Benefit Summary for Group:
City of Lockport
Effective Date: 1/1/2022

	POS 200 Group # 10595940-41-42 ASO			
	Core	**Plus**	**OON**	**Additional Information**
General Information				
Provider Network	200 Network			
Deductible	N/A	N/A	$500 single / $1,000 family	
Deductible Administration Type	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	
Coinsurance	N/A	N/A	25% coinsurance after deductible	
Out of Pocket Maximum	$6,350 single/$12,700 family	$6,350 single/$12,700 family	$2,500 single / $5,000 family	
Out of Pocket Administration Type	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	
Benefit Administration Date	1/1			
Dependent Coverage				
Dependent Age	26/26			
Dependent Coverage Ends	End of birth month			
Domestic Partner and Children	Not covered			
Prescription Drug Coverage				
Prescription Drugs	$7/$15/$35	$7/$15/$35		
Mail Order	3 copays per 90 day supply	3 copays per 90 day supply	Not Covered	
Physician and Other Services				
Primary Office Visit	$15 copayment	$10 or $15 copayment	25% coinsurance after deductible	
Specialist Office Visit	$15 copayment	$20 or $15 copayment	25% coinsurance after deductible	
Telemedicine	$15	$10 or $15	Not covered	

Highmark Blue Cross Blue Shield of Western New York and Highmark Blue Shield of Northeastern New York are trade names of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association.

	POS 200 Group # 10595940-41-42 ASO			
	Core	Plus	OON	Additional Information
Physician and Other Services				
Allergy Injections	$15/$15	$10/$20 or $15/$15	25% coinsurance after deductible	
Allergy Testing	$15/$15	$10/$20 or $15/$15	25% coinsurance after deductible	
Outpatient Surgical Procedures (in physician's office)	$15/$15	$10/$20 or $15/$15	25% coinsurance after deductible	
PCP Copay/Coinsurance for Dependents up to age 19	Covered in Full	Covered in Full	25% coinsurance after deductible	
Specialist Copay/Coinsurance for Dependents up to age 19	$15 copayment	$20 or $15 copayment	25% coinsurance after deductible	
Emergency and Urgent Care Services				
Emergency Room	$50 copayment	$50 copayment	Covered as in-network	Prudent layperson language applies. Emergency Room cost-share waived if admitted; Inpatient benefits now apply.
Ambulance	$50 copayment	$50 copayment	Covered as in-network	
Urgent Care Center	$15	$10 or $15	25% coinsurance after deductible	
Preventive Services				
Bone mineral density measurement or test	Covered in full	Covered in full	25% coinsurance after deductible	
Cholesterol Test (lipid panel)	Covered in full	Covered in full	25% coinsurance after deductible	
Immunizations	Covered in full	Covered in full	25% coinsurance after deductible	
Mammogram	Covered in full	Covered in full	25% coinsurance after deductible	
Prostate Test (Prostate Specific Antigen "PSA")	Covered in full	Covered in full	25% coinsurance after deductible	
Routine Physical Exam	Covered in full	Covered in full	Not covered	
Well Child Visits	Covered in full	Covered in full	25% coinsurance after deductible	

	POS 200 Group # 10595940-41-42 ASO			
	Core	Plus	OON	Additional Information
Hospital Services				
Inpatient Hospital	$250 per admission, not to exceed $250 single/ $500 family	$250 per admission, not to exceed $250 single/ $500 family	25% coinsurance after deductible	
Outpatient Surgical Procedure (Facility)	$15	$20 or $15	25% coinsurance after deductible	
Skilled Nursing Facility	$250 per admission, not to exceed $250 single/ $500 family	$250 per admission, not to exceed $250 single/ $500 family	25% coinsurance after deductible	Unlimited Days per plan yr aggregate IN + OON
Diagnostic Testing Services				
Laboratory Tests	Covered in full	Covered in full	25% coinsurance after deductible	
Radiology	$15/$15	$10/$20 or $15/$15	25% coinsurance after deductible	
Maternity Services				
Physician Services: Prenatal and Postnatal Care (initial visit)	$15	$10 or $15	25% coinsurance after deductible	
Inpatient Maternity	Covered in full	Covered in full	25% coinsurance after deductible	
Mental Health and Substance Abuse				
Inpatient Mental Health	$250 per admission, not to exceed $250 single/ $500 family	$250 per admission, not to exceed $250 single/ $500 family	25% coinsurance after deductible	Unlimited visits: Subject to medical necessity
Outpatient Mental Health	$15	$10 or $15	25% coinsurance after deductible	
Inpatient Substance Abuse - Rehab	$250 per admission, not to exceed $250 single/ $500 family	$250 per admission, not to exceed $250 single/ $500 family	25% coinsurance after deductible	
Inpatient Substance Abuse - Detox	$250 per admission, not to exceed $250 single/ $500 family	$250 per admission, not to exceed $250 single/ $500 family	25% coinsurance after deductible	
Outpatient Substance Abuse	$15	$10 or $15	25% coinsurance after deductible	
Diabetic Supplies and Services				
Diabetic Equipment	$15	$10 or $15	25% coinsurance after deductible	
Insulin and Other Oral Agents	$15	$10 or $15	25% coinsurance after deductible	If administered by pharmacy vendor copay is lesser of Rx or office visit copay
Diabetic Medical Supplies (Test strips, Syringes, etc)	$15	$10 or $15	25% coinsurance after deductible	

	POS 200 Group # 10595940-41-42 ASO			
	Core	Plus	OON	Additional Information
Rehabilitation Services				
Chiropractic Care	$15 copayment	$15 copayment	25% coinsurance after deductible	
Physical - Occupational - Speech Therapies	$15	$20 or $15	25% coinsurance after deductible	30 visits, aggregate IN & OON with PT/OT/ST, per plan year
Pulmonary Rehabilitation	$15	$20 or $15	25% coinsurance after deductible	24 visits per year within a 12 week period
Additional Services				
Chemotherapy - Outpatient Facility	$15	$20 or $15	25% coinsurance after deductible	
Durable Medical Equipment	50% coinsurance	50% coinsurance	50% coinsurance after deductible	
Home Health Care	$15	$20 or $15	25% coinsurance after deductible	
Hospice	Covered in full	Covered in full	25% coinsurance after deductible	210 days per cal yr IN & OON aggregate
Prosthetics and orthotics	Not covered	Not covered	Not covered	
Dialysis	Covered in full	Covered in full	25% coinsurance after deductible	
Wellness Card	Not covered	Not covered	Not covered	
Pediatric Vision Services				
Routine Exam	Covered in full	Covered in full	Not covered	1 every calendar year
Medical Eye Exam	$15	$20 or $15	25% coinsurance after deductible	
Adult Vision Services				
Routine Exam	Covered in full	Covered in full	Not covered	1 every calendar year
Medical Eye Exam	$15	$20 or $15	25% coinsurance after deductible	

*Cost share may vary based on place of service for services listed above.

**For a list of Medicare Part D creditable coverage prescription drug plans, please refer to our website.

***This is a summary of covered benefits and exclusions and is not intended as an actual contract or group plan. It does not detail all benefits, limitations and exclusions that may apply.