SUMMARY OF P-15-15-250

BENEFITS AND SCHEDULE OF COPAYMENTS

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Annual Deductible:	None	Out of pocket maximum individual $6,350
Pre-Existing Conditions:	Covered	OOP Maximum family $12,700
Lifetime Maximum:	None	

TYPE OF SERVICE	PATIENT CO-PAY (U.S. DOLLARS)
PHYSICIAN SERVICES	
Office Visits – IPA Facility	100% Covered After $15.00 Copayment
Surgical Services	100% Covered, No Copayment
Assistant Surgeon	100% Covered, No Copayment
Anesthesiologist	100% Covered, No Copayment
Annual Physical Examinations	
(After 90 days of participation)	100% Covered, No Copayment
OUTPATIENT SERVICES	
Laboratory Services	100% Covered, No Copayment
Radiology Services	100% Covered, No Copayment
Home Health Care – If required, available for post-operative care only	100% Covered, No Copayment
Speech, Physical and Occupational Therapy	100% Covered After $15.00 Copayment
Massage Therapy	100% Covered After $15.00 Copay
Prosthesis	100% Covered, No Copayment

HOSPITAL SERVICES	
Hospital Room and Board	100% Covered after $100/day copay
Intensive Care Unit	100% Covered, No Copayment
Operating Room and Recovery	100% Covered, No Copayment
Ancillary Services	100% Covered, No Copayment
URGENT CARE SERVICES	
In Plan's Area	
Urgent Care Services	100% Covered After $25.00 Copayment (Waived if Member is Admitted)
Supplies and Treatment Room	100% Covered, No Copayment
Out-of-Area	
Urgent Care Services	100% Covered After $50.00 Copayment
EMERGENCY SERVICES[i]	100% Covered After $250.00 Copayment
In and Out of Plan's Area	(based on usual and customary charges)
AMBULANCE SERVICE	
Ambulance Service	100% Covered, No Copayment

PRESCRIPTION DRUGS[ii]

Prescription Drugs *no copay limit	100% Covered After $15.00 Copayment
(including insulin, glucagon and prescription medications for treating diabetes	

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment	100% Covered, No Copayment
(including equipment and supplies for the management and treatment of diabetes)	

MENTAL HEALTH AND SUBSTANCE ABUSE

Outpatient	100% Covered After $15.00 Copayment
Inpatient	100% Covered, No Copayment

MATERNITY CARE (At Participating Facility)

Prenatal and Postnatal Visits	100% Covered After $15.00 Copayment
Delivery Including Cesarean Section	100% Covered, No Copayment
Newborn Including Well Baby Care	100% Covered, No Copayment

PREVENTIVE CARE SERVICES

Pap Smears	100% Covered, No Copayment
Mammogram	100% Covered, No Copayment
Immunizations	100% Covered, No Copayment
Birth Control Methods	100% Covered, No Copayment
Testing and Treatment for Phenylketonuria	100% Covered, No Copayment
All Cancer Screening Tests consistent with professionally recognized standards of practice, including annual screening for cervical cancer and screening for prostate cancer and breast cancer, including mammograms.	100% Covered, No Co-payment

EYE CARE SERVICES

Office Visits	100% Covered After $15.00 Copayment
Eye Examinations	100% Covered After $15.00 Copayment
Eye Surgery	100% Covered, No Copayment

EXCLUSIONS AND LIMITATIONS

Please refer to your Evidence of Coverage Booklet for an explanation of what is not covered under the Plan.

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[i] For emergency services received outside the Plan's Network, the Member must notify the Plan within 48 hours after care is received, unless it is not reasonably possible to do so. The services will be reviewed retrospectively by the Plan to determine whether services are eligible for coverage.

[ii] Coverage is provided for drugs determined by the Participating Physician to be medically necessary. Drugs obtained at non-participating pharmacies are not covered unless medically necessary for a covered emergency.