

## BROOME COUNTY ADVANTAGE PLAN SCHEDULE OF BENEFITS

Applies to Employees in Active Service, COBRA Beneficiaries, Retirees and their Dependents, Surviving Spouses and Surviving Dependents.

**All claims must be filed no later than 180 days after the claim incurred or the claim will be denied.  
IF YOU SELECT THIS PLAN, YOU CANNOT CHANGE TO ANOTHER PLAN DURING OPEN ENROLLMENT.**

<b>TYPE OF SERVICE</b>	<b>BENEFITS</b>
The limits and maximums are combined for in and out-of-network Providers.	The Allowable Expense is limited to the Reasonable and Customary amount or the Preferred Provider Reimbursement Schedule. The deductible applies to all services prior to benefit payment, except where noted.
<b>Hospital</b> (also see Mental Illness, Substance Abuse, and maternity care for inpatient benefits) <ul style="list-style-type: none"> <li>• Inpatient Hospital <sup>(1)</sup> <span style="float: right;">80%</span></li> <li>• Outpatient Hospital               <ul style="list-style-type: none"> <li>-Emergency room for a medical Emergency (Includes physician) <span style="float: right;">80%</span></li> <li>-Emergency room treatment for a Non-emergency. (Includes physician) <span style="float: right;">80%</span></li> <li>-Outpatient surgical center <span style="float: right;">80%</span></li> <li>-Clinic <span style="float: right;">80%</span></li> <li>-Laboratory <span style="float: right;">80%</span></li> <li>-X-rays – diagnostic <sup>(1)</sup> <span style="float: right;">80%</span></li> <li>-Diagnostic tests <span style="float: right;">80%</span></li> <li>-Radiation/chemotherapy <span style="float: right;">80%</span></li> <li>-Respiratory therapy <span style="float: right;">80%</span></li> <li>-Physical therapy (Limited to 40 visits per calendar year) <span style="float: right;">80%</span></li> <li>-Occupational/speech therapy <span style="float: right;">80%</span></li> <li>-Cardiac rehabilitation <span style="float: right;">80%</span></li> <li>-Dialysis or hemodialysis <span style="float: right;">80%</span></li> </ul> </li> </ul>	
<b>Freestanding Surgical Facility</b> <sup>(1)</sup>	80%
<b>Urgent Care Facility</b>	80%
<b>Ambulance</b>	80%
<b>Preadmission Testing</b>	80%
<b>Convalescent/Skilled Nursing Facility</b> <ul style="list-style-type: none"> <li>• Inpatient <sup>(1)</sup> <span style="float: right;">80%</span> (Limit 120 days per calendar year)</li> <li>• Outpatient <span style="float: right;">80%</span></li> </ul>	

(1) All inpatient admissions, (excluding maternity admissions, which require Post-Certification if stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section) magnetic resonance imaging (MRI), chiropractic services, home health care, outpatient surgery, and Durable Medical Equipment rentals/purchases greater than \$500 annually require Pre-Certification. Failure to Pre-Certify may result in a penalty of \$200 or services may be denied because they are not Medically Necessary.

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<b>Rehabilitation Facility</b> <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Outpatient</li> </ul>	<p style="text-align: right;">80%</p> <p style="text-align: right;">80%</p>
<b>Home Health Care <sup>(1)</sup></b> (Limited to 40 visits per calendar year) <ul style="list-style-type: none"> <li>• Aide visit or nurse/therapist shift service</li> <li>• Home IV therapy and respiratory care</li> </ul>	<p style="text-align: right;">80%</p> <p style="text-align: right;">80%</p>
<b>Hospice Care</b> <ul style="list-style-type: none"> <li>• Treatment (Limited to a Lifetime maximum of 6 months of care)</li> <li>• Bereavement Counseling (Limited to 15 visits for up to 6 months after patient's death)</li> </ul>	<p style="text-align: right;">80%</p> <p style="text-align: right;">80%</p>
<b>Private Duty Nursing</b> (Not covered on an inpatient basis)	<p style="text-align: right;">80%</p>
<b>Mental Illness Services</b> <ul style="list-style-type: none"> <li>• Inpatient <sup>(1)</sup> (Hospital or Behavioral Health Care Facility) (Limited to 30 days per calendar year)</li> <li>• Inpatient physician</li> <li>• Outpatient Hospital/facility/office</li> </ul>	<p style="text-align: right;">80%</p> <p style="text-align: right;">80%</p> <p style="text-align: right;">80%</p>
<b>Substance Abuse Treatment</b> <ul style="list-style-type: none"> <li>• Inpatient <sup>(1)</sup> (Hospital or Behavioral Health Care Facility)</li> <li>• Inpatient physician</li> <li>• Outpatient Hospital/facility/office</li> </ul>	<p style="text-align: right;">80%</p> <p style="text-align: right;">80%</p> <p style="text-align: right;">80%</p>
<b>Diabetic Education</b>	<p style="text-align: right;">80%</p>
<b>Nutritional Counseling</b>	<p style="text-align: center;">Not covered</p>
<b>IV Therapy</b> <ul style="list-style-type: none"> <li>• Outpatient</li> <li>• Office</li> </ul>	<p style="text-align: right;">80%</p> <p style="text-align: right;">80%</p>

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<b>Maternity Care – Mother</b> <ul style="list-style-type: none"> <li>• Inpatient Hospital Post-Certification required <sup>(1)</sup></li> <li>• Physician for prenatal care and delivery</li> </ul>	80%  80%
<b>Newborn Care</b> (Prior to discharge) Post-Certification required <sup>(1)</sup> <ul style="list-style-type: none"> <li>• Hospital</li> <li>• Physician</li> <li>• Newborn Circumcision (Not covered after discharge)</li> </ul>	80% 80% 80%
<b>Physician</b> (except for routine care and delivery, or treatment of Mental Illness or Substance Abuse) <ul style="list-style-type: none"> <li>• Inpatient visit</li> <li>• Office visit</li> <li>• Home visit</li> <li>• Consultation (Specialist) <ul style="list-style-type: none"> <li>-Inpatient</li> <li>-Outpatient</li> <li>-Office</li> </ul> </li> <li>• Surgery <ul style="list-style-type: none"> <li>-Inpatient</li> <li>-Outpatient <sup>(1)</sup></li> <li>-Office</li> <li>-Assistant surgeon</li> </ul> </li> <li>• Second surgical opinion – voluntary</li> </ul>	80% \$20 Copayment, then 100%, not subject to deductible \$20 Copayment, then 100%, not subject to deductible  80% 80% 80%  80% 80% 80% 80%
<b>Anesthesia</b> <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Office</li> <li>• Outpatient</li> </ul>	80% 80% 80%
<b>Allergy Care</b> <ul style="list-style-type: none"> <li>• Treatment, serum, and scratch testing</li> <li>• Testing - laboratory</li> </ul>	80% 80%
<b>Chiropractor</b> <sup>(1)</sup> (Limited to a \$1,000 calendar year maximum)	80%

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<p><b>Preventative/Well Care</b></p> <ul style="list-style-type: none"> <li>• GYN office visit <sup>(2)</sup></li> <li>• Pap smear <sup>(2)</sup></li> <li>• Mammogram (Limited to one per year for Covered Family Members 40 and older)</li> <li>• Well child care to age 19 (Includes immunizations.) Exams for ages 0-7 are covered per AMA guidelines. Exams for ages 7 to 19 are covered once per calendar year.</li> <li>• Routine adult physicals (Limited to one exam, including lab and x-ray testing, per calendar year for adults age 19 and over)</li> <li>• Routine immunizations (Covered for adults over age 19 as recommended by the American Academy of Family Physicians)</li> <li>• PSA test <sup>(2)</sup></li> <li>• Routine colon cancer screening <sup>(2)</sup></li> </ul>	<p style="text-align: center;">100%, not subject to deductible 100%, not subject to deductible 100%, not subject to deductible</p> <p>100%, not subject to deductible, if rendered by a Participating Provider. 80%, subject to deductible if rendered by a Non-Participating Provider.</p> <p>100%, not subject to deductible, if rendered by a Participating Provider. 80%, subject to deductible if rendered by a Non-Participating Provider.</p> <p>100%, not subject to deductible, if rendered by a Participating Provider. 80%, subject to deductible if rendered by a Non-Participating Provider.</p> <p style="text-align: center;">100%, not subject to deductible 80%</p>
<p><b>Mammogram (Medically Necessary)</b></p>	<p style="text-align: center;">100%, not subject to deductible</p>
<p><b>Outpatient Diagnostic Tests</b> <sup>(1)</sup></p> <ul style="list-style-type: none"> <li>• <b>Freestanding Facility</b> Laboratory/diagnostic tests, x-rays</li> <li>• <b>Physicians Office</b> Laboratory/diagnostic tests, x-rays</li> <li>• <b>Home</b></li> </ul>	<p style="text-align: center;">80%</p> <p style="text-align: center;">80%</p> <p style="text-align: center;">80%</p>
<p><b>Outpatient Treatments</b></p> <ul style="list-style-type: none"> <li>• <b>Freestanding Facility</b> Chemotherapy Radiation therapy</li> <li>• <b>Physician's Office</b> Chemotherapy Radiation therapy</li> </ul>	<p style="text-align: center;">80%</p> <p style="text-align: center;">80%</p> <p style="text-align: center;">80%</p> <p style="text-align: center;">80%</p>
<p><b>Foot Orthotics</b> (Only covered if required within 90 days of surgery as part of post-surgical treatment)</p>	<p style="text-align: center;">80%</p>
<p><b>Prosthetics, Medical Supplies, Diabetic Supplies and Oxygen</b></p>	<p style="text-align: center;">80%</p>
<p><b>Durable Medical Equipment</b> <sup>(1)</sup></p>	<p style="text-align: center;">80%</p>

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(2) Routine screenings are covered as recommended by the attending physician.

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<b>Other Services &amp; Therapy</b> <ul style="list-style-type: none"> <li>• <b>Outpatient Freestanding Facility and Physician's Office</b> <ul style="list-style-type: none"> <li>-Blood and blood products</li> <li>-Dialysis or hemodialysis</li> <li>-Respiratory therapy</li> <li>-Physical therapy (Limited to 40 visits per calendar year)</li> <li>-Occupational therapy</li> <li>-Speech therapy</li> <li>-Cardiac rehabilitation</li> </ul> </li> </ul>	80% 80% 80% 80% 80% 80% 80%
<b>Oxygen and Supplies</b>	80%
<b>Smoking Cessation Programs</b> (Limited to a Lifetime maximum of two programs)	80%
<b>CALENDAR YEAR DEDUCTIBLE</b>	\$250 Individual/\$500 Family
<b>CALENDAR YEAR COINSURANCE MAXIMUM</b> (Does not include deductible)	\$2,500 Individual
<b>LIFETIME MAXIMUM</b> (Includes Hospital and Major Medical services)	\$1,000,000 Once the Lifetime Maximum benefit is reached, no additional Hospital or Major Medical benefits will be paid.

<b>PRESCRIPTION DRUG PLAN</b>	
<b>Retail</b> - Up to a 30 day supply	<ul style="list-style-type: none"> <li>• \$10 Copayment for Generic Drugs</li> <li>• \$25 Copayment for Preferred Drugs</li> <li>• \$40 Copayment for Non-Preferred Drugs</li> </ul>
<b>Mail Order Maintenance Drugs - Up to a 90 day supply</b>	<ul style="list-style-type: none"> <li>• \$20 Copayment for Generic Drugs</li> <li>• \$50 Copayment for Preferred Drugs</li> <li>• \$80 Copayment for Non-Preferred Drugs</li> </ul>
Copayments under the Prescription Drug Plan do not apply toward the medical Coinsurance Maximum. The prescription drug benefits do not apply toward the medical Lifetime Maximum.	

**Note: This Coverage Summary is intended to be a general description of benefits only. Some limitations, conditions, or exclusions may apply. The benefits listed above are subject to change at any time. If there is a discrepancy between this overview and the Plan Document, the Plan Document will prevail. Services must be Medically Necessary treatment of Sickness or Injury, unless otherwise stated. The fact that a physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it Medically Necessary even though it is not specifically listed as an exclusion. All of the facts and circumstances surrounding the claim must be considered.**