Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
Lab	$40 copay	None
X-Ray/Radiology	$150 copay after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	$200 copay after deductible	None
Mammograms (Outpatient)		

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical Therapy	$5 copay	25 visits per Benefit Year
Occupational Therapy	$5 copay	25 visits per Benefit Year
Speech Therapy	20% coinsurance after deductible	25 visits per Benefit Year
Pulmonary Rehabilitation	20% coinsurance after deductible	25 visits per Benefit Year
Cardiac Rehabilitation Services	20% coinsurance after deductible	36 visits per Benefit Year
Manipulation Therapy	20% coinsurance after deductible	20 visits per Benefit Year
Post-Cochlear Implant Aural Therapy	20% coinsurance after deductible	30 visits per Benefit Year
Cognitive Rehabilitation Therapy	20% coinsurance after deductible	20 visits per Benefit Year
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	20% coinsurance after deductible	Refer to your Evidence of Coverage

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Home Health Private Duty Nursing Home Infusion Therapy All Other Services	 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible	 250 visits per Benefit Year. A visit equals 8 hours. None 100 combined visits per Benefit Year. A visit equals at least 4 hours.
Hospice Care		