Excellus

Excellus BluePPO

Benefit Time Period: 06/01/2015 - 05/31/2016

Broome County - Advantage Plan

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$250	$250	
Deductible - Two Person	$500	$500	
Deductible - Family	$500	$500	
Services that Apply to Deductible			Medical Only
Deductible Aggregation - Single and Family			Individual
Deductible Aggregation - In Network and Out of Network			In Network & Out of Network aggregate together
Deductible Carryover Months	No	No	
History Credit	No	No	
Coinsurance	20%	20%	
Annual Out of Pocket Maximum - Single	$2750	$2750	Out-of-pocket maximums accumulate the office visit copays, coinsurance amount and include the deductible, including carry over deductible if applicable.
Annual Out of Pocket Maximum - Two Person	$5500	$5500	Out-of-pocket maximums accumulate the office visit copays, coinsurance amount and include the deductible, including carry over deductible if applicable.
Annual Out of Pocket Maximum - Family	$8000	$8000	
Services that Apply to Out of Pocket Maximum			Medical Only
Annual Out of Pocket Maximum Aggregation - Single and Family			Individual
Annual Out of Pocket Maximum Aggregation - In Network and Out of Network			In Network & Out of Network aggregate together

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	$20 Copayment, not subject to deductible for PCP Visit only. All other benefits subject to deductible and 20% coinsurance unless otherwise noted.
Cost Share - Specialist	20% 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 & Out of Network aggregate together
Annual Maximum			Unlimited
Lifetime Benefit Maximum			$1,000,000 (applies to non-Essential Health Benefits Only). Once Lifetime maximum benefit is reached, no additional benefits will be paid.
Kids Copay Age Limit			Does Not Apply
Kids Copay Age Applies To			Does Not Apply
Kids Copay Network			None
Referrals Required			No
Employer Deductible Funding Percentage			0%
HSA vs HRA			Does Not Apply
Plan/Calendar Year			Calendar Year Benefits
Coordination of Benefits			Made Whole
Prior Authorization			Applies
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			No

Additional Group Characteristics

Benefit Name	In Network	Out of Network	Limits and Additional Information
Total Employees			
Total Eligible			
Group Size			
Funding Arrangement			ASC
Retiree Only			No
Sovereign Nation			No

Benefit Name	In Network	Out of Network	Limits and Additional Information
Religious Group			No
Grandfathered			No

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	30 Days per year
Mental Health Residential Care	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	30 Days per year
Substance Use Detoxification	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Substance Use Rehabilitation	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Substance Use Residential Care	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Skilled Nursing Facility	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	120 Days per year Limits are combined INN and OON.
Physical Rehabilitation	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Maternity Care	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Routine Newborn Nursery Care	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Prosthetic - Implanted Devices	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Mastectomy	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Observation Stay	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Anesthesia	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
In Hospital Physician Visits and Consults	PCP / Specialist - 20% 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	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Preadmission Pre-Operative Testing	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans.
Routine X-ray	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Advanced Imaging Services	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans.
Diagnostic Laboratory and Pathology	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Routine Laboratory and Pathology	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diagnostic Testing	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Radiation Therapy	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Chemotherapy	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service Subject to Deductible	Inclusive of Primary Service Subject to Deductible	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Injectable Drugs	Inclusive of Primary Service Subject to Deductible	Inclusive of Primary Service Subject to Deductible	Excludes vaccines, allergy injections & treatment of diabetes. Cost share is inclusive of services in which the injection is rendered with.
Mental Health Care	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Substance Use Care	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Autism Applied Behavior Analysis	Not Covered	Not Covered	Not Covered
Substance Use Family Counseling	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Pulmonary Rehabilitation	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Cardiac Rehabilitation	20% 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	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	40 Visits per year Limits are combined INN and OON.

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	180 Days Treatment (Limited to a Lifetime max of 180 days of care. Limits are combined INN and OON.
Hospice Care Outpatient	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	180 Days Treatment (Limited to a Lifetime max of 180 days of care. Limits are combined INN and OON.
Family Bereavement	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	15 Visits per year Limited to 15 Visits for up to 6 months after patient's death. Limits are combined INN and OON.

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	20% Coinsurance Subject to Deductible	
Office Surgery	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Routine X-ray	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Advanced Imaging Services	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans
Diagnostic Laboratory and Pathology	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Routine Laboratory and Pathology	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Radiation Therapy	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Chemotherapy	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Infusion Therapy	PCP / Specialist - Inclusive of Primary Service Subject to Deductible	Inclusive of Primary Service Subject to Deductible	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Injectable Drugs	PCP / Specialist - Inclusive of Primary Service Subject to Deductible	Inclusive of Primary Service Subject to Deductible	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	20% Coinsurance Subject to Deductible	
Substance Use Treatment	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Maternity Care	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% 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	20% Coinsurance Subject to Deductible	
Second Medical Opinion for Cancer	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Pulmonary Rehabilitation	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Office Visits - Diagnostic	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	PCP - $20 copay,no deductible. Specialist subject to deductible and 20% coinsurance. 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.
Medications Administered in Office	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Excludes injections for vaccines, allergy injections & treatment of diabetes.
Eye Exams Diagnostic	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Hearing Evaluations Diagnostic	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Chiropractic Care	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Limited to a $1,000 calendar year max
Allergy Testing	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP / Specialist - Not Covered	Not Covered	Not Covered
Adult Hearing Aids	PCP / Specialist - Not Covered	Not Covered	Not Covered
Pediatric Hearing Aid Age Limit			Does Not Apply
Pediatric Hearing Aids	PCP / Specialist - Not Covered	Not Covered	Not Covered
Cochlear Implants	PCP / Specialist - 20% 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	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	40 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical therapy.
Occupational Rehabilitation	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Unlimited
Speech Rehabilitation	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Unlimited
Physical Habilitation	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	40 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical therapy.
Occupational Habilitation	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Unlimited
Speech Habilitation	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Unlimited

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	40 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical therapy.
Occupational Rehabilitation	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Unlimited
Speech Rehabilitation	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Unlimited
Physical Habilitation	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	40 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical therapy.
Occupational Habilitation	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Unlimited
Speech Habilitation	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Unlimited

Preventive Services

Outpatient Facility and Professional Provider

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 year Includes associated labs and xrays
Adult Immunizations	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Routine GYN Visit	PCP / Specialist - Covered in Full	Covered in Full	
Cervical Cytology Preventative	Covered in Full	Covered in Full	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screenings	PCP / Specialist - Covered in Full	Covered in Full	
Mammography Preventive Facility	Covered in Full	Covered in Full	Routine covered in full. Diagnostic subject to ded/coins
Mammography Preventive Professional	PCP / Specialist - Covered in Full	Covered in Full	Routine covered in full. Diagnostic subject to ded/coins
Bone Density Testing Facility	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Bone Density Testing Professional	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	Routine Covered in Full. Diagnostic subject to ded/coins
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	Covered in Full	Routine Covered in Full. Diagnostic subject to ded/coins.
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	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Education	PCP / Specialist - Covered in Full	Covered in Full	
Diabetic Equipment	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Autism Assistive Communication Device	PCP / Specialist - Not Covered	Not Covered	Not Covered
Autologous Blood Banking	PCP / Specialist - Not Covered Subject to NC Deductible	Not Covered Subject to NC Deductible	Not Covered
Durable Medical Equipment (DME)	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Mastectomy Prosthesis	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Orthotics	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Foot Orthotics	PCP / Specialist - Not Covered	Not Covered	Not Covered
Prosthetic - External Benefit	PCP / Specialist - 20% 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 - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Acupuncture	PCP / Specialist - Not Covered	Not Covered	Not Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Private Duty Nursing	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Not covered on an inpatient basis

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 - Not Covered	Not Covered	Not Covered
Nutritional Counseling	PCP / Specialist - Included Subject to Deductible	Included Subject to Deductible	Nutritional Counseling is covered in full
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	
Elective Sterilization	PCP / Specialist - Included Subject to Deductible	Included Subject to Deductible	
Interruption of Pregnancy	PCP / Specialist - Included Subject to Deductible	Included Subject to Deductible	Elective Termination of Pregnancy is Not Covered.

Custom Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Smoking Cessation Programs	PCP / Specialist - Covered in Full	Covered in Full	

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
OP Facility Emergency Room Visit	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to 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 - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to 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 Services Transportation	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Air Ambulance	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Water Ambulance	Not Covered	Not Covered	Not Covered

Urgent Care Facility

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

Incentive Programs

Benefit Name	Applies	Additional Information
Gym Membership Reimbursement	No	
Exercise Rewards	No	Earn up to $600 per family per contract year for fitness facility memberships in this offline program by tracking 50 visits in a 6-month period. The program also includes free online tools to help in meeting wellness goals.
HealthyRewards/ActiveRewards	No	
BlueHealthyDollars/UniveraFit Dollars	No	
Blue4U	No	
Other Incentive Plan	No	

Vision and Dental

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Eye Exams - Routine	Not Covered	Not Covered	Not Covered
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered
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

Dental

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Dental	Not Covered	Not Covered	Not Covered
Pediatric Dental Age Limit			Does Not Apply
Pediatric Dental - Emergency Care	Not Covered	Not Covered	Not Covered
Pediatric Dental - Preventive	Not Covered	Not Covered	Not Covered
Pediatric Dental - Routine	Not Covered	Not Covered	Not Covered
Pediatric Dental - Endodontic	Not Covered	Not Covered	Not Covered
Pediatric Dental - Prosthodontics	Not Covered	Not Covered	Not Covered
Pediatric Dental - Orthodontics	Not Covered	Not Covered	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
Services with No Charge	Yes

Benefit Name	Excluded
War	Yes
Workers Compensation	Yes

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	NA		
Generics for Kids Age Limit	Does not apply		
MAC Penalty	NA		
Step Therapy	NA		
Prior Authorization	NA		
Oral Contraceptives	NA		
Mandatory MO for Maintenance Drugs	NA		
Days Supply Per Retail Order	NA		
Days Supply Per Mail Order	NA		
Copays Per Mail Order Supply	NA		
Deductible	Subject to NA Deductible		
Family Deductible	Subject to NA Deductible		
Deductible applies to	NA		
Embedded Rx	No		
Annual benefit maximum	NA		
Benefit maximum applies to	NA		
OOP Maximum	NA		
OOP Maximum Applies to	NA		

The group has reviewed the benefit grid 566787-1 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 theterms 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 list of items and services rated "A" or "B" that are covered pursuant to the Patient Protection and Affordable Care Act requirements.