2014 COPAY GRID - REVISED 6/2/14

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Deductible	NONE	NONE
Out-of-Pocket Maximum	$6,350 Single/ $12,700 Family	NONE
HOSPITAL INPATIENT FACILITY - NON MATERNITY		
Medical/Surgical	$250 copay per admit	$2,000 copay per admit, then 40% coinsurance
Skilled Nursing Facility	$250 copay per admit (60 DAY LIMIT)	NOT COVERED
LTAC & Rehabilitation	$250 copay per admit (60 DAY LIMIT)	NOT COVERED
23 Hour Observation	$250 copay per admit	$2,000 copay per admit, then 40% coinsurance
HOSPITAL INPATIENT FACILITY - MATERNITY		
Maternity	$250 copay per admit	NOT COVERED
Birthing Center	25% coinsurance	NOT COVERED
MENTAL HEALTH & ADDICTION		
Inpatient Hospital Admission	$250 copay per admit	$2,000 copay per admit, then 40% coinsurance
Partial Hospital Admission	$250 copay per admit	NOT COVERED
Residential Treatment	$250 copay per admit	NOT COVERED
Intensive Outpatient Program	$250 copay per admit	NOT COVERED
Outpatient Visits	$20 copay (NO COPAY FIRST 5 VISITS)	NOT COVERED
HOSPITAL OUTPATIENT FACILITY		
Emergency Room	$350 copay	$350 copay
Surgery	$250 copay	NOT COVERED
Cardio/Pulmonary Rehabilitation (after discharge from an inpatient Hospital admission)	$40 copay (30 VISIT LIMIT)	NOT COVERED
Diabetic Education	NO COPAY	NOT COVERED
Dialysis	NO COPAY	NOT COVERED
Lab/Pathology (for Hospital-based preoperative/diagnostic services only)	$15 copay	NOT COVERED
PT/OT/ST (after discharge from an inpatient Hospital admission)	$30 copay (30 VISIT LIMIT)	NOT COVERED
Radiology - General	$45 copay per visit	NOT COVERED
Radiology - CT/MRA/MRI	$125 copay per visit	NOT COVERED
Radiology - PET/PET CT	$225 copay per visit	NOT COVERED
Interventional Radiology and Diagnostic Radiology Services only performed in a Hospital Outpatient setting	$250 copay per visit	NOT COVERED
Other	25% coinsurance	NOT COVERED

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NON HOSPITAL FREE STANDING FACILITY		
Surgery	$150 copay	NOT COVERED
Cardio/Pulmonary Rehabilitation	$30 copay (30 VISIT LIMIT)	NOT COVERED
Dialysis	NO COPAY	NOT COVERED
Lab/Pathology	NO COPAY	NOT COVERED
Radiology - General	$20 copay per visit	NOT COVERED
Radiology - CT/MRA/MRI	$125 copay per visit	NOT COVERED
Radiology - PET/PET CT	$175 copay per visit	NOT COVERED
Interventional Radiology Services	$150 copay per visit	NOT COVERED
Physical Therapy - Post Surgery	$0 copay (30 VISITS PER EVENT)	NOT COVERED
Physical Therapy	$0 copay	NOT COVERED
Occupational Therapy/Speech Therapy	$20 copay (30 VISIT LIMIT)	NOT COVERED
Sleep Center	$125 copay	NOT COVERED

PROFESSIONAL SERVICES		
Inpatient services	NO COPAY	NOT COVERED
Office Visit - PCP	$20 copay per visit	NOT COVERED
Office Visit - Specialist	$30 copay per visit	NOT COVERED
Chiropractor	$25 copay per visit	NOT COVERED
Vision Exams	$40 copay per visit	NOT COVERED
Hearing and Speech Exams	$40 copay per visit	NOT COVERED
Urgent Care Visit	$40 copay per visit includes all covered services	NOT COVERED
Allergy Testing/Immunotherapy	$7 copay per test type/injection	NOT COVERED
Chemotherapy	$7 copay per visit	NOT COVERED
Dialysis Management	NO COPAY	NOT COVERED
Lab/Pathology	NO COPAY	NOT COVERED
Injections	NO COPAY	NOT COVERED
IV Treatment	$7 copay per visit	NOT COVERED
Nerve conduction studies	$7 copay per visit	NOT COVERED
Pulmonary Test	$7 copay per visit	NOT COVERED
Pulmonary Treatment	$5 copay per procedure	NOT COVERED
Radiation therapy	$7 copay per visit	NOT COVERED
Radiology - General (in select physician offices)	$30 copay per visit	NOT COVERED
Radiology - CT/MRA/MRI (in select physician offices)	$125 copay per visit	NOT COVERED
Radiology - PET/ PET CT (in select physician offices)	$225 copay per visit	NOT COVERED
Surgery in office	$7 copay per procedure	NOT COVERED

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All other Physician office procedures	$7 copay per procedure	NOT COVERED

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PREVENTIVE SERVICES		
Immunizations for Adults & Children	NO COPAY	NOT COVERED
Well Baby/Child Exams	NO COPAY	NOT COVERED
Wellness/Physical Exams	NO COPAY	NOT COVERED
Colonoscopy/Sigmoidoscopy	NO COPAY (AGES 50-74)	NOT COVERED
Mammogram	NO COPAY	NOT COVERED
Dexascan	NO COPAY	NOT COVERED
Nutritional Counseling	NO COPAY	NOT COVERED

PRESCRIPTION DRUGS		
Culinary Pharmacy (select medications available)	NO COPAY	NOT COVERED
Tier 1 - Generic	$10 copay	NOT COVERED
Tier 2 - Formulary	$30 copay	NOT COVERED
Tier 3 - Non Formulary	$50 copay	NOT COVERED

OTHER		
Ambulance	25% coinsurance	
Compression Stockings	$22 copay per pair (3 PAIR PER YEAR)	NOT COVERED
Diabetic Shoes	$55 copay per pair (2 PAIR PER YEAR)	NOT COVERED
Diabetic Supplies	NO COPAY	NOT COVERED
DME & Medical Supplies	25% coinsurance	NOT COVERED
Glasses/Contact Lenses	$150 maximum benefit every 2 years	NOT COVERED
Hearing Aids	$300 maximum benefit every 5 years	
Home Health	$15 per day (60 VISIT LIMIT)	NOT COVERED
Home Infusion Therapy	NO COPAY	NOT COVERED
Hospice - Inpatient and Outpatient	NO COPAY	NOT COVERED
Mastectomy Bra	$12 copay per item ($350 MAX PER YEAR)	NOT COVERED
Orthotic Shoe Inserts - Non Diabetic	$10 per pair copay (1 PAIR OR 2 INSERTS EVERY 5 YEARS)	NOT COVERED
Prosthetic & Orthotic Appliances	25% coinsurance	NOT COVERED