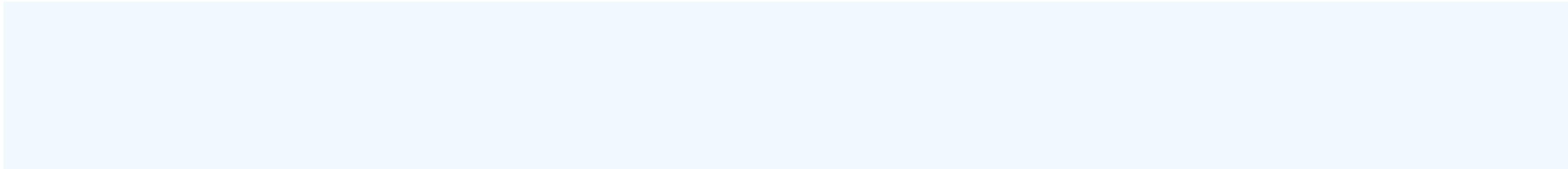

	All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
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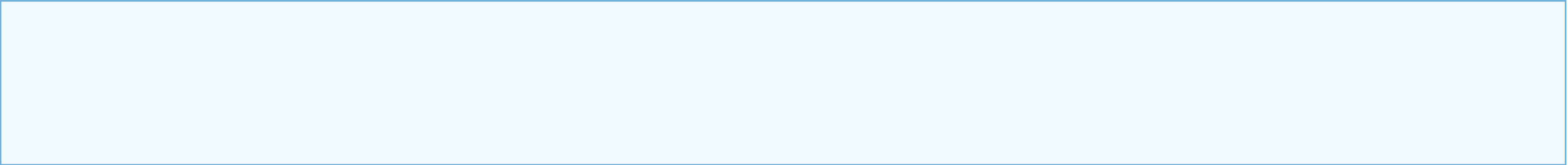
Common Medical Event	Services You May Need	What You Will Pay	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you have mental health, behavioral health, or s				

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	Preauthorization is required.
	Rehabilitation services	$30 Copay per visit; Deductible Waived office therapy; 20% Coinsurance hospital therapy	40% Coinsurance	60 Maximum visits per calendar year OT; 60 Maximum visits per calendar year PT; 40 Maximum visits per calendar year ST; Habilitation services for Learning Disabilities are not covered.
	Habilitation services	$30 Copay per visit; Deductible Waived office therapy; 20% Coinsurance hospital therapy	40% Coinsurance	
	Skilled nursing care	20% Coinsurance	40% Coinsurance	Preauthorization is required.
	Durable medical equipment	20% Coinsurance	40% Coinsurance	None
	Hospice service	No charge; Deductible Waived	No charge; Deductible Waived	None
If your child needs dental or eye care	Children's eye exam	No charge; Deductible Waived	No charge; Deductible Waived	1 Maximum exam per calendar year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
x Acupuncture	x Hearing aids	x Routine foot care
x Cosmetic surgery	x Infertility treatment	x Weight loss programs
x Dental care (Adult)	x Long	



Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	Managing Joe’s Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia’s (SHu.5 (H)re0.7 (avi)-5.8 (n)

The plan would be responsible for the other costs of these EXAMPLE covered services.