Clarus Commerce, LLC dba ebbo Employee Benefits Plan S2936
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NON-GRANDFATHERED PLAN
BENEFIT SHEET

NOTE: Any service or supply required by the ACA to be covered as Preventive Care is payable at the benefit level shown for Preventive Care, even if the service/supply is listed at a different benefit level elsewhere in the Schedule of Benefits

GENERAL PLAN INFORMATION	
Coordination of Benefits	Standard COB
Dependents	Children birth to 26
Filing Limit	365 days

Mailing Address & PPO Company.
Remit claims to:
***CIGNA Physicians* & Hospitals**
PPO & NonPPO: Mail claims to Cigna, PO Box 188061 Chattanooga, TN 37422-8061. Electronic Payer ID 62308

Certain Cigna Ancillary Providers are required to file claims to the Ancillary Vendor Network

If members access a Third-Party Network, they will have remit info as follows (and reflected on ID cards):

Community Health Network Cigna Mt-CHN P.O. Box 3018 Missoula, MT 59806 EDI# 81040
Mississippi Health Partners MHP Systems P.O. Box 23908 Jackson, MS 39225-3908 EDI# 64068

Don't forget to get a copy of the Patient's ID Card for claim filing directions in order to expedite claims processing

Pre-Existing	Does not apply

Utilization Review/Precertification:
MedCom Care Management (985) 284-3242. Precertification 14 days prior to a scheduled admission, Emergency admissions within 48 hours or 1 business day following admission.

Bariatric Surgery
Chemotherapy & Radiation Therapy
Diagnostic Testing (Advanced Imaging – MRI, CAT, PET, Nuclear Stress Tests, etc.)
Dialysis Services
Hospital Observation unit stays of more than 48 hours
Home Health Care
Inpatient confinements
Intensive Outpatient Treatment
Organ Transplants, Peripheral Stem Cell Replacement and Similar procedures
Partial Hospitalization
Skilled Nursing Facility Stays

Penalty: Additional $250 deductible for covered expenses for failure to Pre-certify

BENEFIT DESCRIPTION	**In-Network**	**Out-Of-Network**
ANNUAL MAXIMUM BENEFIT	Unlimited	
DEDUCTIBLE, PER CALENDAR YEAR		
Deductible amounts are combined and cross-accumulate. The Deductible will apply to all covered services unless specifically noted in the schedule.		
Individual Only Coverage	$1,500	$3,000
All Other Coverage Levels Embedded Per Person Deductible	$1,500	$3,000
Overall Family Deductible	$3,000	$6,000
MAXIMUM OUT-OF-POCKET EXPENSES STOPLOSS AMOUNT, PER CALENDAR		
Out-of-pocket expenses are combined and will cross-accumulate.		

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BENEFIT DESCRIPTION	In-Network	Out-Of-Network
Individual Only Coverage	$5,000	$8,000
All Other Coverage Levels Embedded Per Person Maximum	$5,000	$8,000
Overall Family Maximum	$10,000	$16,000
NOTE: The following charges do not apply toward the out-of-pocket expense and are never paid at 100%: • Prescription Drug Brand Penalties • Utilization Management Penalties		
HEALTH BENEFITS: COPAYMENTS AND BENEFIT PERCENTAGES		
Accident Benefit	Refer to applicable service for benefits	
Acupuncture	Not Covered	
Ambulance	100% after Network deductible	100% after Network deductible
Bariatric Surgery Precertification Required Limited to One (1) surgical procedure per Lifetime.	100% after deductible	60% after deductible
Behavioral/Mental Health and Substance Use Disorders – Inpatient Includes Residential Treatment Precertification Required	100% after deductible	60% after deductible
Behavioral/Mental Health and Substance Use Disorders – Outpatient Includes Partial Hospitalization Precertification required for Partial Hospitalization ABA/ABT is covered.		
Office Visits including psychotherapy in the office (Covered services rendered by a Mental Health or Substance Abuse professional)	$30 copay, then 100%, no deductible	60% after deductible
Services other than in a Physician's office	100% after deductible	60% after deductible
Chemotherapy & Radiation Therapy Precertification Required	100% after deductible	60% after deductible
Chiropractic Treatment Limited to 20 visits per calendar year. Provider must send letter of medical necessity and all applicable notes. (OV & X-ray not included. Please refer to those benefit sections for applicable benefits)	$30 Copay then 100%, no deductible	60% after deductible
Clinical Trials (as defined by this Plan for cancer or other life-threatening diseases or conditions) Includes coverage for routine patient costs associated with participation in approved Clinical Trials only. If one or more PPO providers are participating in a Clinical Trial, the Plan may require that the qualified individual participate in the Clinical Trial with the PPO provider. The Plan will cover Non-PPO providers outside the state in which the qualified individual resides only if there is not a PPO provider conducting the same trial in state.	Refer to applicable service for benefits	
COVID-19 / Coronavirus Services or items furnished to covered Members for diagnostic testing or during an office visit (including in-person or telehealth visits), urgent care visits and emergency room visits that result in an order for or administration of diagnostic test.	Refer to applicable service for benefits	
Dental	Covered under Dental plan	
Impacted Wisdom Teeth	Covered under Medical / Refer to Physician Services Surgeon for physician benefit (Facility charges will follow facility benefits).	

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Diabetes Self-Management Training	100% after deductible	60% after deductible
Diagnostic Testing Inpatient **(Advanced Imaging – MRI, CAT, PET, nuclear stress tests, etc.) –Professional and Facility Components**	Refer to "Hospital / Facility Inpatient" for facility charges, and "Physician Services-Inpatient" for Physician charges	
Diagnostic Testing Outpatient **(Advanced Imaging – MRI, CAT, PET, nuclear stress tests, etc.) – Professional and Facility Components** Precertification Required	100% after deductible	60% after deductible
Diagnostic Testing (X-ray, Blood work) – Physician Component **(Refer to "Hospital/Facility" for Facility Component)** All outpatient drug testing will be subject to a medical necessity review. Inpatient Office, Outpatient Hospital, & Stand-Alone Facility	 100% after deductible 100%, deductible waived	 60% after deductible 100%, deductible waived
Dialysis Precertification Required	100% after deductible	60% after deductible
Durable Medical Equipment Replacement allowed only after 5 years. Precertification Required	100% after deductible	60% after deductible
Emergency Services in an Emergency Room* Copay waived if admitted directly to Hospital from Emergency room. *Benefits for covered Emergency Services will be paid at the Network benefits. For Independent Freestanding Emergency Departments that bill as an urgent care facility, refer to the "Urgent Care Facility" benefit.	$150 copay then 100%, deductible waived	
Extended Care/Skilled Nursing Facility Limited to 60 days per Calendar Year.	100% after deductible	60% after deductible
Foot Conditions Physicians' services in connection with corns, calluses or toenails are excluded, unless the charges are for the partial or complete removal of the nail roots Routine foot care is not covered. Foot Orthotics are Not Covered.	Refer to applicable service for benefits	
Gastric Bypass	Refer to "**Bariatric Surgery**"	
Hearing Aid Limited to $1,500 per Calendar Year.	100% after deductible	60% after deductible
Hearing Exam Limited to one (1) exam per person per Calendar Year for ages 22 and over.	100% after deductible	60% after deductible
Home Health Care Limited to 100 visits per Calendar Year. Precertification Required	100% after deductible	60% after deductible
Hospice Care	100% after deductible	60% after deductible
Hospital / Facility Inpatient Precertification required Room and Board is limited to the semiprivate room rate, or if the Hospital has private rooms only, the private room rate billed. ICU as billed.	100% after deductible	60% after deductible
Hospital / Facility Outpatient	100% after deductible	60% after deductible
Infertility/Sterility Limited to $10,000 per Lifetime.	100% after deductible	60% after deductible
Massage Therapy	Not Covered	

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Maternity Maternity-related expenses for a dependent Child are covered. Prenatal care as required by federal law. Other eligible charges	Refer to "**Preventive Care**" Refer to applicable service for benefits	
Newborn Care (routine inpatient)	100% after deductible	60% after deductible
Nutritional Counseling	100% after deductible	60% after deductible
Obesity Non-Surgical obesity treatment limited to Lifetime Maximum of $5,000.	Refer to applicable service for benefits	
Organ Transplants The Employer maintains an Organ & Tissue Transplant Policy separate and apart from this Plan. Providers and members must call 1-888-215-9841 directly for precertification of all transplant services including evaluation and consult of transplant related services	100% after deductible	60% after deductible
Organ Transplant Travel & Accommodation Limited to $50 per day with a total limit of $10,000 per Calendar Year	100% after deductible	Not Covered
Orthotics / Prosthetics Foot Orthotics are Not Covered.	100% after deductible	60% after deductible
Physician Services- Inpatient Visits	100% after deductible	60% after deductible
Physician Services- Inpatient Surgeon	100% after deductible	60% after deductible
Physician Services- Outpatient Visits (services other than in a Physician's Office)	100% after deductible	60% after deductible
Physician Services- Outpatient Surgeon (services other than in a Physician's Office)	100% after deductible	60% after deductible
Physician Services- Office Visits Copay is per provider and applies only to office visit charge. Primary Care Physician/Specialist All other eligible expenses not covered under the copays listed above and not specifically listed, including allergy testing & allergy treatment. Primary Care Physicians are: General Practice, Osteopath, Internal Medicine, Family Practice, OB/GYN, and Pediatrician	 $30 copay, then 100%, no deductible 100% deductible waived	 60% after deductible 60% after deductible
Physician Services- In-office Surgeon	Refer to **"Physician Services: Office Visits"**	Refer to **"Physician Services: Office Visits"**
Physician Services- TelaDoc Consultations (Visit www.teladoc.com or use the TelaDoc App on your mobile device to receive general health care and pediatric care information for a Participant's condition. The TelaDoc program is available 24/7/365. See the plan document for more details about this benefit.)	100% deductible waived	
Prescription Drugs – Inpatient	Refer to **"Hospital / Facility Inpatient"**	
Prescription Drugs – Outpatient	Refer to **"Prescription Drug Benefits schedule and section"**	

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Preventive Care Benefit Breast pumps are limited to one per calendar year Services are also covered as required by the ACA. Such services include evidence-based items or services rated A or B in the United States Preventive Services Task Force (USPSTF) recommendations, the comprehensive guidelines for infants, children, adolescents, and women supported by the Health Resources and Services Administration (HRSA), and immunization practices adopted by the Centers for Disease Control (CDC). All services, including prostate/ PSA test, are limited to no more than once annually or as recommended by the USPSTF, HRSA, or CDC. Hearing screenings from birth through age 21 are limited to no more than once annually.	100%, no deductible	60% after deductible
Private Duty Nursing	Not Covered	
Rehabilitation Services **(Cardiac Rehab, Occupational, Physical, Pulmonary, Speech, and Vision Therapies)** Provider must send letter of medical necessity and all applicable notes. Habilitative services are covered. Limits do not apply to Therapy Services for Autism		
Cardiac rehab therapies limited to phase I & II	100% after deductible	60% after deductible
Occupational and Physical Therapies Limited to 20 visits combined per Calendar Year.	$30 Copay then 100%, no deductible	60% after deductible
Speech Therapy Limited to 20 visits per Calendar Year.	$30 Copay then 100%, no deductible	60% after deductible
Vision Therapy	Not Covered	Not Covered
Sleep Disorder Covered only if medically necessary.		
Sleep Study	100% after deductible	60% after deductible
Other eligible expenses	Refer to applicable service for benefits	Refer to applicable service for benefits
Sterilization		
Vasectomy	100% after deductible	60% after deductible
Female Sterilization as required by federal law	Refer to "**Preventive Care**"	Refer to "**Preventive Care**"
Temporomandibular Joint Syndrome Limited to $1,000 per Lifetime.	Refer to applicable service for benefits	

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Urgent Care Facility* (Includes all covered charges billed by facility) *Charges for Emergency Services Incurred in an urgent care facility that is authorized to perform Emergency Services (and is therefore considered an Independent Freestanding Emergency Department (IFED)) will be paid at the Network level of benefits.	$30 copay then 100%, no deductible	60% after deductible
Vision Exam	Not Covered	
Wig After Chemotherapy Limited to $500 per 5 Calendar Years	100% after deductible	60% after deductible

Southern Scripts AKA Liviniti Member Services: (800) 710-9341 RxBIN: 015433, RxPCN: SSN, Rx Grp: S2936 https://liviniti.com If your Physician authorizes the use of a Generic drug, but you choose to use the Brand Name drug, you must pay the difference between the actual cost of the Generic and Brand Name in addition to the Brand Name copayment. Prescriptions purchased through a non-participating pharmacy or non-participating mail order must be filed with prescription drug company. Prescriptions purchased through a participating pharmacy, but the drug card is not used must be filed with the prescription drug company. Compound Drugs are covered.	
Retail Pharmacy Option (30-day supply)	
Prescribed Preventive Medications and Contraceptives as required by federal law. Subject to existing brand costs if a generic both exists and is allowed by the physician.	100%, no deductible
Generic drug	$5
Preferred Brand Name drug	$25
Non-Preferred Brand Name drug	$50
Specialty drugs (high dollar or injectable drugs)	Follows above tiers
Retail Pharmacy Option (90-day supply)	
Prescribed Preventive Medications and Contraceptives as required by federal law. Subject to existing brand costs if a generic both exists and is allowed by the physician.	100%, no deductible
Generic drug	$15
Preferred Brand Name drug	$75
Non-Preferred Brand Name drug	$150
Mail Order Option (90-day supply)	
Prescribed Preventive Medications and Contraceptives as required by federal law. Subject to existing brand costs if a generic both exists and is allowed by the physician.	100%, no deductible
Generic drug	$15
Preferred Brand Name drug	$75
Non-Preferred Brand Name drug	$150

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