
Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
Lab	$40 copay	None
X-Ray/Radiology	$200 copay after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	$250 copay after deductible	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	$200 copay after deductible	None
Inpatient Services		
Facility Fee	$450 copay after deductible per stay	None
Physician/Surgeon Fees	No charge after deductible	1 visit per physician per day
Skilled Nursing Facility	$450 copay after deductible per stay	90 Day limit per Benefit Year
Outpatient Services		
Facility Fee	30% coinsurance after deductible	None
Physician/Surgeon Fees	30% coinsurance after deductible	None
Maternity Services		
Prenatal Visit, Office Visits, and Postpartum Care	$70 copay	None
Inpatient Services	$450 copay after deductible	None
Outpatient Services	30% coinsurance after deductible	None
Ambulance Services	30% coinsurance after deductible	Refer to your Evidence of Coverage
Emergency Health Care Services	$450 copay after deductible which also applies	

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical Therapy	$30 copay	25 visits per Benefit Year
Occupational Therapy	$30 copay	25 visits per Benefit Year
Speech Therapy	30% coinsurance after deductible	25 visits per Benefit Year
Pulmonary Rehabilitation	30% coinsurance after deductible	25 visits per Benefit Year
Cardiac Rehabilitation Services	30% coinsurance after deductible	36 visits per Benefit Year
Manipulation Therapy	30% coinsurance after deductible	20 visits per Benefit Year
Post-Cochlear Implant Aural Therapy	30% coinsurance after deductible	30 visits per Benefit Year
Cognitive Rehabilitation Therapy	30% coinsurance after deductible	20 visits per Benefit Year
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	30% coinsurance after deductible	Refer to your Evidence of Coverage
Chiropractor Services	$30 copay	Limits for Physical Therapy and Manipulation apply
Autism Spectrum Disorder Services		
Physical Therapy	$30 copay	None
Occupational Therapy	$30 copay	None
Speech Therapy	30% coinsurance after deductible	None
Adaptive Behavior Treatment		
ChiropractoPer 65 100es		

The No Surprises Act is meant to ensure you're kept out of the middle of provider plan billing disputes for those specific services by prohibiting facilities and providers from pursuing payment from you for more than the in-network cost-sharing amount as based on the Recognized Amount in most situations. One situation where you may still be involved is regarding non-emergency services provided by a non-network provider while you are in a network facility. The No Surprises Act prohibits these providers from balance billing you unless the provider gives you notice of their network status and an estimate of charges 72 hours prior to receiving the services, or same day as the appointment if scheduled less than 72 hours in advance. If you receive this notice and then consent to continue to receive the out-of-network care, the provider will be allowed to pursue payment from you for any amounts that we do not cover, otherwise known as balance billing.

See your Evidence of Coverage for further details.

Dependent Information

Dependent Name	[John Doe]