GENESEE EDUCATION CONSULTANT SERVICES
SCHEDULE OF BENEFITS
HSA $1,650 PLAN

EFFECTIVE: 01/01/2025

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
MAXIMUM CALENDAR YEAR BENEFIT AMOUNT	None (unlimited)	
DEDUCTIBLE, PER CALENDAR YEAR		
Individual *(per covered person)*	$1,650	$3,000
Family	$3,300	$6,000

Amounts applied to the Deductible for charges from Network Providers will NOT be used to satisfy the Deductible for charges from Non-Network Providers and vice versa.

The Plan has a non-embedded deductible. This means, for family coverage, the entire family Deductible must be satisfied (either by one individual or collectively by the family unit) before benefits subject to the deductible for a Covered Person in the family until will be considered for payment by the Plan.

MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Individual *(per covered person)*	$4,000 *(includes copays, deductible and coinsurance)*	$8,000 *(includes copays, deductible and coinsurance)*
Family	$8,000 *(includes copays, deductible and coinsurance)*	$16,000 *(includes copays, deductible and coinsurance)*

Amounts applied to the Maximum Out-Of-Pocket Amount for charges from Network Providers will NOT be used to satisfy the Maximum Out-of-Pocket Amount for charges from Non-Network Providers and vice versa.

For family coverage, the Plan has an embedded individual Maximum Out-of-Pocket Amount. This means Covered Services will be paid at 100% for a Covered Person in the family unit after the Covered Person meets a Maximum Out-of-Pocket Amount. The family unit must satisfy the family Maximum Out-of-Pocket Amount before the Plan will pay benefits at 100% for all Covered Persons in the family.

The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.

The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%.

- Cost containment penalties
- Non-Covered Expenses
- Amounts that exceed an Allowable Charge
- Amounts that exceed benefit maximums

NOTE: Prescription drug co-payments ARE included in the out-of-pocket maximum amount.

COVERED SERVICES

Percentages listed indicate the portion of the Allowable Charge that the Plan will pay in benefits subject to all exclusions and limitations described in this document. Copayments and deductibles are the Covered Person's responsibility to pay.

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
PREVENTIVE CARE The Plan will cover the following preventive services from a Network Provider with no charge for the Covered Person: ➢ Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force *except* for the recommendations issued in or around November of 2009 for breast cancer screening, mammography, and prevention are not considered to be current. ➢ Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. ➢ With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and ➢ With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. *Benefits are subject to frequency guidelines set forth in the Affordable Care Act.*		
Routine Well Adult Care		
Office Visit including physical examination	100%, deductible waived	Not Covered
Immunizations/flu shots	100%, deductible waived	Not Covered
Lab tests and X-rays	100%, deductible waived	Not Covered
Gynecological exam	100%, deductible waived	Not Covered
Pap smear	100%, deductible waived	Not Covered
Mammogram	100%, deductible waived	Not Covered
Prostate exam/PSA	100%, deductible waived	Not Covered
Bone Density	100%, deductible waived	Not Covered
Endoscopic Tests (Sigmoidoscopy/Colonoscopy)	100%, deductible waived	Not Covered
Hearing Screening	Not Covered	Not Covered
Annual Vision Exam	Not Covered	Not Covered
Vision Hardware (frames, lenses, and contacts)	Not Covered	Not Covered
Routine Well Child Care (for individuals from age 0 up to age 18)		
Office Visit including physical exam	100%, deductible waived	Not Covered
Lab tests and X-rays	100%, deductible waived	Not Covered
Immunizations/Flu shots	100%, deductible waived	Not Covered
Hearing Screening	Not Covered except as required under the Affordable Care Act	Not Covered
Vision Services (exams, frames, lenses, etc.)	Not Covered except as required under the Affordable Care Act	Not Covered

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
HOSPITAL SERVICES		
Room and Board* *Benefits payable at the facility's semi-private room rate.*	100% after deductible	80% after deductible
Intensive Care Unit* *Benefits payable at the facility's ICU rate*	100% after deductible	80% after deductible
Skilled Nursing Facility* *Calendar Year maximum: 90 days*	100% after deductible	80% after deductible
Emergency Room *All services rendered during visit*	100% after in-network deductible	
PHYSICIAN SERVICES		
Office Visit – Primary Care Physician *All services rendered in office visit*	100% after deductible	80% after deductible
Office Visit – Specialist Care Physician *All services rendered in office visit*	100% after deductible	80% after deductible
Telephonic or Virtual Consultations *Primary Care Physician* *Specialist Care Physician*	 100% after deductible 100% after deductible	 80% after deductible 80% after deductible
Telemedicine via Teladoc *General Medicine*	$57 fee	Not Applicable

*****Requires Precertification*

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
OTHER SERVICES		
Ambulance Services	100% after in-network deductible	
Organ Transplants*	100% after deductible	Not Covered
Elective Surgery*	100% after deductible	80% after deductible
Lab	100% after deductible	80% after deductible
X-Rays	100% after deductible	80% after deductible
Advanced Imaging*	100% after deductible	80% after deductible
Diagnostic Testing	100% after deductible	80% after deductible
Maternity Services	100% after deductible *Deductible and coinsurance are waived for services included in the recommendations and guidelines listed above in this Schedule under preventive care (e.g., preventive prenatal and breastfeeding support services).*	80% after deductible
Home Health Care*	100% after deductible	80% after deductible
Infusion Therapy *Home or Office setting*	100% after deductible	80% after deductible
Hospice Care	100% after deductible	80% after deductible
Applied Behavioral Analysis	100% after deductible	80% after deductible
Spinal Manipulation/Chiropractic *Calendar Year maximum: 12 visits*	100% after deductible	80% after deductible
Physical Therapy *Calendar Year maximum: 30 visits combined with Speech and Occupational Therapy. Unlimited with Autism diagnosis*	100% after deductible	80% after deductible
Speech Therapy *Calendar Year maximum: 30 visits combined with Physical and Occupational Therapy. Unlimited with Autism diagnosis*	100% after deductible	80% after deductible
Occupational Therapy *Calendar Year maximum: 30 visits combined with Physical and Speech Therapy. Unlimited with Autism diagnosis*	100% after deductible	80% after deductible

Requires Precertification

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
OTHER SERVICES		
Testing for the 2019 NOVEL Coronavirus (COVID – 19)	100%, deductible waived	
Urgent Care	100% after deductible	80% after deductible
Chemotherapy*	100% after deductible	80% after deductible
Radiation Therapy*	100% after deductible	80% after deductible
Dialysis	100% after deductible	80% after deductible
Infertility *Lifetime maximum: $10,000*	100% after deductible	80% after deductible
Allergy Services *Includes serum, injections, and testing*	100% after deductible	80% after deductible
Durable Medical Equipment*	100% after deductible	80% after deductible

***Requires Precertification*

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
MENTAL HEALTH DISORDERS		
Inpatient/Partial Hospitalization*	100% after deductible	80% after deductible
Outpatient Facility	100% after deductible	80% after deductible
Office Visit	100% after deductible	80% after deductible
SUBSTANCE USE DISORDERS		
Inpatient/Partial Hospitalization*	100% after deductible	80% after deductible
Outpatient Facility	100% after deductible	80% after deductible
Office Visit	100% after deductible	80% after deductible

***Requires Precertification*

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
ALL OTHER COVERED SERVICES	100% after deductible	80% after deductible

PRESCRIPTION DRUG BENEFITS
HSA $1,650 PLAN

NOTE: If a Covered Person requests a Brand Name Drug instead of a Generic Drug recommended by the pharmacy, the Covered Person will pay the Brand Name Drug copayment as well as the prescription cost between the Brand Name and the Generic Drug. A Covered Person will not be required to pay the difference in price between a Brand Name and Generic Drug when the Physician writes "DAW," or "Dispense as Written" on the prescription.

PRESCRIPTION DRUGS		
	RETAIL PHARMACY *30-day supply*	**RETAIL/MAIL ORDER PHARMACY** *90-day supply*
Generic (Tier 1)	$15 copayment after deductible	$30 copayment after deductible
Preferred Brand Name (Tier 2)	$50 copayment after deductible	$100 copayment after deductible
Non-Preferred Brand Name (Tier 3)	$70 copayment after deductible	$140 copayment after deductible
SPECIALTY DRUGS		
	SPECIALTY PHARMACY *30- day supply*	
Specialty Generic	$100 copayment after deductible	
Specialty Preferred Brand Name	$100 copayment after deductible	
Specialty Non-Preferred Brand Name	$100 copayment after deductible	
OVER THE COUNTER		
	OVER THE COUNTER	
Over-the-Counter Testing for the 2019 Novel Coronavirus (COVID-19) *Limit: 8 per participant per calendar month**, and reimbursement of $12 per OTC test****	100%, deductible waived	

**** Please note, all Specialty medication must be obtained via the Specialty Pharmacy.***
***This quantity limitation does not apply if the OTC Test is acquired with the involvement of or prescription by a Provider.*
****If the OTC Test is acquired with the involvement of or prescription by a Provider or if the Plan has not arranged for adequate In-Network access, the Plan will reimburse the Participant at full cost.*