Benefit Summary for Group:

City of Lockport

Effective Date: 1/1/2022

	POS 200 ASO Group # 10595937-38-39			
	Core	**Plus**	**OON**	**Additional Information**
General Information				
Provider Network	200 Network			
Deductible	N/A	N/A	$250 single / $500 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	20% coinsurance after deductible	
Out of Pocket Maximum	$6,350 single/$12,700 family	$6,350 single/$12,700 family	$1,500 single / $3,000 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	$5 copayment/$5 copayment	$5 copayment/$5 copayment		
Mail Order	3 copays per 90 day supply	3 copays per 90 day supply	Not Covered	
Physician and Other Services				
Primary Office Visit	$5 copayment	$0 or $5 copayment	20% coinsurance after deductible	
Specialist Office Visit	$10 copayment	$15 or $10 copayment	20% coinsurance after deductible	
Telemedicine	$5	$0 or $5	Not covered	

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Physician and Other Services				
Allergy Injections	$5/$10	$0/$15 or $5/$10	20% coinsurance after deductible	
Allergy Testing	$5/$10	$0/$15 or $5/$10	20% coinsurance after deductible	
Outpatient Surgical Procedures (in physician's office)	$5/$10	$0/$15 or $5/$10	20% coinsurance after deductible	
PCP Copay/Coinsurance for Dependents up to age 19	$5 copayment	$0 or $5 copayment	20% coinsurance after deductible	
Specialist Copay/Coinsurance for Dependents up to age 19	$10 copayment	$15 or $10 copayment	20% 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	$5	$0 or $5	20% coinsurance after deductible	
Preventive Services				
Bone mineral density measurement or test	Covered in full	Covered in full	20% coinsurance after deductible	
Cholesterol Test (lipid panel)	Covered in full	Covered in full	20% coinsurance after deductible	
Immunizations	Covered in full	Covered in full	20% coinsurance after deductible	
Mammogram	Covered in full	Covered in full	20% coinsurance after deductible	
Prostate Test (Prostate Specific Antigen "PSA")	Covered in full	Covered in full	20% coinsurance after deductible	
Routine Physical Exam	Covered in full	Covered in full	Not covered	
Well Child Visits	Covered in full	Covered in full	20% coinsurance after deductible	

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Hospital Services				
Inpatient Hospital	Covered in full	Covered in full	20% coinsurance after deductible	
Outpatient Surgical Procedure (Facility)	$10	$15 or $10	20% coinsurance after deductible	
Skilled Nursing Facility	Covered in full	Covered in full	20% coinsurance after deductible	Unlimited days per plan year aggregate INN & OON
Diagnostic Testing Services				
Laboratory Tests	Covered in full	Covered in full	20% coinsurance after deductible	
Radiology	$5/$10	$0/$15 or $5/$10	20% coinsurance after deductible	
Maternity Services				
Physician Services: Prenatal and Postnatal Care (initial visit)	$5	$0 or $5	20% coinsurance after deductible	
Inpatient Maternity	Covered in full	Covered in full	20% coinsurance after deductible	
Mental Health and Substance Abuse				
Inpatient Mental Health	Covered in full	Covered in full	20% coinsurance after deductible	Unlimited visits: Subject to medical necessity
Outpatient Mental Health	$5	$0 or $5	20% coinsurance after deductible	
Inpatient Substance Abuse - Rehab	Covered in full	Covered in full	20% coinsurance after deductible	
Inpatient Substance Abuse - Detox	Covered in full	Covered in full	20% coinsurance after deductible	
Outpatient Substance Abuse	$5	$0 or $5	20% coinsurance after deductible	
Diabetic Supplies and Services				
Diabetic Equipment	$5	$0 or $5	20% coinsurance after deductible	
Insulin and Other Oral Agents	$5	$0 or $5	20% coinsurance after deductible	If administered by pharmacy vendor copay is lesser of Rx or office visit copay
Diabetic Medical Supplies (Test strips, Syringes, etc)	$5	$0 or $5	20% coinsurance after deductible	

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Rehabilitation Services				
Chiropractic Care	$5 copayment	$5 copayment	20% coinsurance after deductible	
Physical - Occupational - Speech Therapies	$10	$15 or $10	20% coinsurance after deductible	30 visits, aggregate IN & OON with PT/OT/ST, per plan year
Pulmonary Rehabilitation	$10	$15 or $10	20% coinsurance after deductible	24 visits per year within a 12 week period
Additional Services				
Chemotherapy - Outpatient Facility	$10	$15 or $10	20% coinsurance after deductible	
Durable Medical Equipment	20% coinsurance	20% coinsurance	50% coinsurance after deductible	
Home Health Care	$10	$15 or $10	20% coinsurance after deductible	
Hospice	Covered in full	Covered in full	20% coinsurance after deductible	210 days per cal yr IN & OON aggregate
Prosthetics and orthotics	20% coinsurance	20% coinsurance	Not covered	
Dialysis	Covered in full	Covered in full	20% 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	$10	$15 or $10	20% coinsurance after deductible	
Adult Vision Services				
Routine Exam	Covered in full	Covered in full	Not covered	1 every calendar year
Medical Eye Exam	$10	$15 or $10	20% 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.