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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<u>Other Practitioner Visits</u>		
Routine Maternity Care (Prenatal and Postnatal) <i>In-Network routine prenatal office visits and other preventive prenatal care and screening are covered at 100%.</i>	10% coinsurance after medical deductible is met	0% coinsurance after medical deductible is met

Covered Medical Benefits

Outpatient Mental Health and Substance Abuse Services

Facility Fee

Doctor Service

Outpatient Surgery

Facility Fees

Hospital

Ambulatory Surgical Center

Doctor and Other Services

Hospital

Ambulatory Surgical Center

Hospital (Including Maternity, Medical, and Nursing Care) **100% Covered**

Medical deductible met
100% coverage after medical deductible met
Medical deductible met
100% coverage after medical deductible met

Covered Medical Benefits

Rehabilitation services

Benefit limit does not apply to services performed in a hospital or medical facility.

Office

Outpatient [REDACTED]

Habilitation services

Benefit limit does not apply to Appliance services performed in a hospital or medical facility.

Office

Outpatient [REDACTED]

Chemo/Radiation Therapy

Office

Outpatient [REDACTED]

Dialysis/Hemodialysis

Office

Outpatient [REDACTED]

Medical deductible is met	Medical deductible is not met	coinsurance after deductible is met

Cardiac rehabilitation

Covered Medical Benefits

Cost if you use an

Covered Prescription Drug Benefits

Cost if you use an In-Network Provider

Cost if you use a Non-Network Provider

Pharmacy Deductible

Covered Vision Benefits

This is a brief outline of your vision coverage. To receive the In-Network benefit, you must:

Cost if you use an In-Network Provider

Cost if you use a Non-Network Provider

Notes:

- Members are encouraged to always contact their member know if the service a covered.
- Non-age mean deductible/copay amounts are subject to change up to 10% annually.
e.g. \$100 deductible will increase to \$110.
- For additional information on limitations, refer to the Evidence of Coverage (EOC) booklet.

This summary of benefits is a brief outline and does not reflect every benefit included in every insurance plan. Exclusions, limitations and other important details are included in the Evidence of Coverage (EOC) booklet.

Acc ss S rv c s

In your language

What a t s says? e wou d be too. Here's t e Eng s vers on
uestions about t s docu ent, you ave t erg t to get e p and nfor at on n your anguge at no
n nterpreter, ca

o our l ng, ge ssist n e progr e ke do l ents ll bie in
p t is

