

**The Greater Tompkins County Municipal Health Insurance Consortium  
PPO Benefit Plan**

Benefit Type	TCCOG Benefit Description		Village of Dryden Benefit Description	
<b>WHO IS COVERED</b>				
Type of Premium Tiers • Individual • Family	<b>2-Tier (Individual and Family)</b>		<b>2-Tier (Individual, family)</b>	
Dependent Coverage • Age to which dependents covered • Age to which students covered	<b>Dependent to 19<sup>th</sup> Birthday Student to 25<sup>th</sup> Birthday</b>		<b>Dependent to 19<sup>th</sup> birthday Student to age 23</b>	
Domestic Partner	<b>Covered</b>			
<b>MEDICAL NECESSITY</b>				
Pre-Certification	<b>Pre-Certification Applies to:</b> <b>All Inpatient admissions, excluding maternity, home health care, infusion therapy, Durable Medical Equipment (DME) over \$200, MRI, CAT scans, and PET scans.</b>		<b>Pre-Certification Applies to:</b> <b>All Inpatient admissions, excluding maternity, home health care, infusion therapy, Durable Medical Equipment (DME) over \$200, MRI, CAT scans, and PET scans. Penalty of \$500 or 50%, which ever is less, will apply if pre-certification is not obtained</b>	
<b>COST SHARING EXPENSES</b>	<b>PPO In Network</b>	<b>PPO Out-of-Network</b>	<b>Fit &amp; Healthy</b>	<b>Healthy Family</b>
Deductible Individual / Family	<b>None</b>	<b>\$250 / \$750</b>	<b>Coverage provided worldwide through the BlueCard program.</b>	<b>Coverage provided worldwide through the BlueCard program.</b>
Deductible Carry-Over Y/N	<b>No</b>	<b>No</b>	<b>N/A</b>	<b>N/A</b>
Co-Payment	<b>\$10, except where noted</b>	<b>None</b>	<b>\$10- PCP, \$20-Specialist, others as noted</b>	<b>\$15- PCP, \$20-Specialist, others as noted</b>
Coinsurance	<b>None</b>	<b>20%, except where noted</b>	<b>N/A</b>	<b>N/A</b>

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Annual Out-of-Pocket Maximum (includes deductible, excludes co-payment)	None	\$1,000/\$3,000 Includes deductible and coinsurance, not co-payment. Excludes artificial insemination and prescription drugs.	N/A	N/A
Lifetime Benefit Maximum	None	None	None	None
<b>HOSPITAL INPATIENT SERVICES</b>			<b>Fit &amp; Healthy</b>	<b>Healthy Family</b>
Inpatient Hospital Services • Inpt. Adm. for mastectomy must be covered for as long as attending physician deems medically necessary (Unlimited days per Calendar Year)	Covered in Full	Deductible/Coinsurance	\$250 Co-payment	\$250 Co-payment
Acute Mental Health Care Includes Partial Hospital 3:1 days. (Mandate: 30 days per calendar year, coverage equal to Inpatient Hospital Services)	Mandatory Rider Covered in Full	Mandatory Rider Deductible/Coinsurance	Mandatory Rider \$250 Copay – 30 Days	Mandatory Rider \$250 Copay – 30 Days
Acute Mental Health Care Mandated for Biologically based Mental Illness & Children with Serious Emotional Disturbances	Coverage is inclusive with Inpatient Hospital Services.		Coverage is inclusive with Inpatient Hospital Services	
Residential Treatment	Not Covered	Not Covered	Not Covered	Not Covered
Detoxification (7 days per Calendar Year)	Covered in Full	Deductible/Coinsurance	\$250 Co-payment for up to 7 days	\$250 Co-payment for up to 7 days
Skilled Nursing Facility	Covered in Full 120 days per calendar year	Deductible/Coinsurance 120 days per calendar year	\$250 Co-payment 45 days per calendar year	\$250 Co-payment 45 days per calendar year
Physical Rehabilitation (60 days per Calendar Year)	Not Covered	Not Covered	\$250 Co-payment for up to 60 days per calendar year	\$250 Co-payment for up to 60 days per calendar year
Chemical Dependence and Abuse Rehabilitation (30 days per Calendar Year) (2 admissions per Life)	Covered in Full	Deductible/Coinsurance	\$250 Co-payment for up to 7 days	\$250 Co-payment for up to 7 days

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Maternity Care (Mandated, 48 hrs regular delivery, 96 for c-section; one home care visit covered in full, not subject to any other home care visit limitations)	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>	<b>\$250 Co-payment for Facility. 20% Coinsurance or \$200 Copay for delivery, which ever is less</b>	<b>\$250 Co-payment for Facility. 20% Coinsurance or \$200 Copay for delivery, which ever is less</b>
Newborn Nursery Care	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>	<b>Covered in Full</b>	<b>Covered in Full</b>
Internal Prosthetics	<b>Included in inpatient services</b>		<b>Included in inpatient services</b>	
<b>HOSPITAL OUTPATIENT SERVICES</b>			<b>Fit &amp; Healthy</b>	<b>Healthy Family</b>
Surgical Care including Surgicenters/Freestanding	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>Facility = \$75 Copay Physician = Covered in full</b>	<b>Facility = \$75 Copay Physician = Covered in full</b>
Pre-admission/Pre-Operative Testing (Mandated benefit; same as inpatient)	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>		<b>Deductible/Coinsurance</b>
Diagnostic Imaging, X-ray, CAT, MRI	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>\$20 Co-payment</b>	<b>\$20 Co-payment</b>
Diagnostic Laboratory and Pathology	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>	<b>Covered in Full</b>	<b>Covered in Full</b>
Radiation Therapy and Chemotherapy	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>	<b>Radiation - \$20 Copayment Chemo - \$10 Copay on IV injectable + \$10 Copay for OV</b>	<b>Radiation - \$20 Copayment Chemo - \$15 Copay on IV injectable + \$15 Copay for OV</b>
Hemodialysis	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>		
Mammogram	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>	<b>Covered in Full</b>	<b>Covered in Full</b>
Cervical Cytology (Pap Smear, does not include exam)	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>

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Mental Health Care (Federal Mandate – Unique financial limits no imposed on other benefits prohibited. NYS Mandate – 20 visits per calendar year combined with physician, coverage equal to diagnostic office visit, if OV not covered coverage equal to CD)	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>\$20 Co-payment for up to 20 visits</b>	<b>\$20 Co-payment for up to 20 visits</b>
Mental Health Care Mandated for Biologically based Mental Illness & Children with Serious Emotional Disturbances	<b>Coverage is equivalent to Diagnostic Office visits.</b>		<b>Coverage is equivalent to Diagnostic Office visits</b>	
Chemical Dependency (Mandated 60 visits, includes 20 family visits; should be on par with inpatient)	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>\$10 Co-payment</b>	<b>\$15 Co-payment</b>
Covered Therapies (Includes aggregate of [45] per calendar year of Physical, Speech, Occupational and Respiratory Therapy)	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>\$20 Co-Payment for a combined 30 visits for physical, speech and occupational therapy</b>	<b>\$20 Co-Payment for a combined 30 visits for physical, speech and occupational therapy</b>
Cardiac Rehabilitation	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>		
<b>HOME CARE</b> (Mandated; benefits of not less than 40 4 hr. visits per 12 month period, no more than 25% coinsurance & no more than \$50 deductible) (Unlimited visits per Calendar Year)	<b>Covered in Full</b>	<b>\$50 Ded/20% Coins</b>	<b>Covered in Full 40 visits per CY</b>	<b>Covered in Full 40 visits per CY</b>
<b>HOSPICE CARE</b> (Includes 5 bereavement counseling visits) (Unlimited visits per Calendar Year)	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>	<b>Covered in Full</b>	<b>Covered in Full</b>
<b>PHYSICIAN SERVICES</b>			<b>Fit &amp; Healthy</b>	<b>Healthy Family</b>
Inpatient Hospital Surgery	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>	20% coinsurance or a \$200 Copay, whichever is less	20% coinsurance or a \$200 Copay, whichever is less
Outpatient Hospital & Ambulatory Surgery	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>	Facility = \$75 Co-payment Physician = Covered in full	Facility = \$75 Co-payment Physician = Covered in full
Office Surgery	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>		

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Covered Therapies (Includes aggregate of [45] per calendar year of Physical, Speech, Occupational and Respiratory Therapy)	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>\$20 Co-Payment for a combined 30 visits for physical, speech and occupational therapy</b>	<b>\$20 Co-Payment for a combined 30 visits for physical, speech and occupational therapy</b>
Anesthesia	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>	<b>Covered in Full</b>	<b>Covered in Full</b>
Additional Surgical Opinion (mandate)	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>\$20 Co-Payment</b>	<b>\$20 Co-Payment</b>
Second Medical Opinion (mandated for cancer; cover same as office visit)	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>\$20 Co-Payment</b>	<b>\$20 Co-Payment</b>
Normal Pregnancy	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>	<b>\$10 Co-payment for first 10 visits, remainder covered in full</b>	<b>Covered in Full</b>
Prenatal and Postpartum Care	<b>Co-Payment for initial visit, then covered in full</b>	<b>Deductible/Coinsurance</b>	<b>\$10 Co-payment for first 10 visits, remainder covered in full</b>	<b>Covered in Full</b>
Complications of Pregnancy and Termination	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>		
Delivery Anesthesia	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>	<b>Covered in Full</b>	<b>Covered in Full</b>
In-Hospital Physician Visits (IHM for mastectomy must be covered for as long as attending physician deems medically necessary)	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>	<b>Covered in Full</b>	<b>Covered in Full</b>
<b>Physician's Office – Preventive Services</b>			<b>Fit &amp; Healthy</b>	<b>Healthy Family</b>
Routine Physical Examinations (1 per Calendar Year)	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>\$10 Co-payment</b>	<b>\$15 Co-payment</b>
Well Child Visits and Immunizations (mandated visits/immunizations full coverage)	<b>Covered in full</b>	<b>Covered in full</b>	<b>Covered in full</b>	<b>Covered in full</b>
Adult Immunizations	<b>Not Covered</b>	<b>Not Covered</b>	<b>\$20 Co-payment</b>	<b>\$20 Co-payment</b>

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			Fit & Healthy	Healthy Family
<b>Physician's Office - Other Services</b>				
Diagnostic Laboratory and Pathology	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>	<b>Covered in Full</b>	<b>Covered in Full</b>
Eye Exams Routine	<b>Co-Payment 1 per Calendar Year</b>	<b>Deductible/Coinsurance 1 per Calendar Year</b>	<b>\$10 Co-payment – one per year, \$20 Co-payment for children to age 19.</b>	<b>\$10 Co-payment – one per year, \$0 Co-payment for children to age 19.</b>
Eyewear Routine (must purchase eye exam)	<b>\$60 allowance 1 per Calendar year</b>	<b>\$60 allowance 1 per Calendar year</b>		<b>\$100 allowance for children to age 19</b>
Eye Exams - Diagnostic	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>\$20 Co-Payment</b>	<b>\$20 Co-payment</b>
Hearing Evaluations Routine	<b>Not Covered</b>	<b>Not Covered</b>		
Hearing Evaluations Diagnostic	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>\$10 PCP, \$20 Specialist.</b>	<b>\$15 PCP, \$20 Specialist.</b>
Hearing Aids (Children to age 19)	<b>\$600 allowance every 3 years</b>	<b>Not Covered</b>	<b>Hearing aids not covered</b>	<b>\$600 hearing aid allowance once every three years for children to age 19</b>
Diagnostic Office Visits	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>PCP - \$10 per visit Spec - \$20 per visit</b>	<b>PCP - \$15 per visit Kids to 19 - \$0 Copay Spec - \$20 per visit</b>
Office Consultations	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>Spec - \$20 per visit</b>	<b>Spec - \$20 per visit</b>
Diagnostic Imaging Services, X-ray, CAT, MRI, etc.	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>\$20 Co-payment</b>	<b>\$20 Co-payment</b>
Radiation Therapy and Chemotherapy	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>	<b>Radiation - \$20 Copayment Chemo - \$10 Copay on IV injectable + \$10 Copay for OV</b>	<b>Radiation - \$20 Copayment Chemo - \$15 Copay on IV injectable + \$15 Copay for OV</b>
Hemodialysis	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>		

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Mammogram (Mandated; should be on par with other basic physician services; co-payment allowed on PPO)	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>	<b>Covered in Full</b>	<b>Covered in Full</b>
Routine GYN Visits including Pap Smear (Mandated; same as other basic physician services; co-payment allowed on PPO)	<b>Covered In Full, including Lab</b>	<b>Deductible/Coinsurance</b>	<b>Covered In Full, including Lab</b>	<b>Covered In Full, including Lab</b>
Diagnostic GYN Visits	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>\$20 Co-payment</b>	<b>\$20 Co-payment</b>
Prostate Cancer Screenings (Mandated if office visits covered; coverage must be equal to office visits)	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>\$10 Co-payment</b>	<b>\$15 Co-payment</b>
Allergy Testing and Treatment (Injections are inclusive)	<b>Co-Payment – Testing Covered In Full – Treatment</b>	<b>Deductible/Coinsurance</b>	<b>PCP - \$10 Copayment Spec - \$20 Copayment For both testing and injections</b>	<b>PCP - \$15 Copayment Spec - \$20 Copayment For both testing and injections Children to age 19 - \$0 Copay</b>
Mental Health Care (Federal Mandate – Unique financial limits not imposed on other benefits prohibited. NYS Mandate – 20 visits per calendar year combined with physician, coverage equal to diagnostic office visit.)	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>\$20 Co-Payment for up to 20 visits per calendar year</b>	<b>\$20 Co-Payment for up to 20 visits per calendar year</b>
Mental Health Care Mandated for Biologically based Mental Illness & Children with Serious Emotional Disturbances	<b>Coverage is equivalent to Diagnostic Office visits.</b>		<b>Coverage is equivalent to Diagnostic Office visits.</b>	
Chiropractic Care (Mandated if office visits covered; coverage must be equal to office visits)	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>\$20 Co-Payment</b>	<b>\$20 Co-Payment</b>
Inpatient Consultations	<b>Covered in Full</b>	<b>Deductible/Coinsurance</b>	<b>Covered in Full</b>	<b>Covered in Full</b>
Infertility Care (Mandated if inpatient hospital, medical/surgery covered)	<b>Covered same as similar services under benefit plan – i.e. labs see Diagnostic Laboratory and Pathology benefit, office visit see Diagnostic Office visit benefit.</b>		<b>Covered same as similar services under benefit plan – i.e. labs see Diagnostic Laboratory and Pathology benefit, office visit see Diagnostic Office visit benefit.</b>	

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Bone Density Testing (Mandated if x-ray covered; coverage must be equal office visit or x-ray benefit, whichever is better benefit)	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>\$20 Co-Payment</b>	<b>\$20 Co-Payment</b>
<b>ADDITIONAL BENEFITS</b>			<b>Fit &amp; Healthy</b>	<b>Healthy Family</b>
Treatment of Diabetes (Insulin & Supplies) Education and DME (Mandated if physician office visits covered; must be covered equal to office visits for a 30 day supply)	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>\$10 Co-Payment</b>	<b>\$15 Co-payment</b>
Durable Medical Equipment (DME)	<b>20% Coinsurance</b>	<b>Deductible/Coinsurance</b>	<b>Covered @ 50% up to a \$5,000 maximum per calendar year</b>	<b>Covered @ 50% up to a \$5,000 maximum per calendar year</b>
External Prosthetics Orthotics (foot orthotics excluded) (\$15,000 max per Calendar Year)	<b>Included in DME Benefit</b>		<b>Covered @ 50% up to a \$15,000 maximum per calendar year</b>	<b>Covered @ 50% up to a \$15,000 maximum per calendar year</b>
Medical Supplies	<b>20% Coinsurance</b>	<b>Deductible/Coinsurance</b>		
Foot Orthotics	<b>Not Covered</b>	<b>Not Covered</b>		
Ambulance Service (Includes air)	<b>Co-Payment</b>	<b>Deductible/Coinsurance</b>	<b>\$50 Co-Payment</b>	<b>\$50 Co-Payment</b>
Pre-Hospital Emergency Services/Transportation (Mandated for ambulance, coverage must be equal to or better than emergency benefit. Excludes air.)	<b>Co-Payment</b>		<b>\$50 Co-Payment</b>	<b>\$50 Co-Payment</b>
Acupuncture (10 visits per Calendar Year)	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>
Prescription Drugs (If Rx covered, enteral nutrition mandated; coverage must be equal to all other drugs; certain formulas capped at \$2,500 annually.)	<b>Covered – see RX options</b>	<b>Not covered</b>	<b>\$10/\$25/\$40 with \$0 copay for kids to age 19</b>	<b>\$10/\$25/\$40 with \$0 copay for kids to age 19</b>

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<b>EMERGENCY SERVICES</b> (Emergency Condition Mandated; coverage on par with inpatient; copayment allowed for POS/PPO; O/N benefit for Emergency Condition must be same covered same as I/N)				
Facility – Emergency Room	<b>\$35 Co-Payment</b>		<b>\$50 Co-Payment</b>	<b>\$50 Co-Payment</b>
Freestanding Urgent Care Ctr	<b>\$25 Co-Payment</b>	<b>Deductible/ Coinsurance</b>	<b>\$25 Co-Payment</b>	<b>\$25 Co-Payment</b>
Emergency Room Physician	<b>Covered in Full</b>		<b>Covered in Full</b>	
<b>Prescription Drug Coverage</b>	<b>Retail</b>	<b>Mail-Order</b>	<b>Retail</b>	<b>Mail-Order</b>
Prescription Drugs (If Rx covered, enteral nutrition mandated; coverage must be equal to all other drugs; certain formulas capped at \$2,500 annually.)	<b>Tier I - 20% Tier II - 30% Tier III – 50%</b>	<b>Tier I - 20% Tier II - 30% Tier III – 50%</b>	<b>Tier I - \$10 Tier II - \$25 Tier III – \$40</b>	<b>Tier I - \$20 Tier II - \$50 Tier III – \$80</b>
<b>WAITING PERIODS</b>				
Pre-Existing Condition Waiting Period	<b>No – waived</b>		<b>Fit &amp; Healthy</b>	<b>Healthy Family</b>
<b>CLUSIONS:</b> The following are common exclusions that will apply. Indicate if coverage should be provided and the applicable deductible/copayment/coinsurance.			<b>CLUSIONS:</b> The following are common exclusions that will apply. Indicate if coverage should be provided and the applicable deductible/copayment/coinsurance.	
Acupuncture	<b>Excluded</b>		<b>Excluded</b>	
Blood products	<b>Excluded</b>		<b>Excluded</b>	
Certification Examinations	<b>Excluded</b>		<b>Excluded</b>	
Cosmetic Services	<b>Excluded</b>		<b>Excluded</b>	
Custodial Care	<b>Excluded</b>		<b>Excluded</b>	
Dental (non-accidental services)	<b>Excluded</b>		<b>Excluded</b>	
Developmental Delay	<b>Excluded</b>		<b>Excluded</b>	
Experimental Investigational Svcs	<b>Excluded</b>		<b>Excluded</b>	
Free Care	<b>Excluded</b>		<b>Excluded</b>	
Hypnosis/Biofeedback	<b>Excluded</b>		<b>Excluded</b>	
Military Svc-Connected Conditions	<b>Excluded</b>		<b>Excluded</b>	
No-Fault Automobile Insurance	<b>Excluded</b>		<b>Excluded</b>	
Nutritional Therapy	<b>Excluded</b>		<b>Excluded</b>	
Private Duty Nursing	<b>Excluded</b>		<b>Excluded</b>	
Reproductive Procedures	<b>Excluded</b>		<b>Excluded</b>	

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Reversal of elective sterilization	<b>Excluded</b>		<b>Excluded</b>	
Routine Care of the Feet	<b>Excluded</b>		<b>Excluded</b>	
Self-Help Diagnosis, Training, Treatment	<b>Excluded</b>		<b>Excluded</b>	
Smoking Cessation Prgms	<b>Excluded</b>		<b>Excluded</b>	
Transsexual Surgery - Related Svcs	<b>Excluded</b>		<b>Excluded</b>	
Weight Loss Services	<b>Excluded</b>		<b>Excluded</b>	

**Note:** This benefit grid provides a summary of benefits only and does not, nor is it intended to, replace the legal contract.

\*Payments for all out-of-network benefits are based on participating provider allowances. Any difference between the allowance and the out-of-network provider's actual charge is the responsibility of the member, in addition to any applicable deductible, copayment or coinsurance amounts.