			No

Allowable Expense

Allowable Expense

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility in Area	Negotiated Amount. Member's cost share is based on 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 75 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 200 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.	
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 200 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.	
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.	

Benefit Name	In Network	Out of Network	Limits and Additional Information
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.	
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 75 Percent of Charge.	

Benefit Name	In Network	Out of Network	Limits and Additional Information
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 200 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 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 200 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.	

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	\$100 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	INN-Deductible first then apply \$100 copay. OON Deductible first then apply \$200 copay and 30% coinsurance
Mental Health Care	\$100 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	INN-Deductible first then apply \$100 copay. OON Deductible first then apply \$200 copay and 30% coinsurance
Mental Health Residential Care	\$100 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	INN-Deductible first then apply \$100 copay. OON Deductible first then apply \$200 copay and 30% coinsurance
Substance Use Detoxification	\$100 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	INN-Deductible first then apply \$100 copay. OON Deductible first then apply \$200 copay and 30% coinsurance
Substance Use Rehabilitation	\$100 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	INN-Deductible first then apply \$100 copay. OON Deductible first then apply \$200 copay and 30% coinsurance
Substance Use Residential Care	\$100 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	INN-Deductible first then apply \$100 copay. OON Deductible first then apply \$200 copay and 30% coinsurance
Skilled Nursing Facility	\$100 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	60 Days per year Limits are combined INN and OON. INN-Deductible first then apply \$100 copay. OON Deductible first then apply \$200 copay and 30% coinsurance
Physical Rehabilitation	\$100 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	60 Days per year Limits are combined INN and OON. INN-Deductible first then apply \$100 copay. OON Deductible first then apply \$200 copay and 30% coinsurance
Maternity Care	\$100 Copayment	30% Coinsurance Subject to Deductible	INN-Deductible first then apply \$100 copay. OON Deductible first then apply \$200 copay and 30% coinsurance
Routine Newborn Nursery Care	Covered in Full	30% Coinsurance Subject to Deductible	OON Deductible first then apply \$200 and 30% coinsurance

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prosthetic - Implanted Devices	\$100 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	INN-Deductible first then apply \$100 copay. OON Deductible first then apply \$200 copay and 30% coinsurance
Mastectomy	\$100 Copayment Subject to Deductible	30% Coinsurance Subject to Deductible	INN-Deductible first then apply \$100 copay. OON Deductible first then apply \$200 copay and 30% coinsurance
Observation Stay	Covered in Full Subject to Deductible	30% Coinsurance Subject to Deductible	Includes physician services

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to \$400 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 - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	Covered in Full Subject to Deductible	30% Coinsurance Subject to Deductible	
Colonoscopy Facility Diagnostic	Covered in Full Subject to Deductible	30% Coinsurance Subject to Deductible	
Preadmission Pre-Operative Testing	Covered in Full Subject to Deductible	30% Coinsurance Subject to Deductible	
Diagnostic X-ray	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Routine X-ray	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Advanced Imaging Services	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans.
Mammography Facility Diagnostic	Covered in Full	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Routine Laboratory and Pathology	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Testing	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	20% Coinsurance Subject to Deductible	40% 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	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Injectable Drugs	Inclusive of Primary Service	Inclusive of Primary Service	Excludes vaccines, allergy injections & treatment of diabetes. Cost share is inclusive of services in which the injection is rendered with.

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mental Health Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Opioid Treatment Program	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Autism Applied Behavior Analysis	Not Covered	Not Covered	Not Covered
Substance Use Family Counseling	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Pulmonary Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Cardiac Rehabilitation	20% Coinsurance Subject to Deductible	40% 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 Subject to Deductible	30% Coinsurance Subject to Deductible	40 Visits per year Limits are combined INN and OON.
Home Infusion Therapy	Covered in Full Subject to Deductible	30% Coinsurance Subject to Deductible	
Home Dialysis	20% Coinsurance Subject to \$50 Deductible	25% Coinsurance Subject to \$50 Deductible	Limits are combined INN and OON.

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full Subject to Deductible	30% Coinsurance Subject to Deductible	180 Days per year Limits are combined INN and OON and combined with Inpatient and Outpatient.
Hospice Care Outpatient	Covered in Full Subject to Deductible	30% Coinsurance Subject to Deductible	180 Days per year Limits are combined INN and OON and combined with Inpatient and Outpatient.
Family Bereavement	Covered in Full Subject to Deductible	30% Coinsurance Subject to Deductible	5 Visits per year

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Outpatient Hospital and Ambulatory Surgery	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Office Surgery	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to \$400 Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.
Colonoscopy Professional Diagnostic	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Diagnostic X-ray	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Routine X-ray	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Advanced Imaging Services	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans
Mammography Professional Diagnostic	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Routine Laboratory and Pathology	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Testing	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% 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 - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Injectable Drugs	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	Excludes vaccines, allergy injections & treatment of diabetes. Cost share is inclusive of services in which the injection is rendered with.
Mental Health Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Substance Use Treatment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Opioid Treatment Program	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Autism Applied Behavior Analysis	PCP/Specialist - Not Covered	Not Covered	Not Covered
Additional Surgical Opinion	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Second Medical Opinion for Cancer	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Pulmonary Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Cardiac Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Visits - Diagnostic	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Covered for the diagnosis and treatment of injury, disease and medical conditions. All professional provider specialties e.g. GYN, cardiac, orthopedists, etc. are included. This also includes eye exams or hearing exams for the diagnosis or treatment of illness or injury. Office visits may include house calls.
Telehealth	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - \$10 Copayment	Not Covered	Covers online internet consultations between the member and the providers who participate in our TeleMedicine MDLive Program for medical and behavioral health conditions that are not emergency conditions.
Teledermatology	PCP/Specialist - 20% Coinsurance Subject to Deductible	Not Covered	Covers online internet consultations between the member and the providers who participate with MDLive.
Medications Administered in Office	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Excludes injections for vaccines, allergy injections & treatment of diabetes.
Eye Exams Diagnostic	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Hearing Evaluations Diagnostic	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chiropractic Care	PCP/Specialist - 50% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	\$550 maximum per individual per year Maximum benefit of \$550 per individual per calendar year combined INN and OON
Allergy Testing	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - Covered in Full	Covered in Full	\$1,000 Exam every 3 years Limits are combined INN and OON. \$1,000 maximum toward the cost of hearing aids, audiologist hearing exam or both every 3 years.
Adult Hearing Aids	PCP/Specialist - Covered in Full	Covered in Full	\$1,000 Hearing Aids every 3 years Limits are combined INN and OON. \$1,000 maximum toward the cost of hearing aids, audiologist hearing exam or both every 3 years.
Pediatric Hearing Aid Age Limit			Does Not Apply
Pediatric Hearing Aids	PCP/Specialist - Covered in Full	Covered in Full	\$1,000 Hearing Aids every 3 years Limits are combined INN and OON. \$1,000 maximum toward the cost of hearing aids, audiologist hearing exam or both every 3 years.
Cochlear Implants	PCP/Specialist - Not Covered	Not Covered	Not Covered

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Occupational Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Speech Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Physical Habilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Occupational Habilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Speech Habilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Occupational Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Speech Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Physical Habilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Occupational Habilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Speech Habilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	1 Exam per year
Adult Immunizations	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Routine GYN Visit	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Family Planning	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	30% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible	

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

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

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

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible	

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 - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Treatment of Diabetes - Insulin	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% 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 - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diabetic Retail Max Day Supply	Not Covered		
Diabetic Retail Copay for Max Day Supply	20% Coinsurance		
Diabetic Mail Order Max Day Supply	Not Covered		
Diabetic Mail Order Copay for Max Day Supply	20% Coinsurance		

Benefit Name	In Network	Out of Network	Limits and Additional Information
Autism Assistive Communication Device	PCP/Specialist - Not Covered	Not Covered	Not Covered
Autologous Blood Banking	PCP/Specialist - Not Covered	Not Covered	Not Covered
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Antiembolism and vascular support garments (e.g., Jobst) limited to two (2) per year.
Mastectomy Prosthesis	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Orthotics	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Orthotics (except for feet) subject to \$3,000 maximum per claim.
Foot Orthotics	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	\$1,000 annual maximum on all foot orthotics.
Prosthetic - External Benefit	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Prosthetic - Wigs External Benefit	PCP/Specialist - Not Covered	Not Covered	Not Covered
Medical Supplies	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Breast Pump Purchase or Rental	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	1 Rental or Purchase per pregnancy
Acupuncture	PCP/Specialist - Not Covered	Not Covered	Not Covered
Reproductive Services	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered
PUVA Treatment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Nutritional Therapy	PCP/Specialist - Not Covered	Not Covered	Not Covered
Biofeedback	PCP/Specialist - Not Covered	Not Covered	Hypnosis and Hypnotherapy are 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	Treatment for accidental injury to teeth or jaws must be received by a Dentist or Physician within twelve (12) months of injury.
Dental Oral Surgery	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	Treatment for accidental injury to teeth or jaws must be received by a Dentist or Physician within twelve (12) months of injury
Temporomandibular Joint (TMJ)	PCP/Specialist - Not Covered	Not Covered	Not Covered
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 - Not Covered	Not Covered	Not Covered
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	

Benefit Name	In Network	Out of Network	Limits and Additional Information
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

Custom Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Gene Therapy, CAR-T Therapy & Anti-Amyloid Agents	Not Covered	Not Covered	Note: Only the drugs will be excluded. Routine services associated with treatment (such as lab testing) may be covered.
Allogenic Processed Thymus Tissue & Hypoplasminogenemia Agents	Not Covered	Not Covered	Note: Only the drugs will be excluded. Routine services associated with treatment (such as lab testing) may be covered.
Gender Reassignment	Not Covered	Not Covered	

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	Covered in Full Subject to Deductible	Covered in Full Subject to \$400 Deductible	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 - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to \$400 Deductible	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	Covered in Full Subject to Deductible	Covered in Full Subject to \$400 Deductible	Non-emergency transportation services are not covered.
Air Ambulance	Covered in Full Subject to Deductible	Covered in Full Subject to \$400 Deductible	Air Transportation only covered as medically necessary due to inaccessibility by ground transport and/or use of ground transport would be detrimental to the health status of the patient.
Ambulance - Inter Hospital Transportation	Covered in Full Subject to Deductible	Covered in Full Subject to \$400 Deductible	Non-emergency transportation services are not covered.

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	Covered in Full Subject to Deductible	Covered in Full Subject to \$400 Deductible	

Urgent Care - Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physician Urgent Care Center Visit	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to \$400 Deductible	
Physician Office Visit for Urgent Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to \$400 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	Not Covered	Not Covered	Not Covered
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	Not Covered	Not Covered	Not Covered
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered

Rx Benefits

Rx Plan

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

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
\$0 Generics for Kids	N/A		
Generics for Kids Age Limit	Does not apply		
MAC Penalty	N/A		
Step Therapy	N/A		
Prior Authorization	N/A		
Oral Contraceptives	N/A		
Mandatory MO for Maintenance Drugs	N/A		
Days Supply Per Retail Order	N/A		
Days Supply Per Mail Order	N/A		
Copays Per Mail Order Supply	N/A		
Deductible	N/A		
Family Deductible	N/A		
Deductible applies to	N/A		
Embedded Rx	N/A		
Annual benefit maximum	N/A		
Benefit maximum applies to	N/A		
OOP Maximum	N/A		
OOP Maximum Applies to	N/A		

Exclusions

Exclusions

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

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

The group has reviewed the benefit grid 2354254-1 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.