

As defined by federal & state law	No charge	Refer to your Evidence of Coverage
Zero Cost Telemedicine Partner	No charge	Refer to your Evidence of Coverage
Primary		
Includes Primary Care Provider, Mental Health/Substance Abuse, and Retail Clinics	$30 copay	None
Specialist	$60 copay	None
	$45 copay	None

	(Network Providers Only)	(If Applicable)
Lab	40% coinsurance after deductible	None
X-Ray/Radiology	40% coinsurance after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	40% coinsurance after deductible	None
(Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	40% coinsurance after deductible	None
Facility Fee	40% coinsurance after deductible	None
Physician/Surgeon Fees	40% coinsurance after deductible	1 visit per physician per day
Skilled Nursing Facility	40% coinsurance after deductible	90 Day limit per Benefit Year
Facility Fee	40% coinsurance after deductible	None
Physician/Surgeon Fees	40% coinsurance after deductible	None
Prenatal Visit, Office Visits, and Postpartum Care	$60 copay	None
Inpatient Services	40% coinsurance after deductible	None
Outpatient Services	40% coinsurance after deductible	None
	40% coinsurance after deductible	Refer to your Evidence of Coverage
	40% coinsurance after deductible	If admitted to the hospital directly from the Emergency Department, these services will be covered the same as inpatient services and the applicable copayment and coinsurance will apply.
Physical Therapy	$30 copay	20 visits per Benefit Year
Occupational Therapy	$30 copay	20 visits per Benefit Year
Speech Therapy	$30 copay	20 visits per Benefit Year

	(Network Providers Only)	(If Applicable)
Private Duty Nursing	40% coinsurance after deductible	100 visits per Benefit Year. A visit equals 8 hours.
Home Infusion Therapy	40% coinsurance after deductible	None
All Other Services	40% coinsurance after deductible	100 combined visits per Benefit Year. A visit equals at least 4 hours.
	40% coinsurance after deductible	Refer to your Evidence of Coverage
Education Equipment Supplies	40% coinsurance after deductible	Refer to your Evidence of Coverage
Appliances Durable Medical Equipment Medical Supplies Orthotic Device Prosthetics	40% coinsurance after deductible	Refer to your Evidence of Coverage
Tier 0 (Preventive) Tier 1 (Low Cost) Tier 2 (Preferred) Tier 3 (Non-Preferred) Tier 4 (Specialty)	No charge Up to $20 copay Up to $40 copay Up to $80 copay after deductible Up to $350 copay after deductible	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 All others limited to a 30-day supply 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.
(pediatric) Children's Eye Exam Low Vision Testing and Aids Children's Eyewear	No charge No charge No charge	1 routine eye exam per Benefit Year Limited to one evaluation and aid per Benefit Year. Limited to one pair of glasses or contact lenses per Benefit Year. If medically necessary, a replacement pair of glasses is allowed.
Accidental Dental Dental Anesthesia	40% coinsurance after deductible 40% coinsurance after deductible	$3,000 per Member Per Injury All Services combined Refer to your Evidence of Coverage

(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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