



COVERED SERVICE	COPAYMENT
<p><b>PHYSICIAN OFFICE SERVICES</b></p> <p>Physician Office Services Include:</p> <ul style="list-style-type: none"> <li>• Physician Office Visits</li> <li>• Medications, supplies and materials administered in the office</li> <li>• Second Surgical Opinion</li> </ul> <p>Laboratory Tests and X-Ray performed in the Physician’s office</p> <p>MRI, CT Scans, Sleep Study, Nuclear Stress Tests and PET Scan performed in the Physician’s office</p> <p>Allergy Services</p> <ul style="list-style-type: none"> <li>• Office Visits</li> <li>• Allergy Testing</li> <li>• Serum</li> <li>• Injection Administration</li> </ul> <p>Surgical Procedures performed in the Physician’s Office</p>	<p>\$30 per visit to the PCP – Deductible Waived \$50 per visit to the Specialist – Deductible Waived</p> <p>No Copay – After Deductible</p> <p>20% Copay – After Deductible</p> <p>\$30 per visit to the PCP – Deductible Waived \$50 per visit to the Specialist – Deductible Waived</p> <p>50% of the Allowable Amount – After Deductible 50% of the Allowable Amount – After Deductible 50% of the Allowable Amount – After Deductible</p> <p>20% Copay – After Deductible</p>
<p><b>PREVENTIVE SERVICES</b></p> <p>Preventive Services Include:</p> <ul style="list-style-type: none"> <li>• Annual Routine Physicals</li> <li>• Well Baby and Well Child Care</li> <li>• Routine Eye, Speech and Hearing Screenings for Children when performed during an office visit</li> <li>• Routine Immunizations for ages 6 and older</li> <li>• Examinations and Testing for the detection of Prostate Cancer</li> <li>• Routine Laboratory and X-Ray</li> </ul> <p>Immunizations for Newborns (birth to 6-years of age)</p> <p>Newborn Child Hearing Screenings (birth to 30-days old)</p> <p>Well Woman Exam including Routine Annual Physicals including low dose mammography screening.</p> <p>Preventive Diagnostics and Testing:</p> <ul style="list-style-type: none"> <li>• Non-routine screening mammograms including Digital, X-ray and Ultrasound</li> <li>• Screening for the detection of Colorectal Cancer <i>(If other procedures are needed during the screening, additional Copayments, Deductible, and/or Coinsurance will apply.)</i></li> <li>• Bone Mass Measurement</li> </ul>	<p>\$30 per visit to the PCP – Deductible Waived \$50 per visit to the Specialist – Deductible Waived</p> <p>No Copay – Deductible Waived</p> <p>No Copay – Deductible Waived</p> <p>\$30 per office visit – Deductible Waived</p> <p>20% Copay – After Deductible</p>

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<p><b>FAMILY PLANNING SERVICES</b> Family Planning and Counseling</p> <p>Contraceptive Devices, Implants and Injections including:</p> <ul style="list-style-type: none"> <li>• Diaphragm</li> <li>• IUD</li> <li>• Subdermal Contraceptive Implants &amp; Removal</li> <li>• Depo-Provera™ Injections</li> </ul> <p><u>STERILIZATION PROCEDURES</u> (Vasectomy &amp; Tubal Ligation)</p> <ul style="list-style-type: none"> <li>• When performed in an Outpatient Facility</li> <li>• When performed in the Physician's Office</li> <li>• When performed in an Inpatient Facility</li> </ul>	<p>\$30 per visit to the PCP – Deductible Waived \$50 per visit to the Specialist – Deductible Waived</p> <p>50% of the Allowable Amount for all charges – After Deductible. Applies to materials, procedures, and services.</p> <p>20% Copay – After Deductible 20% Copay – After Deductible See Inpatient Services</p>
<p><b>DIABETIC SERVICES</b> Diabetic Self-Management Education</p> <p>Insulin and Diabetic Insulin</p> <ul style="list-style-type: none"> <li>• 30 Day Supply <ul style="list-style-type: none"> <li>○ 1<sup>st</sup> tier - Generic Drugs</li> <li>○ 2<sup>nd</sup> tier - Brand name drugs on drug list</li> <li>○ 3<sup>rd</sup> tier - Brand name drugs not on drug list</li> </ul> </li> <li>• Mail Order (up to 90- day supply) <ul style="list-style-type: none"> <li>○ 1<sup>st</sup> tier - Generic Drugs</li> <li>○ 2<sup>nd</sup> tier - Brand name drugs on drug list</li> <li>○ 3<sup>rd</sup> tier - Brand name drugs not on drug list</li> </ul> </li> </ul> <p>Test Strips</p> <ul style="list-style-type: none"> <li>• Level 1 Strips</li> <li>• Level 2 Strips</li> </ul> <p>Other Diabetic Supplies and Equipment (30 Day Supply)</p>	<p>\$30 per visit to the PCP – Deductible Waived \$50 per visit to the Specialist – Deductible Waived</p> <p>\$20 per prescription – After Deductible \$50 per prescription – After Deductible \$100 per prescription – After Deductible</p> <p>\$60 per prescription – After Deductible \$150 per prescription – After Deductible \$300 per prescription – After Deductible</p> <p>10% per item – After Deductible 20% per item – After Deductible</p> <p>20% per item – After Deductible</p>
<p><b>SPECIALTY SERVICES/PHARMACY</b> Specialty Services/Pharmacy Include:</p> <ul style="list-style-type: none"> <li>• Medical Injectable Drugs (excluding Depo-Provera™ injectables)</li> <li>• Defined Hybrid Injectables</li> <li>• Radiation Therapy</li> <li>• Transplant Anti-rejection Therapy</li> <li>• Home Infusion Medications (excluding “self-injectable” drugs)</li> <li>• Specified Cancer Chemotherapy</li> <li>• Defined Associated Agents</li> </ul>	<ul style="list-style-type: none"> <li>• When covered service cost is \$500 or less: <i>See physician office services, outpatient services/surgery, or inpatient services for applicable copayments.</i></li> <li>• When covered service cost is more than \$500: <i>30% Copay – After Deductible, not to exceed \$3,000 Out-of-Pocket Maximum for these specific services. See Section 10, Definitions in Your Evidence of Coverage</i></li> </ul>

COVERED SERVICE	COPAYMENT
<p><b>EMERGENCY ROOM SERVICES</b></p> <p>Emergency Room</p> <p>Minor Emergency/Urgent Care Center</p> <p>Ambulance</p>	<p>20% Copay – After Deductible Emergency Room Copay is waived if admitted to Hospital</p> <p>20% Copay – After Deductible</p> <p>20% Copay – After Deductible</p>
<p><b>OTHER HEALTH CARE SERVICES</b></p> <p>Limited Accidental Dental Care and Medically Related Oral Surgeries: <i>Limited to \$1,000 Calendar Year Maximum Benefit</i></p> <p>Therapy Services: <i>Limited to 20 visits per Therapy Service per Calendar Year</i></p> <ul style="list-style-type: none"> <li>• Rehabilitation Therapy</li> <li>• Speech Therapy</li> <li>• Occupational Therapy</li> <li>• Physical Therapy</li> </ul> <p>Hospice Care: <i>Lifetime Maximum of \$10,000</i></p> <p>Spinal Manipulation: <i>Limited to 10 visits per Calendar Year</i></p> <p>Pain Management Services</p> <p>Durable Medical Equipment (DME): <i>DME is limited to \$2,000 per Calendar Year. DME used in the treatment of diabetes, oxygen and monitoring devices are not included in the \$2,000 maximum.</i></p> <p>Medical Supplies</p> <p>Prosthetics: External Devices: <i>Lifetime Maximum of \$4,000 per Device/Limb</i></p> <p>Orthotics</p> <p>Internal Implantable Devices</p> <p>Dialysis Services (Inpatient &amp; Outpatient)</p>	<p>20% Copay – After Deductible</p> <p>\$30 per visit to the PCP – Deductible Waived \$50 per visit to the Specialist – Deductible Waived</p> <p>20% Copay – After Deductible</p> <p>\$50 per visit – Deductible Waived</p> <p>Included in the physician office services, outpatient services/surgery, or inpatient services copayment.</p> <p>50% of the Allowable Amount per piece of equipment or supply – After Deductible</p> <p>50% of the Allowable Amount per piece of equipment or supply – After Deductible</p> <p>50% of the Allowable Amount per device – After Deductible</p> <p>50% of the Allowable Amount per device – After Deductible</p> <p>50% of the Allowable Amount per device – After Deductible</p> <p>Included in the physician office services, outpatient services/surgery, or inpatient services copayment.</p>

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<p>Organ Transplant Services (Inpatient &amp; Outpatient) <i>Lifetime Maximum of \$300,000</i></p> <p>Home Health Services: <i>Limited to 20 visits per Covered Service per Calendar Year</i></p> <ul style="list-style-type: none"> <li>• Includes treatment of covered illness or injury in your home</li> <li>• EXCLUDES speech, physical, and occupational therapy</li> </ul>	<p>Included in the physician office services, outpatient services/surgery, or inpatient services copayment.</p> <p>20% Copay – After Deductible</p>

**NOTE:** This benefit plan does not include maternity coverage.