

**SUMMARY OF P-10-15**

**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  
Pre-Existing Conditions: Covered  
Lifetime Maximum: None

**TYPE OF SERVICE**

**PATIENT CO-PAY (U.S. DOLLARS)**

**PHYSICIAN SERVICES**

Office Visits – IPA Facility	100% Covered After \$10.00 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 \$10.00 Copayment
Prosthesis	100% Covered, No Copayment

**HOSPITAL SERVICES**

Hospital Room and Board	\$100/day copayment
Intensive Care Unit	100% Covered, No Copayment
Operating Room and Recovery	100% Covered, No Copayment
Ancillary Services	100% Covered, No Copayment

### **EMERGENCY SERVICES<sup>i</sup>**

#### In Plan's Area

Emergency/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	100% Covered After \$100.00 Copayment (based on usual and customary charges)

### **AMBULANCE SERVICE**

Ambulance Service	100% Covered, No Copayment
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### **PRESCRIPTION DRUGS<sup>ii</sup>**

Prescription Drugs	100% Covered After \$15.00 Copayment
(including insulin, glucagon and prescription medications for treating diabetes)	

## **DURABLE MEDICAL EQUIPMENT**

Durable Medical Equipment (including equipment and supplies for the management and treatment of diabetes)	100% Covered, No Copayment
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## **MENTAL HEALTH AND SUBSTANCE ABUSE**

(Outpatient)	100% Covered After \$10.00 Copayment
(Inpatient)	100% Covered, No Copayment

## **MATERNITY CARE (At Participating Facility)**

Prenatal and Postnatal Visits	100% Covered After \$10.00 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	100% Covered, No Co-payment

cancer and breast cancer, including mammograms.

## **EYE CARE SERVICES**

Office Visits	100% Covered After \$10.00 Copayment
Eye Examinations	100% Covered After \$10.00 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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<sup>i</sup> 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.

<sup>ii</sup> 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.

<sup>iii</sup> For a listing of severe mental illnesses including serious emotional disturbances of a child and other benefit details, please refer to the Combined Evidence of Coverage/Disclosure Form or Group Contract.