GENESEE EDUCATION CONSULTANT SERVICES
SCHEDULE OF BENEFITS
PPO $0 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)*	$0	Not Applicable
Family	$0	Not Applicable

For family coverage, the Plan has an embedded individual Deductible Amount. This means the Deductible for a Covered Person in the family unit will be satisfied after the Covered Person meets the deductible. The family unit must satisfy the family Deductible before the Plan considers the Deductible met for all Covered Persons in the family.

MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Individual *(per covered person)*	$2,000 *(includes copays, deductible and coinsurance)*	Not Applicable
Family	$4,000 *(includes copays, deductible and coinsurance)*	Not Applicable

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 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% covered	Not Covered
Immunizations/flu shots	100% covered	Not Covered
Lab tests and X-rays	100% covered	Not Covered
Gynecological exam	100% covered	Not Covered
Pap smear	100% covered	Not Covered
Mammogram	100% covered	Not Covered
Prostate exam/PSA	100% covered	Not Covered
Bone Density	100% covered	Not Covered
Endoscopic Tests (Sigmoidoscopy/Colonoscopy)	100% covered	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% covered	Not Covered
Lab tests and X-rays	100% covered	Not Covered
Immunizations/Flu shots	100% covered	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.*	75% coinsurance	Not Covered
Intensive Care Unit* *Benefits payable at the facility's ICU rate*	75% coinsurance	Not Covered
Skilled Nursing Facility* *Calendar Year maximum: 45 days*	100% covered	Not Covered
Elective Surgery*/** *In a hospital setting including Surgeon Charges*	75% coinsurance	Not Covered
Emergency Room *All services rendered during visit*	$150 copayment *(Copayment waived if admitted)*	
Labs *In a hospital setting*	100% covered	Not Covered
X-Rays *In a hospital setting*	75% coinsurance	Not Covered
Diagnostic Testing *In a hospital setting*	75% coinsurance	Not Covered
PHYSICIAN SERVICES		
Office Visit – Primary Care Physician *All services rendered in office visit*	$30 copayment	Not Covered
Office Visit – Specialist Care Physician *All services rendered in office visit*	$50 copayment	Not Covered
Telephonic or Virtual Consultations *Primary Care Physician* *Specialist Care Physician*	 $30 copayment $50 copayment	 Not Covered Not Covered
Telemedicine via Teladoc *General Medicine*	$0 fee	Not Applicable

***Requires Precertification*

**Contact a WellNet Advocate for assistance locating 2-3 recommended High Quality Providers in your area. When utilizing a recommended provider your coinsurance or co-pay will be reimbursed via a HRA established by your Employer.

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
OTHER SERVICES		
Ambulance Services	$100 copayment	
Organ Transplants*	75% coinsurance	Not Covered
Elective Surgery*/** *In an office setting or Ambulatory Surgery Center*	75% coinsurance	Not Covered
Lab *In an office setting, free-standing facility, or independent lab*	100% covered	Not Covered
X-Rays *In an office setting or free-standing facility*	100% covered	Not Covered
Diagnostic Testing *In an office setting or free-standing facility*	100% covered	Not Covered
Advanced Imaging*/**	$150 copayment	Not Covered
Maternity Services – office visit	$30 copayment *Cost share is 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).*	Not Covered
Maternity Services – all other services	100% covered *Coinsurance is 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).*	Not Covered
Home Health Care*	$50 copayment	Not Covered
Infusion Therapy *Home or Office setting*	75% coinsurance	Not Covered
Hospice Care	100% covered	Not Covered
Applied Behavioral Analysis	$30 copayment	Not Covered
Spinal Manipulation/Chiropractic *Calendar Year maximum: 30 visits*	$50 copayment	Not Covered
Physical Therapy *Calendar Year maximum: 60 visits combined with Speech and Occupational Therapy*	$50 copayment	Not Covered
Speech Therapy *Calendar Year maximum: 60 visits combined with Physical and Occupational Therapy*	$50 copayment	Not Covered
Occupational Therapy *Calendar Year maximum: 60 visits combined with Physical and Speech Therapy*	$50 copayment	Not Covered

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	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
OTHER SERVICES		
Testing for the 2019 NOVEL Coronavirus (COVID – 19)	100% covered	
Urgent Care	$60 copayment	Not Covered
Chemotherapy*	75% coinsurance	Not Covered
Radiation Therapy*	100% covered	Not Covered
Dialysis	75% coinsurance	Not Covered
Infertility *Lifetime maximum: $10,000*	50% coinsurance	Not Covered
Allergy Services *Includes serum and testing*	75% coinsurance	Not Covered
Allergy Services *Includes injections*	$5 copayment	Not Covered
Durable Medical Equipment*/**	50% coinsurance	Not Covered

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	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
MENTAL HEALTH DISORDERS		
Inpatient/Partial Hospitalization*	75% coinsurance	Not Covered
Outpatient Facility	$30 copayment	Not Covered
Office Visit	$30 copayment	Not Covered
SUBSTANCE USE DISORDERS		
Inpatient/Partial Hospitalization*	75% coinsurance	Not Covered
Outpatient Facility	$30 copayment	Not Covered
Office Visit	$30 copayment	Not Covered

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	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
ALL OTHER COVERED SERVICES	50% coinsurance	Not Covered

PRESCRIPTION DRUG BENEFITS
PPO $0 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	$30 copayment
Preferred Brand Name (Tier 2)	$50 copayment	$100 copayment
Non-Preferred Brand Name (Tier 3)	$80 copayment	$160 copayment
SPECIALTY DRUGS		
	SPECIALTY PHARMACY *30- day supply*	
Specialty Generic	20% coinsurance, max $150	
Specialty Preferred Brand Name	20% coinsurance, max $300	
Specialty Non-Preferred Brand Name	20% coinsurance, max $300	
OVER THE COUNTER		
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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% covered	

**** 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.*