Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
Lab	$15 copay	None
X-Ray/Radiology	$150 copay after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	$200 copay after deductible	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	$150 copay after deductible	None
Inpatient Services		
Facility Fee	$325 copay after deductible per stay	None
Physician/Surgeon Fees	No charge after deductible	1 visit per physician per day
Skilled Nursing Facility	$250 copay after deductible per stay	90 Day limit per Benefit Year
Outpatient Services		
Facility Fee	20% coinsurance after deductible	None
Physician/Surgeon Fees	20% coinsurance after deductible	None
Maternity Services		
Prenatal Visit, Office Visits, and Postpartum Care	$35 copay	None
Inpatient Services	$325 copay after deductible	None
Outpatient Services	20% coinsurance after deductible	None
Ambulance Services	20% coinsurance after deductible	Refer to your Evidence of Coverage
Emergency Health Care Services	$325 copay 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.
Habilitative Services		
Physical Therapy	$5 copay	20 visits per Benefit Year
Occupational Therapy	$5 copay	20 visits per Benefit Year
Speech Therapy	20% coinsurance after deductible	20 visits per Benefit Year

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services Physical Therapy Occupational Therapy Speech Therapy Pulmonary Rehabilitation Cardiac Rehabilitation Services Manipulation Therapy Post-Cochlear Implant Aural Therapy Other Rehabilitative Services		

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Dental (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	20% coinsurance after deductible	Refer to your Evidence of Coverage
Class III - Major/Comprehensive	40% coinsurance after deductible	Refer to your Evidence of Coverage
Class IV - Orthodontics	50% coinsurance after deductible	Refer to your Evidence of Coverage

Prior Authorization: Some services and items require prior authorization, which is the process used by the Plan to determine if it meets medical necessity and coverage requirements prior to the service being provided. The provider, or the member when using an out-of-network provider, is responsible for obtaining prior authorization for the services and items described on the prior authorization list. Please refer to the prior authorization list attached to your Evidence of Coverage for additional abenes3NiT4ior a8.3j2.21s to your Ei6Lin[trerivice5 Tden I(ko)-1ibal .ca0 0 -14m7meBaocom/s(overage800.7 TmpaID

Dependent Information

Dependent Name	[John Doe]
Relationship to You	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2024]