Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
Lab	$40 copay	None
X-Ray/Radiology	$175 copay after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	$225 copay after deductible	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	$175 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	$400 copay after deductible per stay	90 Day limit per Benefit Year
Outpatient Services		
Facility Fee	40% coinsurance after deductible	None
Physician/Surgeon Fees	40% 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	40% coinsurance after deductible	None
Ambulance Services	40% coinsurance after deductible	Refer to your Evidence of Coverage
Emergency Health Care Services	$450 copay after deductible which also applies to out-of-network providers	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	$30 copay	25 visits per Benefit Year
Occupational Therapy	$30 copay	25 visits per Benefit Year
Speech Therapy	40% coinsurance after deductible	25 visits per Benefit Year Visit limits do not apply to Behavioral Health/1 0 oi rJabvit

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Home Health		
Private Duty Nursing	40% coinsurance after deductible	250 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.
Hospice Care	No charge for in-network and out-of-network by Medicare approved providers	Refer to your Evidence of Coverage
Diabetic Services		
Education	40% coinsurance after deductible	Refer to your Evidence of Coverage
Equipment	40% coinsurance after deductible	Refer to your Evidence of Coverage
Supplies	40% coinsurance after deductible	Refer to your Evidence of Coverage
Medical Supplies, Durable Medical Equipment, and Appliances		
Appliances		
Durable Medical Equipment		
Medical Supplies	40% coinsurance after deductible	Refer to your Evidence of Coverage
Orthotic Device		
Prosthetics		
Hearing Aids	40% coinsurance after deductible	1 hearing aid per hearing-impaired ear every 36 months
Prescription Drugs		
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 drugs in Tiers 0-3
Tier 1 (Low Cost)	Up to $3 copay	
Tier 2 (Preferred)	Up to $70 copay	All others limited to a 30-day supply
Tier 3 (Non-Preferred)	40% coinsurance 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)	50% coinsurance after deductible	Insulin cost share not to exceed $30 per 30-day supply in aggregate.
Vision (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 a 12-month supply of contact lenses per

Dependent Information

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