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|  |  | |  |  |  | | --- | --- | --- | |  |  |  | |  | **BENEFIT MATRIX MOCK-UP FOR EQN-806 (NEW OFFICE VISIT CHARGE REQUIREMENTS)**   |  | | --- | | **MEDICAL & RX BENEFIT MATRIX** | |  | |  |  |  | |  | |  | | --- | | **Walmart ACPMO**  **Associate’s Health and Welfare Plan**  **Non-Grandfathered Plan**  **Customer Service: 1-800-804-1272**  EFFECTIVE DATE: 01/01/2016 | |  | |  |  |  | | | |  |  |
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|  |  | |  | | --- | | **BULLETIN PAGE** | | | |  |  |
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|  | |  | | --- | | **CONSIDERATIONS** | | | |  |  |  |
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|  |  | |  |  | | --- | --- | | **PLAN FEATURES** | | | Benefit Options | Medical Dental - 1-800-462-5410 Vision - VSP, 1-866-240-8390 | | Benefit Period | Calendar Year(Jan - Dec) | | COB | Integration  Birthday Rule | | Dependent Child Limiting Age | Eligible Children : Through age 25; Coverage terminates on birthday  Incapacitated Child: Begins at age 19; | | Dependent Eligibility | **Covered:**  Spouse, Child, Common Law Spouse, Domestic Partner opposite sex, Domestic Partner same sex, Same Gender Spouse, Child for whom employee has legal guardianship  **Not Covered:**  Civil Union Partners (same sex), Civil Union Partners (opposite sex), Stepchildren, Children of Civil Union, Children of Domestic Partners, Children for whom employee has legal guardianship, Children for whom spouse has legal guardianship, Children for whom partner has legal guardianship, Grandchild (Legal Guardianship with parent absent from home) | | EAP | Not Applicable | | Pre-existing condition waiting period | Not Applicable | | Subrogation | Pay and Pursue (Standard); administered by Walmart's Vendor $500 Threshold | | ERISA | Yes | | Grandfathered | No | | Additional Plan Features |  | | | | |  |
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|  |  | |  |  | | --- | --- | | **PRECERTIFICATION & CASE MANAGEMENT** | | |  | | | Precertification Scheduled Hospital Admission | The following scheduled Inpatient services must be precertified:  Failure to obtain precertification will result in penalty | | Certification Non-Scheduled (Emergency) Hospital Admission | Emergency, non-scheduled, admissions must be certified within after the admission, or on the next business day after admission  Failure to obtain certification will result in penalty | | Precertification Other Procedures | The following services must be precertified:  Failure to obtain precertification will result in penalty | | Additional Precertification Information |  | | Case Management | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  | |  |  |  | |  | | --- | | Voluntary | | |  | |  | |  | | --- | |  | |  |  | |  |  |  |  | |  |  |  |  |  |  | |  | |  | | --- | |  | |  | |  | | --- | | Mandatory | |  |  | |  |  |  |  |  |  | | | Referral | Referrals not Required | | Oncology Care Management | Not Applicable | | Additional Member Support Service Information |  | | | | |  |

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|  | |  |  | | --- | --- | | **NETWORK INFORMATION** | | | Networks | HEALTHLINK | | Out-of-Network Exceptions  (Ology & Out of Area) | **Ology:**  Apply in network level of benefits to Non network physician’s services if rendered at a PPO facility, In-patient or outpatient.  The following services are covered under Ology:   * Radiology * Lab * Pathology * Anesthesia * Emergency Room Fee   **Out of Area:**  Not a Benefit | | Usual & Customary reductions for OON Claims |  | | Additional Network Information |  | |  |

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|  | |  |  | | --- | --- | | **PHARMACY BENEFITS MANAGER INFORMATION** | | | Pharmacy Benefits Manager | Express Scripts  Member Services: 800-887-6194  www.express-scripts.com  Speciality Pharmacy  Walmart Specialty Rx or Accredo  Express Scripts  Speciality Pharmacy is Mandatory  Prior Auth is Not Required  1-800-803-2523  Specialty Drugs are filled by Walmart or by CuraScript. | | Additional Pharmacy Information |  | |  |

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|  |  | |  |  | | --- | --- | | **CLAIM INFORMATION** | | | Appeal Address |  | | Appeal Filing Timeframe | 180 Days from receipt of claim denial | | Claim Check Payment Cycle | Wednesday | | Claim Filing Timeframe |  | | EOB | Monthly | | Additional Claim Information |  | | |  |
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|  | |  |  | | --- | --- | | **ADDITIONAL ADMINISTRATIVE SERVICES** | | | COBRA Administration | HSB Does Not Administer Cobra (800-570-1863) | | Employee ID Cards | HSB Prints ID Cards | | FSA | Not Applicable | | HIPAA Certificates | Not Applicable | | Life Billing | Not Applicable | | Medicare Part D Notices | Not Applicable | | Retiree Billing | Not Applicable | | 1094 / 1095 Forms | Not Applicable | | SBC Distribution |  | | Additional Administrative Services Information |  | | |  |  |

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|  |  | |  | | --- | | **PRESCRIPTION BENEFITS** | | | |  |  |
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|  | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | | | | | |  | **GENERIC** | **PREFERRED BRAND** | **NON-PREFERRED**  **BRAND** | **SPECIALTY MEDICATIONS** | | **30 Day Supply - Retail** | $4 | $50 or 25% whichever is greater | $50 or 25% whichever is greater | $50 or 20% of allowed cost whichever is greater | | **30/31/34 Day up to 60 Day Supply - Mail** | $8 | $50 or 25% whichever is greater | $50 or 25% whichever is greater | not applicable | | **30/31/34 Day up to 60 Day Supply - Retail** | $8 | $50 or 25% whichever is greater | $50 or 25% whichever is greater | not applicable | | | |  |  |  |
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|  |  | |  | | --- | | **MEDICAL & RX BENEFITS** | | | |  |  |
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|  |  |  | |  |  |  | | --- | --- | --- | | **SCHEDULE OF BENEFITS MEDICAL BENEFITS** | | | | **COVERED SERVICE/PLAN CATEGORY** | **In Network** | **Out of Network** | | Payment for in-network services is based on provider's negotiated amount. Provider cannot balance bill charges in excess of negotiated amount. Payment for out-of-network services is based on provider's customary & reasonable amount. Provider can balance bill charges in excess of C & R amount. | | | | **GENERAL INFORMATION** | | | | **Deductible** | Family: $2,500.00 | Family: $2,500.00 | |  | * All buckets combined * One member can meet in full - non embedded deductible * Deductible Carry Forward Does Not Apply | | | **Coinsurance** | Unless otherwise specified | Unless otherwise specified | | **Out-of-Pocket Limit** | Maximums Per Covered Person is | | |  | Family: $3,000.00  Thereafter, 100% until end of benefit period or maximum benefit reached | Family: $4,000.00  Thereafter, 100% until end of benefit period or maximum benefit reached | |  | * All buckets combined * One member cannot meet in full | | | **Lifetime Maximum Benefit** | Unlimited | | |  | | | | **COVERED SERVICES** | | | | **Abortion Services** | 100% Covered | 100% Covered | |  | * Eligible Members will be All female members * Maternity Abortion expenses are not covered under the plan if due to rape or incest. * Complications of pregnancy for dependent children are covered under the plan. * Maternity - Abortion for dependent children is covered under the plan only if mother's life is endangered. * Maternity Abortion expenses for dependent children are not covered under the plan if due to rape or incest. | | | **Acupuncture Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Acupuncture Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **Acupuncture Services** | 100% Covered | 100% Covered | | **ADD/ADHD Services** | 100% Covered | 100% Covered | |  | * Attention Deficit and Attention Deficit Hyperactivity Disorders are covered * Hyperactivity is covered * Behavior or conduct disorders are covered | | | **Allergy Office Visits - PCP** | $10.00 copay | $35.00 copay | | **Allergy Office Visits - Specialist** | $15.00 copay | $30.00 copay | | **Allergy Testing** | 100% Covered | 100% Covered | | **Allergy Treatment & Serum** | $15.00 copay | $30.00 copay | | **Ambulance Services**  Ground or Air | 100% Covered | 100% Covered | |  | * Benefits for Ground and Air Ambulance are combined * Air Ambulance is Medical Necessity Only * Ground Ambulance is Medical Necessity Only | | | **Ambulatory Surgical Facility** | 100% Covered | 100% Covered | | **Anesthesiologist Services** | 100% Covered | 100% Covered | | **Autism Services** | 100% Covered | 100% Covered | |  | * Autism Spectrum Disorders are covered * Hyperactivity is covered | | | **B12 Injections** | 100% Covered | 100% Covered | |  | * Coverage is limited to diagnosis of pernicious anemia/Vitamin B-12 deficiency. | | | **Birthing Center** | 100% Covered | 100% Covered | | **Birth Control** | 100% Covered | 100% Covered | | **Birth Control Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Birth Control Office Visit-Specialist** | $15.00 copay | $30.00 copay | | **Breast Pumps**  The plan only covers the listed models and only through the datafield process.  Reimbursement will not be paid for any other models.  Covered only after mother delivers for babies born 01.01.2013 and after. | When the member calls to order a breast pump:     * Confirm the type requested is the one the group made available: * Confirm the member's address and must advise the member that we cannot guarantee the model ordered will be the actual pump delivered. Depending on availability a similar model may be substituted. * Complete the highlighted sections on the Breast pump Invoice and email to Ashley Stokes. * Document in tracking that order form was emailed | | | **Cardiac Rehabilitation** | 100% Covered | 100% Covered | | **Cataract Contacts or Glasses** | 100% Covered | 100% Covered | | **Chemical Face Peels** | 100% Covered | 100% Covered | | **Chemotherapy Office Visit-PCP** | $10.00 copay | $35.00 copay | | **Chemotherapy Office Visit-Specialist** | $15.00 copay | $30.00 copay | | **Chemotherapy** | 100% Covered | 100% Covered | | **Chiropractic Services** | $15.00 copay | $30.00 copay | | **Christian Science Practitioner** | 100% Covered | 100% Covered | | **Cochlear Devices** | 100% Covered | 100% Covered | | **Cosmetic Surgery** | 100% Covered | 100% Covered | |  | * Cosmetic Surgery covered under Injury/malformation * Cosmetic Surgery covered under Breast reduction (medically necessary) | | | **Custodial Care Services** | 100% Covered | 100% Covered | | **Dental Services Accident Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Dental Services Accident Office Visit-Specialist** | $15.00 copay | $30.00 copay | | **Dental Services Accident** | 100% Covered | 100% Covered | |  | * If this plan has supplemental Accident Benefits, apply to dental accidents is allowed. * Services must be completed within 6 months | | | **Dental Services Non Accident Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Dental Services Non Accident Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **Dental Services Non Accident**  Dental surgery subject to deductible and coinsurance | 100% Covered | 100% Covered | | **Dermabrasion Services** | 100% Covered | 100% Covered | | **Diabetic Insulin, Supplies, and Syringes** | 100% Covered | 100% Covered | | **Diagnostic Lab & Radiology**  Facility, includes preadmission testing | 100% Covered | 100% Covered | | **Durable Medical Equipment Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Durable Medical Equipment Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **Durable Medical Equipment** | 100% Covered | 100% Covered | |  | * Rental or Purchased - whichever is economically justified covered under DME * Repair covered under DME * Replacement due to participant's growth and development covered under DME | | | **Educational Services Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Educational Services Office Visit- Specialist** | $15.00 copay | $30.00 copay | | **Education Services** | 100% Covered | 100% Covered | | **Electronic Telephone Calls** Physician | 100% Covered | 100% Covered | | **Emergency Room Facility Fee** | $20.00 copay | $40.00 copay | | **Emergency Room Services**  True Emergency  Non True Emergency | 100% Covered  $20.00 copay  $20.00 copay | 100% Covered  $40.00 copay  $40.00 copay | | **Exercise Equipment** | 100% Covered | 100% Covered | | **Experimental Drugs** | 100% Covered | 100% Covered | | **Experimental Procedures** | 100% Covered | 100% Covered | |  | * NGF Mandate - regular patient care covered under Experimental or Investigational Services * Experimental/Investigational Services as determined within confines of Oncology Management Services covered under Experimental or Investigational Services | | | **Family or Marital Counseling Services** | 100% Covered | 100% Covered | | **Genetic Testing** | 100% Covered | 100% Covered | |  | * Amniocentesis prenatal testing for at risk pregnancies (standardly covered) covered under common genetic tests * BRCA 1 & BRCA 2 Testing - Breast cancer (Mandate for NGF plans) covered under common genetic tests | | | **Group Therapy Services** | 100% Covered | 100% Covered | | **Hemodialysis Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Hemodialysis Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **Hemodialysis** | 100% Covered | 100% Covered | | **Home Health Care & Home Infusion Services** | 100% Covered | 100% Covered | |  | Home Health, 100 Visits Limits Per Calendar Year, Per Date of Service | | | **Hospice Services** | 100% Covered | 100% Covered | | **Hospital (Inpatient)** | 100% Covered | 100% Covered | | **Hospital (Outpatient)**  Surgery | 100% Covered | 100% Covered | | **Hospital (Outpatient)**  Non surgical/routine | 100% Covered | 100% Covered | | **Hypnotherapy Services** | 100% Covered | 100% Covered | | **Infertility Diagnostic Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Infertility Diagnostic Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **Infertility Treatment Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Infertility Treatment Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **Infertility Services** | 100% Covered | 100% Covered | | **Investigational Drugs/Procedures** | 100% Covered | 100% Covered | | **LCM, Cost Management, Discount Negotiation Fees** | 100% Covered | 100% Covered | |  | * LCM covered under Plan Benefits | | | **Massage Therapy Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Massage Therapy Office Visit-Specialist** | $15.00 copay | $30.00 copay | | **Massage Therapy** | 100% Covered | 100% Covered | | **Maternity Services**  Physician Services  Refer to Hospital - Inpatient for facility benefits | 100% Covered | 100% Covered | | Office Visit Copay only applies to the first physician visit, subsequent physician visits will be part of global delivery billing and subject to deductible and coinsurance | * Eligible Members will be All female members * 2 number of routine Ultrasounds per pregnancy are allowed. * Initial newborn services are Paid Under Mother * Complications of pregnancy for dependent children are covered under the plan. | | | **Medical and Surgical Supplies** | 100% Covered | 100% Covered | | **Member Request, Medical Record Copy Fees** | 100% Covered | 100% Covered | |  | * Member Request Copy Fees covered under Plan Benefits | | | **Mental Health & Substance Abuse**  Inpatient | 100% Covered | 100% Covered | | **Mental Health & Substance Abuse**  Outpatient | 100% Covered | 100% Covered | | **MILIEU Situational Therapy Services** | 100% Covered | 100% Covered | | **Morbid Obesity Weight Control Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Morbid Obesity Weight Control Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **Morbid Obesity Weight Control- Non Surgical** | 100% Covered | 100% Covered | | **Morbid Obesity - Surgical Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Morbid Obesity - Surgical Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **Morbid Obesity Surgical** | 100% Covered | 100% Covered | |  | * Lap Band Adjustment is covered under approved Obesity Surgical Procedures * Gastric Bypass is covered under approved Obesity Surgical Procedures * Complications is covered under approved Obesity Surgical Procedures | | | **Non Routine Hearing Exams & Hearing Aids** | 100% Covered | 100% Covered | | **Non Routine Hearing Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Non Routine Hearing Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **Nutritional Supplies** | 100% Covered | 100% Covered | | **Orthotics Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Orthotics Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **Orthotics (back, neck, knee, wrist, etc.)** | 100% Covered | 100% Covered | |  | * Repair is covered under Orthotics applicable services * Replacement due to participants growth and development is covered under Orthotics applicable services | | | **Orthopedic Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Orthopedic Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **Orthopedic Shoes** | 100% Covered | 100% Covered | |  | * Corrective attached to a brace is a type of Orthopedic Shoes. * Corrective not attached to a brace is a type of Orthopedic Shoes. * Custom molded due to foot deformity is a type of Orthopedic Shoes. * Replacement is covered under Orthopedic Shoes applicable types | | | **Outpatient Occupational Therapy** | 100% Covered | 100% Covered | |  | Occupational Therapy Only, 20 Visits Limits Per Calendar Year, Per Date of Service | | | **Outpatient Physical Therapy** | 100% Covered | 100% Covered | |  | Physical Therapy Only, 20 Visits Limits Per Calendar Year, Per Date of Service | | | **Outpatient Speech Therapy** | 100% Covered | 100% Covered | |  | Speech Therapy Only, 20 Visits Limits Per Calendar Year, Per Date of Service | | | **Personal Convenience Items** | 100% Covered | 100% Covered | | **Physician Visits During Inpatient Hospital/SNF Confinement** | 100% Covered | 100% Covered | | **Podiatry Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Podiatry Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **Podiatry Services** | $15.00 copay | $30.00 copay | |  | * Palliative Services is covered under Podiatry applicable services * Capsular or bone surgery for bunions is covered under Podiatry applicable services * Procedures or injections related to bone-nerve-muscle-tendon is covered under Podiatry applicable services * Cutting or removal of corns-calluses-toenails for an underlying medical condition is covered under Podiatry applicable services | | | **Primary Care Physician (PCP) Office Visits for Non-Routine Care** | $10.00 copay | $35 copay | | **Private Duty Nursing Services** | 100% Covered | 100% Covered | | **Prosthetic Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Prosthetic Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **Prosthetic Appliances** | 100% Covered | 100% Covered | |  | * Dental prosthesis is not covered. * Penile prosthesis is not covered. * Routine Maintenance is covered under Prosthetic Appliances applicable types * Repair is covered under Prosthetic Appliances applicable types * Replacement due to participant's growth and development is covered under Prosthetic Appliances applicable types | | | **Pulmonary Rehab Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Pulmonary Rehab Office Visit- Specialist** | $15.00 copay | $30.00 copay | | **Pulmonary Rehab** | 100% Covered | 100% Covered | | **Radiation Therapy** | 100% Covered | 100% Covered | | **Robotic Surgery** | 100% Covered | 100% Covered | | **Routine Health Maintenance**  All ages | 100% Covered | Not Covered | | Additional Covered Routine Adult services    Additional Covered Routine Pediatric services | * Routine physical exam annually * Routine OB/GYN exam annually, in addition to routine physical exam * Routine mammogram   + Baseline: ages 35 -39   + Annually: age 40 and older * Routine pap smear * Routine lab/pathology * Routine bone density * Routine prostate exam * Flu shot and mist * Routine immunizations * HPV testing * Routine colonoscopy, ages 50 - 75, once every 10 years * Routine sigmoidoscopy * Routine hearing exam not covered * Routine vision exam not covered * The plan uses the US Preventive Service Task Force A&B Guidelines for routine coverage. * The plan doesnot consider Well Baby Care as a separate benefit. * Well Baby Care is not combined with Well Child Care. | | | **Routine Nursery Care of Newborn Infant** | 100% Covered | 100% Covered | | **Second Surgical Opinion Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Second Surgical Opinion Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **Self Inflicted Injury** | 100% Covered | 100% Covered | | **Sexual Dysfunction Services** | 100% Covered | 100% Covered | | **Sexual Transformation Services** | 100% Covered | 100% Covered | | **Skilled Nursing Facility** | 100% Covered | 100% Covered | |  | Skilled Nursing, 60 Visits Limits Per Calendar Year, Per Date of Service | | | **Sleep Disorders Office Visit - PCP** | $10.00 copay | $35.00 copay | |  | * Exam is covered under Sleep Disorders. * Testing is covered under Sleep Disorders. * CPAP/BIPAP/DPAP/VPAP/AutoPAP is covered under Sleep Disorders. | | | **Sleep Disorders Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **Sleep Disorders - Sleep Study** | $15.00 copay | $30.00 copay | | **Sleep Disorders** | 100% Covered | 100% Covered | | **Smoking Cessation Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Smoking Cessation Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **Smoking Cessation** | 100% Covered | 100% Covered | | **Specialist Physician Office Visits for Non-Routine Care** | $10.00 copay | $35.00 copay | | **Surgeon** | 100% Covered | 100% Covered | | **Surgical Stockings** | 100% Covered | 100% Covered | |  | Surgical Stockings, 1 Visits Limits Per Calendar Year, Not Applicable | | | **TMJ Non-Surgical Pediatric Office Visit - PCP** | $10.00 copay | $35.00 copay | | **TMJ Non-Surgical Pediatric Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **TMJ Surgical Pediatric Office Visit - PCP** | $10.00 copay | $35.00 copay | | **TMJ Surgical Pediatric Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **TMJ Non-Surgical Adult Office Visit - PCP** | $10.00 copay | $35.00 copay | | **TMJ Non-Surgical Adult Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **TMJ Surgical Adult Office Visit - PCP** | $10.00 copay | $35.00 copay | | **TMJ Surgical Adult Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **TMJ Treatment** | 100% Covered | 100% Covered | |  | * TMJ Combined Services Pay as medical * TMJ Surgery Services Pay as medical | | | **Transplant Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Transplant Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **Transplants** | $15.00 copay | $30.00 copay | |  | * For the patient transplant benefit, the transportation is covered for Not Covered * For the donor transplant benefit, the transportation is covered for Not Covered * For the patient transplant benefit, the meals and lodging is covered for Not Covered * For the donor transplant benefit, the meals and lodging is covered for Not Covered * Live Donor is covered under types of expenses covered for donor Procurement. * Cadaver Donor is covered under types of expenses covered for donor Procurement. | | | **Urgent Care Facility Fee** | $25.00 copay | $50.00 copay | | **Urgent Care Service**  Facility 456, 516, 526  Physician place of service 20 | 100% Covered | 100% Covered | | **Vasectomy** | 100% Covered | 100% Covered | | **Vision Non Routine Medical Condition Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Vision Non Routine Medical Condition Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **Vision Non Routine Medical Condition Cataracts** | 100% Covered | 100% Covered | | **Vision Non Routine Medical Condition Cataracts Glasses/Contacts** | 100% Covered | 100% Covered | | **Vision Routine** | 100% Covered | 100% Covered | | **Wigs Office Visit - PCP** | $10.00 copay | $35.00 copay | | **Wigs Office Visit - Specialist** | $15.00 copay | $30.00 copay | | **Wigs** | 100% Covered | 100% Covered | | | |  |

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|  | |  | | --- | | **EXCLUSIONS** | |  |
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|  | |  |  | | --- | --- | | **Select the applicable Limitations and Exclusions** | Standard Limitations and Exclusions:   * Custodial Care * Deductible Applicable * Experimental * Government * Excess | | **Select the applicable Hazardous Pursuit, Hobby or Activity Limitations and Exclusions** |  | | **Select the applicable Family Member Limitations and Exclusions** | * Family Member: That are performed by a person who is related to the Participant as a spouse, parent, child, brother or sister, whether the relationship exists by virtue of “blood” or “in law” | | **Select the Applicable Illegal Activity Limitations and Exclusions** |  | | **Check all applicable Plan exclusions** | Other Limitations and Exclusions:   * Incurred by Other Persons * Non-Medical Necessity * No Legal Obligation * Not Acceptable * Not Actually Rendered * Not Specifically Covered | | **Select the applicable Occupational Injury Limitations and Exclusions** |  | | **List Causes for Treatment you Wish to Exclude, and Corresponding Language will be drafted. Please note customized drafting is subject to additional hourly fees.** | Additional Exclusions  Excluded Treatments:   * Prohibited by Law * Prior to Coverage * surrogate parenting expenses * Talking Aids * Vitamins * Walmart Care Clinic * Work hardening or similar vocational programs * Cosmetic surgery * Educational services * Elective inpatient/outpatient stays or services outside US * Charges for Missed appoints, review or record storage expenses * Illegal occupations, assault, felony, riot or insurrections * Judgments/settlements * Miliatary related injury or illness * Late Claims * Nonaccredited / nonlicensed providers or institutions * Over the counter medications,k except as specified in preventive benefit or pharmacy benefits * Autopsy * Beyond Scope of license or unlicensed providers * Alternative/Nontraditional treatment * Administrative services or interest fees * health or behavior assessment intervention * acupuncture * extracoporeal shock wave therapy * Infertility treatment * Weightloss treatment * Personal Care Items * Neurofeedback * Marital, family or relationship counselding * termination of pregnancy * transgender treatment/ sex therapy * travel and loding, * Non-covered services * out-of-network services * Chiropractic care   Corresponding Language:   * to the extene that payment under this plan is prohibited by law * That are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein * Vitamins (except as specified under Preventive Care) * Services rendered at a Walmart Care Clinic * unrelated to woman's healthcare rights, or unrelated to accidental injury, tumor, or disease * Educational services outside nutritional counseling for approved diagnosis, except as specified herein * claims filed after the timely filing deadline under the plan * for plantar fasciitis and other musculoskeletal conditions * charges including but not limited to medications, diet supplements, or weightloss surgery, except that which is specified as a weightloss surgical benefit for gastric bypas * primarily for personal comfort or convenience, including but not limited to diapers, bathtub grabberfs, handrials, lift chairs, over bed tables, bedboards, incontinence pads, ramps, snug seats, recrea * or counseling to assist in achieving more effective intrapersonal or interpersonal development * except as specified under transplant benefits and Centers of Excellence benefits * services provided afterceeding benefit maximum for specific serivces, non-covered out-of-network charges, costs above the conracgted rates to providers, charges for medical records * except those provided in a true emergency, as defined by the plan, situation * any services performed by a chiropractor; musculoskeletal services provided by a physician may be covered | |  |
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