

Medical Plan Overview

CANOPYCARE HMO-Group Number G0727A

Effective Date: 01/01/2024-12/31/2024

Benefit description	Member responsibility
Plan maximums	
Out-of-pocket maximum (combined with Rx) (Individual/Family)	\$2,000 Individual / \$4,000 Family
Professional services	
PCP office visit ¹	\$25
Specialist office visit ¹	\$25
Preventive care services ¹	\$0
Telehealth services	Telehealth cost share mirrors in-person cost share based on type of service provided.
Rehabilitation therapy ²	\$25
X-ray procedures ¹	\$0
Laboratory procedures ¹	\$0
Complex radiology (includes CT, SPECT, PET, MUGA, and MRI)	\$0
Facility services	
Outpatient surgery (hospital)	\$100 per admit
Outpatient surgery (ambulatory surgery center)	\$100 per admit
Inpatient hospital	\$200 per admit
Skilled nursing facility	\$0 (limited to 100 days per calendar year)
Emergency services	
Urgent care services	\$25
Emergency room facility	\$100
Ambulance services (ground and air)	\$50
Mental health and substance use disorder services	
Outpatient office visit	\$25
Outpatient other (includes partial hospitalization/day treatment/intensive outpatient programs)	\$0
Inpatient	\$200 per admit
Other services	
Durable medical equipment ¹	\$0
Diabetic equipment	\$0
Acupuncture	\$15 per visit / 30 visits maximum per calendar year
Chiropractic services	\$15 per visit / 30 visits maximum per calendar year

¹ Preventive care services are covered for children and adults based on guidelines from the U.S. Preventive Services Task Force Grade A and B recommendations; the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC); and the guidelines for infants, children, adolescents, and women’s preventive health care as supported by the Health Resources and Services Administration (HRSA).

² Rehabilitation therapy includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy.

This is merely a brief summary of benefits. It does not include all covered services, limitations or exclusions. Please refer to the *Evidence of Coverage* for all terms and conditions of coverage.

Nondiscrimination Notice