CLASSIC BLUE TRADITIONAL
Benefit Summary in Certificate Order
-Benefits described as of 01/01/2017-

Group Name: FEH **Group Number(s): 00020989** **Pay Loc(s):** **Sales Consultant:** Doug Grucza	**Region Where Business Sold:** Utica **Financial Arrangement:** Min Premium **Effective Date:** 07/01/2022 **Revision Date:**

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Benefit Type Standard Guidelines	Benefit Level	Benefit description All Benefits, Mandates and limitations apply to both Par & Non-Par services unless noted.
PROVIDER ALLOWABLE EXPENSE (Pricing)		
Facility		**Par:** The Negotiated Amount or Blue Card if applicable, however, member liability is based on charge when less than the negotiated amount or Blue Card. **Non-Par:** In Area: ☐ Priced at 65% of charges (STANDARD) ☒ Priced at 80% of charges ☐ Priced at 100% of charges Out-of-Area: ☐ Priced at 65% of charges ☒ Priced at 80% of charges ☐ Priced at 100% of charges **Business Rule:** Selected allowable expense must be the same for both In & OOA non-par providers
Professional Provider		**Par:** Lowest of fee schedule, Blue Card or charge. **Non-Par:** In Area: Lower of 100% of National Medicare fee schedule or charge. If no Medicare fee schedule, 75% of charge. Out of Area: ☒ Lower of 150% of National Medicare fee schedule or charge. If no Medicare fee schedule, lower of 75% of charge or Blue Card. (STANDARD) ☐ Priced at 90% of charges ☐ Priced at 100% of charges
WHO IS COVERED		
Type of Tiers – check all that apply: • Individual • family • subscriber and spouse • subscriber and child		☒ 2-Tier ☐ 3-Tier ☐ 4-Tier
Dependent Coverage • **Administered to the end of the month**	Basic Hospital Basic Medical Enhanced Benefits	☒ **Dependent/Student to 26th** ☐ Dependents through age 29-NYS available benefit
Domestic Partner	Basic Hospital Basic Medical Enhanced Benefits	☒ Not Covered ☐ Covered
MEDICAL NECESSITY		

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Pre-Cert Apply	Basic Medical Only	☐ Precertification Required (STANDARD) The following services require Pre-certification: • Organ Transplants • Non-mandated Reproductive Procedures (IVF,GIFT,ZIFT); when rider is selected If the services above are not pre-certified, than a 50% or $500 (whichever is less) Penalty will apply. ☒ No Precertification Required
Health & Wellness Programs		☐ Other
Medical Benefit Management Program & Services		Not Covered except those service available to all members because of free access via the intranet
COST SHARING EXPENSES		
Benefit Year Calendar • Calendar begins 1/1 • Plan begins on group renewal date		☒ Calendar year ☐ Plan year

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Deductible • Individual • Family = 2x; 3x Standard: Family is an aggregate of all family members combined. Integrated with Rx Excludes Basic Hosp benefits that roll over to Enhanced When selecting Integrated with Rx or Excludes Basic Hosp Benefits that roll over to Enhanced, it must apply to all applicable Cost Sharing options e.g. deductible, coins, OOP.	Enhanced Benefits ONLY	Check all that apply: Family = 2x individual ☐ $50/$100 ☐ $75/$150 ☐ $100/$200 ☐ $150/$300 ☐ $200/$400 ☐ $300/$600 ☐ $500/$1,000 ☐ $1,000/$2,000 Family = 3x individual ☐ $50/$150 ☐ $75/$225 ☐ $100/$300 ☐ $150/$450 ☒ $200/$600 ☐ $300/$900 ☐ $500/$1,500 ☐ $1,000/$3,000 ☐ No Deductible on Rx (when integrated w/Medical). Coins, Coins Max & OOP Max still applies ☒ No Deductible on Institutional billed services covered under Basic Hospital. Institutional includes – Inpatient Hosp, Inpt Mental, Inpatient Chem Dep, Inpt Detox, Inpt Physical Rehab, SNF. Home Care is excluded. Home care will roll subject to deduct and coins. Must be paired with 0% coins option. **Business Rule:** • Deductible and Coinsurance Max will be paired. • Groups will be able to select 2x Deductible/2x Coins Max or 3x Deductible/3x Coins Max. • Groups will NOT be allowed to choose 3x deductible and 2x Coinsurance Max or 2x deductible and 3x Coins Max

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Deductible 4th quarter calendar year carry-over Integrated with Rx Excludes Basic Hosp benefits that roll over to Enhanced When selecting Integrated with Rx or Excludes Basic Hosp Benefits that roll over to Enhanced, it must apply to all applicable Cost Sharing options e.g. deductible, coins, OOP.	Enhanced Benefits ONLY	Applies
History Conversion	N/A	No
Copayment (Must be whole $ amount)	Basic Hospital ONLY (Enhanced does not apply)	Where applicable
Coinsurance (Out of network coinsurance should be ≥ in network coinsurance). Integrated with Rx Excludes Basic Hosp benefits that roll over to Enhanced When selecting Integrated with Rx or Excludes Basic Hosp Benefits that roll over to Enhanced, it must apply to all applicable Cost Sharing options e.g. deductible, coins, OOP.	Enhanced Benefits ONLY	☒ 20% ☐ 0% coins for Institutional billed services covered under Basic Hosp benefits. 20% coins for all other. Institutional includes – Inpatient Hosp, Inpt Mental, Inpatient Chem Dep, Inpt Detox, Inpt Physical Rehab, and SNF. Home Care is excluded. Home care will roll subject to deduct and coins. Must be paired with no deduct option.

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Annual Coinsurance Maximum **(formerly named OOP Max)** Integrated with Rx • Individual • Family = 2x; 3x Aggregate Family Coins Max: Any combination of individuals can meet the family Coins Max. However, no one person shall exceed the individual Coins Max When selecting Integrated with Rx or Excludes Basic Hosp Benefits that roll over to Enhanced, it must apply to all applicable Cost Sharing options e.g. deductible, coins, OOP.	Enhanced Benefits ONLY	Family = 2x individual ☐ $200/$400 ☐ $400/$800 ☐ $500/$1,000 ☐ $600/$1,200 ☐ $1,000/$2,000 Family = 3x individual ☒ $200/$600 ☐ $400/$1,200 ☐ $500/$1,500 ☐ $600/$1,800 ☐ $1,000/$3,000 **Business Rule:** • Deductible and Coinsurance Max will be paired. • Groups will be able to select 2x Deductible/2x Coins Max or 3x Deductible/3x Coins Max. • Groups will NOT be allowed to choose 3x deductible and 2x Coins Max or 2x deductible and 3x Coins Max
NEW Effective 1/1/14 Annual Out-of-Pocket Maximum All cost shares accumulate to the OOP Max (Deductibles, Coinsurance, and Copays (including Rx copays)	All Benefits	☒ **$6,350/$12,700** Applies to Groups with 2x and 3x Deductible and Coinsurance Max rules. TOTAL Umbrella Max.
Lifetime Benefit Maximum	Enhanced Benefits ONLY	☒ None
HOSPITAL INPATIENT SERVICES		

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Inpatient Hospital Services Federal Mandate - Inpt. Adm. for mastectomy must be covered for as long as attending physician deems medically necessary, includes mastectomy prosthesis Days renew and copays apply based on new single confinement (90 day break)	Basic Hospital	☐ Covered in Full ☐ $100 Copay ☒ $200 Copay ☐ $300 Copay ☐ $500 Copay Limit: ☐ 70 days ☐ 120 days ☒ Unlimited days
	Enhanced Benefits	☐ **Check this box if you selected 20% Coinsurance under COST SHARING EXPENSES**: After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins. ☐ **Check this box if you selected 0% Coinsurance under COST SHARING EXPENSES**: After basic benefits above have exhausted, additional coverage will be payable at 100% of allowance not subject to Deductible.
Mental Health Care Includes Residential Care Essential Health Benefit	Basic Hospital ONLY	Benefit equal to Inpatient Hospital Services cost share and limits.
	Enhanced Benefits	☐ **Check this box if you selected 20% Coinsurance under COST SHARING EXPENSES**: After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins ☐ **Check this box if you selected 0% Coinsurance under COST SHARING EXPENSES**: After basic benefits above have exhausted, additional coverage will be payable at 100% of allowance not subject to Deductible.

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Substance Use Detoxification, Rehabilitation & Residential Care Essential Health Benefit	Basic Hospital Only (Enhanced does not apply)	Benefit equal to Inpatient Hospital Services cost share and limits. ☐ **Check this box if you selected 20% Coinsurance under COST SHARING EXPENSES**: After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins ☐ **Check this box if you selected 0% Coinsurance under COST SHARING EXPENSES**: After basic benefits above have exhausted, additional coverage will be payable at 100% of allowance not subject to Deductible.
Skilled Nursing Facility Up to [45; 100] days per Calendar Year.	Basic Hospital Rider to Basic Hospital Endorsement to Enhanced Benefits	☐ Not Covered Rider: ☒ Cost sharing equal to Inpatient Hospital Services Limit: ☐ 45 days ☒ 100 days ☐ **Check this box if you selected 20% Coinsurance under COST SHARING EXPENSES**: After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins. ☐ **Check this box if you selected 0% Coinsurance under COST SHARING EXPENSES**: After basic benefits above have exhausted, additional coverage will be payable at 100% of allowance not subject to Deductible.

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Benefit Type **Standard Guidelines**	**Benefit Level**	**Benefit description** **All Benefits, Mandates and limitations apply to both Par & Non-Par services unless noted.**
Physical Rehabilitation (30 day limit per cal year. Day limit is NOT counted towards Inpatient Hosp day limit eg 70;120)	Basic Hospital	Cost Sharing equal to Inpatient Hospital Services Limit: 30 days per Calendar Year
	Enhanced Benefits	☒ **Check this box if you selected 20% Coinsurance under COST SHARING EXPENSES**: After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins. ☐ **Check this box if you selected 0% Coinsurance under COST SHARING EXPENSES**: After basic benefits above have exhausted, additional coverage will be payable at 100% of allowance not subject to Deductible.
Maternity Care (Federal Mandate, 48 hrs regular delivery, 96 for c-section; one home care visit covered in full, not subject to any other home care visit limitations)	Basic Hospital ONLY (Enhanced does not apply)	Cost sharing equal to Inpatient Hospital Services
Routine Newborn Nursery Care (Federal Mandate - Must cover under maternity care.)	Basic Hospital ONLY (Enhanced does not apply)	Covered in Full
Internal Prosthetics	Basic Hospital	Benefit inclusive to Inpatient Hospital Services
	Enhanced Benefits	☐ **Check this box if you selected 20% Coinsurance under COST SHARING EXPENSES**: After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins. ☐ **Check this box if you selected 0% Coinsurance under COST SHARING EXPENSES**: After basic benefits above have exhausted, additional coverage will be payable at 100% of allowance not subject to Deductible.
Observation Stay Subject to admission limit.	Basic Hospital	Cost sharing equal to Inpatient Hospital Services
	Enhanced Benefits	After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins
HOSPITAL OUTPATIENT SERVICES		
Surgical Care including Surgicenters & Freestanding Facilities	Basic Hospital ONLY (Enhanced does not apply)	Covered in Full

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Pre-admission/Pre-Operative Testing (State Mandate - benefit; same as inpatient, i.e. if ded/co applies to inpatient it can apply to pre-adm/op)	Basic Hospital ONLY (Enhanced does not apply)	Covered in Full
Diagnostic Imaging, X-ray, CAT, MRI	Basic Hospital ONLY (Enhanced does not apply)	Covered in Full
Advanced Imaging Services - Screening & Diagnostic Breast Cancer Imaging NYS & Federal Essential Health Benefit	Basic Hospital ONLY (Enhanced does not apply)	Covered in Full
Routine Imaging, X-ray, Ultrasound (Benefit must be equal to Diagnostic)	Basic Hospital ONLY (Enhanced does not apply)	Covered in Full
Diagnostic Laboratory and Pathology	Basic Hospital ONLY (Enhanced does not apply)	Covered in Full
Routine Laboratory and Pathology (Benefit must be equal to Diagnostic)	Basic Hospital ONLY (Enhanced does not apply)	Covered in Full
Radiation Therapy (excludes drugs dispensed by a pharmacy)	Basic Hospital ONLY (Enhanced does not apply)	Covered in Full
Chemotherapy (excludes drugs dispensed by a pharmacy)	Basic Hospital ONLY (Enhanced does not apply)	Covered in Full
Dialysis	Basic Hospital ONLY (Enhanced does not apply)	Covered in Full
+Mammogram (Routine) (State Mandated benefit; should be the same as inpatient, i.e. if ded/co applies to inpatient it can apply to mammogram) (For fully insured business, rt. Mammogram, rt. x-ray & diagnostic x-ray must be covered the same.)	Basic Hospital ONLY (Enhanced does not apply)	Covered in Full

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+Cervical Cytology (Pap Smear and pelvic exam does not include breast exam) (State Mandated benefit) (For fully insured business, rt. Pap smear, rt. lab & diagnostic lab must be covered the same.)	Basic Hospital ONLY (Enhanced does not apply)	Covered in Full
Mental Health Care Includes Partial Hospitalization Essential Health Benefit	Basic Hospital ONLY Enhanced Benefits	Covered in Full, unlimited visits After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins. Unlimited visits
Autism Applied Behavior Analysis State Mandate	Basic Hospital ONLY (Enhanced does not apply)	Covered at 100% of Allowable Expense Unlimited hours per contract year combined with both Par and Non-Par
Substance Use Treatment Essential Health Benefit	Basic Hospital ONLY Enhanced Benefits	Covered in Full, unlimited visits After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins. Unlimited visits
Covered Therapies (Includes aggregate of [30;60;80;100;unlimited] per calendar year of physical, speech and occupational therapy combined with professional services)	Enhanced Benefits Endorsement to Enhanced Benefits	☐ Not Covered Rider: ☐ Subject to Deduct/Coins ☒ Covered in Full Limit: ☐ 30 visits ☐ 60 visits ☐ 80 visits ☐ 100 visits ☒ Unlimited visits
Pulmonary Rehabilitation Therapy	Basic Hospital ONLY (Enhanced does not apply)	Covered in Full
Cardiac Rehabilitation	Basic Hospital ONLY (Enhanced does not apply)	Covered in Full
Home Care State Mandated Benefits cannot be less than 40 4hr. visits per 12 month period and member cannot pay more than $50 ded + 25% coinsurance.	Basic Hospital ONLY Enhanced Benefits	Covered in Full Limit: 60 visits per calendar year After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins for up to 325 visits

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Hospice Care (Includes 5 bereavement counseling visits)	Basic Hospital ONLY (Enhanced does not apply)	Covered in Full Limit: Unlimited days
PHYSICIAN SERVICES		
Inpatient Hospital Surgery (Assistant surgeon covered only when medically necessary)	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
Outpatient Hospital & Ambulatory Surgery	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
Office Surgery	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
Covered Therapies (Includes aggregate of [30;60;80;100;unlimited] days per calendar year of physical, speech and occupational therapy combined with facility)	Enhanced Benefits Endorsement to Enhanced Benefit	☐ Not Covered Rider: ☐ Subject to Deduct/Coins ☒ Covered in Full Limit: ☐ 30 visits ☐ 60 visits ☐ 80 visits ☐ 100 visits ☒ Unlimited visits
Anesthesia Includes IP/OP/OV	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
Additional Surgical Opinion State Mandated (Must be covered same as IP surgery physician & second medical opinion.)	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
Second Medical Opinion State Mandated for cancer; (Must be covered equal to or better than office visit and equal to additional surgical opinion.)	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
Normal Pregnancy Federal Mandate coverage Delivery – (Global Charge) Includes coverage for a licensed Midwife	Basic Medical ONLY (Enhanced does not apply)	Covered in Full

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Prenatal Care	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
Newborn Care Federal Mandate – coverage inclusive with maternity.	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
Complications of Pregnancy and Termination [Including elective termination of pregnancy]	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
Delivery Anesthesia	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
In-Hospital Physician Visits (Federal Mandate - IHM for mastectomy must be covered for as long as attending physician deems medically necessary) (Includes IP Mental health and Chemical Dependency visits)	Basic Medical Only Enhanced Benefit	Covered in Full Limit: Inpatient day limit applies After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins
Physician's Office – Preventive Services		
Routine Physical Examinations	Basic Medical ONLY (Enhanced does not apply)	☒ Covered in Full Limit: 1 per calendar year
Well Child Visits and Immunizations (State mandated visits/immunizations full coverage)	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
+Adult Immunizations	Basic Medical ONLY (Enhanced does not apply)	☒ Covered in Full
Physician's Office - Other Services		
Diagnostic Laboratory and Pathology (For fully insured business, rt. Pap smear, rt. lab & diagnostic lab must be covered the same.)	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
Routine Laboratory and Pathology Other then a Rt. Pap smear. (For fully insured business, rt. Pap smear, rt. lab & diagnostic lab must be covered the same.)	Basic Medical ONLY (Enhanced does not apply)	Covered in Full

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Diagnostic Eye Exams	Enhanced Benefit	Subject to Deduct/Coins
Routine Eye Exams	Enhanced Benefit Endorsement to Enhanced Benefit	☒ Not covered Rider: ☐ Subject to Deduct/Coins Limit: 1 per calendar year
Routine Eyewear	Enhanced Benefit Endorsement to Enhanced Benefit	☒ Not covered Rider: ☐ $100 allowance all hardware Limit: 1 per calendar year
Diagnostic Hearing Evaluations	Enhanced Benefit	Subject to Deduct/Coins
Routine Hearing Evaluations	Enhanced Benefits Endorsement to Enhanced Benefits	☒ Not covered Rider: ☐ Subject to Deduct/Coins Limit: 1 per calendar year
Hearing Aids	Enhanced Benefits Endorsement to Enhanced Benefits	☐ Not Covered ☐ Rider – Up to two hearing aids per lifetime (no age limit)
Diagnostic Office Visits	Enhanced Benefit ONLY	Subject to Deduct/Coins
Telemedicine Program	Enhanced Benefit ONLY	Subject to Coins only
Diagnostic Imaging Services, X-ray, CAT, MRI, etc. (For fully insured business, rt. Mammogram, rt. x-ray & diagnostic x-ray must be covered the same.)	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
Advanced Imaging Services - Screening & Diagnostic Breast Cancer Imaging NYS & Federal Essential Health Benefit	Basic Medical ONLY (Enhanced does not apply)	Covered in Full

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Routine Imaging Services, X-ray, Ultrasound, etc. Other than a Routine Mammogram (For fully insured business, rt. Mammogram, rt. x-ray & diagnostic x-ray must be covered the same.)	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
Chemotherapy Note: chemotherapy office visits are covered subject to deductible and coinsurance under Enhanced Benefits.	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
Radiation Therapy	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
Dialysis	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
+Routine Mammogram (State Mandated; should be on par with other basic physician services; copayment allowed on PPO/POS) (For fully insured business, rt. Mammogram, rt. xray & diagnostic x-ray must be covered the same.)	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
+Routine GYN Cervical Screening When done in conjunction with routine GYN visit (State Mandated pap smear and Pelvic exam; cover same as other basic physician services; copay allowed on PPO/POS)	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
Diagnostic GYN Visits	Enhanced Benefits Only	Subject to Deduct/Coins
Prostate Cancer Screenings (State Mandated if office calls covered; coverage must be equal to office calls)	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
Allergy Testing and Treatment (Injections are inclusive)	Enhanced Benefits ONLY	Subject to Deduct/Coins
Allergy Serum	Enhanced Benefits ONLY	Subject to Deduct/Coins
Mental Health Care Essential Health Benefit	Basic Medical ONLY Enhanced Benefits	Covered in Full, unlimited benefits After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins. Unlimited visits

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Autism Applied Behavior Analysis State Mandate: for physician medical services only.	Basic Medical ONLY (Enhanced does not apply)	Covered in Full Unlimited hours per contract year combined with both Par and Non-Par Large Group Option: Unlimited visits
Substance Use Treatment Essential Health Benefit	Basic Medical Enhanced Benefits	Covered in Full, unlimited visits After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins. Unlimited visits
Chiropractic Care (State Mandated covered equal to office visits)	Enhanced Benefits ONLY	Subject to Deduct/Coins
Inpatient Consultations	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
Infertility Care State Mandate: if inpatient hospital or medical/surgery covered	Basic Hospital Basic Medical (mandated services only) Endorsement to Enhanced Benefits	Covered same as similar services under benefit plan – i.e. labs see Diagnostic Laboratory and Pathology benefit, office visit see Diagnostic Office Visit benefit. Rider (non-mandated services only) Requires prior approval : ☐ Subject to Deduct/Coins Invitro, GIFT, ZIFT *Precertification required. Drugs related to these procedures will be covered under the Rx benefit selected
+Bone Density Testing (State Mandated if office visit covered)	Basic Medical ONLY (Enhanced does not apply)	Covered in Full
ADDITIONAL BENEFITS		
Treatment of Diabetes, Insulin & Supplies, Education, and DME (State Mandated; covered equal to office call for a 30 day supply, education and DME. Please Specify)	Enhanced Benefits ONLY	**Medical Provider:** ☒ Covered in full ☐ $5 Copay ☐ $10 Copay ☐ $15 Copay ☐ Subject to Deduct/Coins ☐ Subject to Coins/No Deduct **Pharmacy:** Benefit equal to Medical provider **Business Rule:** • Diabetic day supply/copay frequencies must follow Rx (non diabetic) day supply/copay frequencies chosen

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Benefit Type Standard Guidelines	Benefit Level	Benefit description All Benefits, Mandates and limitations apply to both Par & Non-Par services unless noted.
Durable Medical Equipment (DME) i.e. respirators, canes, crutches, walkers, wheelchairs, trusses, apnea monitors, oxygen-related equipment, etc.	Enhanced Benefits Endorsement to Enhanced Benefits	☐ Not Covered Rider: ☒ Subject to Deduct/20%coins, unlimited ☐ Subject to Deduct/50% coins, unlimited
External Prosthetics/Orthotics i.e. braces and artificial arms, legs, eyes (foot orthotics excluded) NYS Mandate: Fully Insured groups who have elected not to provide coverage for External Prosthetics & Medical Supplies, which are considered EHB's, are required to provide coverage for Ostomy equipment and supplies. Coverage under the law shall be identical to, and shall not enhance or increase, the coverage required as part of EHB. Fully insured large group policies, which are not subject to essential health benefits, are required to add coverage of Ostomy equipment and supplies if not already covered.	Enhanced Benefits Endorsement to Enhanced Benefits	☐ Not Covered Rider: ☐ Not Covered ☒ Benefit equal to DME
Medical Supplies i.e. ostomy supplies, catheters, dressings, elastic stockings NYS Mandate: Fully Insured groups who have elected not to provide coverage for External Prosthetics & Medical Supplies, which are considered EHB's, are required to provide coverage for Ostomy equipment and supplies. Coverage under the law shall be identical to, and shall not enhance or increase, the coverage required as part of EHB. Fully insured large group policies, which are not subject to essential health benefits, are required to add coverage of Ostomy equipment and supplies if not already covered.	Enhanced Benefits Endorsement to Enhanced Benefits	☐ Not Covered Rider: ☒ Covered only if External Prosthetic/Orthotics is purchased. Benefit equal to DME
Foot Orthotics i.e. custom made shoes and arch supports	Enhanced Benefits Endorsement to Enhanced Benefits	☒ Not Covered Rider: ☐ Covered only if External Prosthetic/Orthotics is purchased. Benefit equal to DME

CLASSIC BLUE TRADITIONAL
Benefit Summary in Certificate Order
-Benefits described as of 01/01/2017-

Group Name: FEH **Group Number(s): 00020989** **Pay Loc(s):** **Sales Consultant:** Doug Grucza	**Region Where Business Sold:** Utica **Financial Arrangement:** Min Premium **Effective Date:** 07/01/2022 **Revision Date:**

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Benefit Type Standard Guidelines	Benefit Level	Benefit description All Benefits, Mandates and limitations apply to both Par & Non-Par services unless noted.
Mastectomy Prosthesis Federal Mandate – coverage can be equal to the IP surgery or OV benefit, whichever is better. No limitation unless IP surgery is limited.	Basic Medical ONLY	Covered same as similar services under benefit plan
Autism Assistive Communication Devices (ACD) State Mandate: If physician medical services covered, must cover equal to specialist office visit or better.	Basic Medical ONLY	Covered in full
Air Ambulance Service	Basic Hospital ONLY (Enhanced does not apply)	Covered in Full *Subject to medical review
Prehospital Emergency Services/Transportation – includes all ground transportation State Mandate: coverage must be equal to or better than emergency benefit. Includes all ground transport	Basic Hospital ONLY (Enhanced does not apply)	Covered in Full
Acupuncture	Enhanced Benefits Endorsement to Enhanced Benefits	☒ Not Covered Rider: ☐ 50% Coins (Not subject to Deduct) Limit: 10 visits per calendar year
Family Planning - Contraceptive Devices, Sterilization Essential Health Benefit & Preventive Service	Basic Hospital Basic Medical Enhanced Benefits	**Par**: Covered in full **Non-Par**: Covered in full
Family Planning - Contraceptive Drugs Essential Health Benefit & Preventive Service	Basic Hospital Basic Medical (Enhanced does not apply)	**Par**: Covered in full generic only, brand not covered; **Non-Par**: Not Covered
Private Duty Nursing	Enhanced Benefits Endorsement to Enhanced Benefits	☐ Not Covered Rider: ☒ Subject to Deduct/Coins Limit: Unlimited (must be medically necessary)

CLASSIC BLUE TRADITIONAL
Benefit Summary in Certificate Order
-Benefits described as of 01/01/2017-

Group Name: FEH **Group Number(s): 00020989** **Pay Loc(s):** **Sales Consultant:** Doug Grucza	**Region Where Business Sold:** Utica **Financial Arrangement:** Min Premium **Effective Date:** 07/01/2022 **Revision Date:**

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Benefit Type Standard Guidelines	Benefit Level	Benefit description All Benefits, Mandates and limitations apply to both Par & Non-Par services unless noted.
Prescription Drugs (If Rx covered, enteral nutrition mandated; coverage must be equal to all other drugs; certain formulas capped at $2,500 annually.) Benefits must meet Excellus standards.	Various Rx forms/benefit levels available	☒ **NO Rx - Not Covered** ☐ **INTEGRATED Rx** - Integrate with Medical (includes coins, deductibles, Coins Max, Max and options selected on this grid) ☐ **NON-INTEGRATED Rx** - options that are NOT integrated with medical. **Please refer to the Standard Rx Form for the selection of available Rx Riders**
EMERGENCY SERVICES	**(Emergency Condition State Mandated; coverage on par with inpatient; Non Par services for an Emergency Condition must be same covered same as Par)**	
Facility Emergency Room (Par & Non-Par must be same benefit unless self-funded.)	Basic Hospital ONLY (Enhanced does not apply)	Covered in full up to provider's charge
Freestanding Urgent Care Center	Basic Hospital ONLY (Enhanced does not apply)	Covered in full up to provider's charge
Physician's Hospital Freestanding Urgent Care Visit (CIF If Freestanding Urgent Care is copayment.)	Basic Medical ONLY (Enhanced does not apply)	Covered in full up to provider's charge
Physician's Hospital Emergency Room Visit	Basic Medical ONLY (Enhanced does not apply)	Covered in full up to provider's charge
Organ and Bone Marrow Transplants Prior Approval is required ONLY when group selects pre-certification-see above.	Basic Hospital Basic Medical (Enhanced does not apply)	Covered same as similar services under benefit plan – i.e. labs see Diagnostic Laboratory and Pathology benefit, office visit see Diagnostic Office visit benefit, etc.
MISCELLANEOUS		
Pre-Existing Apply Y/N?	Basic Hospital Basic Medical Enhanced Benefits	Pre-existing condition exclusions can no longer apply
Other Benefit		Use only for benefits not listed in the above grid.

This summary describes in general outline only the main features Par & Non-Par coverage provided by Excellus Blue Cross Blue Shield. If there are any inadvertent discrepancies between this summary and the certificate, the certificate will prevail.

EXCLUSIONS: The following are common exclusions that will apply. Indicate if coverage should be provided and the applicable deductible/copayment/coinsurance.		****PLEASE NOTE:** These are general definitions listed below. Please refer to the Certificate, or Corporate Medical policies for a detailed explanation.
Acupuncture		Offered as rider (see above)
Blood products		Excluded
Certification Examinations		Excluded
Cosmetic Services		Excluded
Court-Ordered Services		Excluded
Criminal Behavior		Excluded
Custodial Care		Excluded
Dental (non-accidental services)		Excluded

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Benefit Summary in Certificate Order
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Group Name: FEH **Group Number(s): 00020989** **Pay Loc(s):** **Sales Consultant:** Doug Grucza	**Region Where Business Sold:** Utica **Financial Arrangement:** Min Premium **Effective Date:** 07/01/2022 **Revision Date:**

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Benefit Type Standard Guidelines	Benefit Level	Benefit description All Benefits, Mandates and limitations apply to both Par & Non-Par services unless noted.
Developmental Delay		Excluded
Disposable Supplies		Excluded
Durable Medical Equipment; Prosthetic Devices; Medical Supplies		Offered as a rider
Experimental and Investigational Services		Excluded
Free Care		Excluded
Government Hospitals		Excluded
Government Programs		Excluded
Hair Prosthetics		Excluded
Household Fixtures		Excludes
Hypnosis/Biofeedback		Excluded
Inpatient Rehabilitation For Chemical Dependence Or Abuse		Offered as a rider
Military Service-Connected Conditions		Excluded
No-Fault Automobile Insurance		Excluded
Non-Covered Service		Excluded
Nutritional Therapy		Excluded
Personal Comfort Services		Excluded
Prescription Drugs		Excluded
Private Duty Nursing		Offered as rider (see above)
Prohibited Referral		Excluded
Reproductive Procedures		Excluded
Extended Reproductive Services		Offered as rider (see above)
Reversal of elective sterilization.		Excluded
Routine Care of the Feet		Excluded
Self-Help Diagnosis, Training, and Treatment		Excluded
Services covered under Hospice Care		Excluded
Services starting before coverage begins		Excluded
Smoking Cessation Programs		Excluded
Special Charges		Excluded
Social Counseling and Therapy		Excluded
Transsexual Surgery and Related Services		Excluded
Unlicensed Provider		Excluded
Vision & Hearing Therapy and Supplies		Excluded
Weight Loss Services		Excluded
Workers' Compensation		Excluded

*Any difference between the allowance and the out-of-network provider's actual charge is the responsibility of the member, in addition to any applicable deductible, copayment or coinsurance amounts.

+This benefit is impacted by the Preventive Care requirements included in the Patient Protections and Affordable Care Act. In accordance with the PPACA preventive care regulations, full coverage (no cost share) will be applied for those services meeting the requirements as outlined in Grade A and B Recommendations of the United States Preventive Services Task Force."

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. Preventive Services coverage required by the Federal 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 Federal Patient Protection and Affordable Care Act requirements

Rates quoted herein are subject to change as a result of efforts to implement the Federal Patient Protection and Affordable Care Act and the Federal Mental Health Parity and Addiction Equity Act.

Medical plans are issued on either a calendar year or a plan year. Please refer to your contract for verification.

The group has reviewed the benefit grid (version noted above) and accepts the benefits as indicated.

Signature of Group Administrator ____

Date ___________________