As defined by federal & state law	No charge

Lab	No charge after deductible	None
X-Ray/Radiology	No charge after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	No charge after deductible	None
(Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	No charge after deductible	None
Facility Fee	No charge after deductible	None
Physician/Surgeon Fees	No charge after deductible	1 visit per physician per day
Skilled Nursing Facility	No charge after deductible	90 Day limit per Benefit Year

Facility Fee

Physician/Surgeon Fees

	(Network Providers Only)	(If Applicable)
Physical Therapy	$0 for first three visits then no charge after deductible	20 visits per Benefit Year
Occupational Therapy	$0 for first three visits then no charge after deductible	20 visits per Benefit Year
Speech Therapy	No charge after deductible	20 visits per Benefit Year
Pulmonary Rehabilitation	No charge after deductible	20 visits per Benefit Year
Cardiac Rehabilitation Services	No charge after deductible	36 visits per Benefit Year
Manipulation Therapy	No charge after deductible	12 visits per Benefit Year
Post-Cochlear Implant Aural Therapy	No charge after deductible	Combined Limit with Speech Therapy
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	No charge after deductible	Refer to your Evidence of Coverage
Physical Therapy	$0 for first three visits then no charge after deductible	Combined limit with Habilitative Services
Occupational Therapy	$0 for first three visits then no charge after deductible	Combined limit with Habilitative Services
Speech Therapy	No charge after deductible	Combined limit with Habilitative Services
Adaptive Behavior Treatment	$0 for first three visits then no charge after deductible	Includes Applied Behavior Analysis (ABA)
Office Visits	$0 for first three visits then no charge after deductible	None
Outpatient Services		
Intensive Outpatient Program (IOP) Services	No charge after deductible	
Partial Hospitalization Program (PHP) Services	No charge after deductible	
Residential Services	No charge after deductible	
Opioid Treatment Program	No charge after deductible	
Inpatient Services	No charge after deductible	
	Covered the same as office visits, inpatient services, and outpatient services	Refer to your Evidence of Coverage
	Covered the same as office visits, inpatient services, and outpatient services	None

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	(Network Providers Only)	(If Applicable)
Private Duty Nursing	No charge after deductible	100 visits per Benefit Year. A visit equals 8 hours.
Home Infusion Therapy	No charge after deductible	None
All Other Services	No charge after deductible	100 combined visits per Benefit Year. A visit equals at least 4 hours.
	No charge after deductible	Refer to your Evidence of Coverage
Education Equipment Supplies	No charge after deductible	Refer to your Evidence of Coverage
Appliances Durable Medical Equipment Medical Supplies Orthotic Device Prosthetics	No charge after deductible	Refer to your Evidence of Coverage
Tier 0 (Preventive)	No charge	Up to a 90-day supply when filled at: Retail for Generic Drugs in Tiers 0-3 Mail Order for any drug in Tiers 0-3
Tier 1 (Low Cost)	No charge after deductible	
Tier 2 (Preferred)	No charge after deductible	All others limited to a 30-day supply
Tier 3 (Non-Preferred)	No charge after deductible	Any copays shown are for a 30-day supply. 90-day supplies for Retail are 3 times the copay and for Mail Order are 2.5 times the copay.
Tier 4 (Specialty)	No charge after deductible	
(pediatric) Children's Eye Exam	No charge	1 routine eye exam per Benefit Year
Low Vision Testing and Aids	No charge	Limited to one evaluation and aid per Benefit Year.
Children's Eyewear	No charge	Limited to one pair of glasses or contact lenses per Benefit Year. If medically necessary, a replacement pair of glasses is allowed.
Accidental Dental	No charge after deductible	$3,000 per Member Per Injury All Services combined
Dental Anesthesia	No charge after deductible	Refer to your Evidence of Coverage

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	(Network Providers Only)	(If Applicable)
(pediatric) Class I – Diagnostic/Preventive	No charge	2 check-ups per Benefit Year. Additional benefits available. Refer to your Evidence of Coverage
Class II – Minor Restorative	25% coinsurance after deductible	Refer to your Evidence of Coverage
Class III - Major/Comprehensive	45% coinsurance after deductible	Refer to your Evidence of Coverage
Class IV - Orthodontics	55% coinsurance after deductible	Refer to your Evidence of Coverage

Dependent Name	[John Doe]
Relationship to You	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2023]

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