

Product Type: Network

Not Applicable         Not Applicable         Not Covered           Medical and Prescription Copays unless otherwise noted)         \$7.150 single / \$14,300 tamly         Not Covered           Prescription Drugs, Insulin & Disposable Diabetic Supplies         Unless otherwise indicated, generic to brand name drugs can be found in any cornular (ter)           Tier 1         \$20 copay         Not Covered           Tier 2         \$45 copay         Not Covered           Tier 3         \$70 copay         Not Covered           Tier 4         \$100 copay         Not Covered           Diagnostic Services         Not Covered         Not Covered           Diagnostic Services (Xrays/Labs)         20% consurance after deductible / 20% consurance after deductible         Not Covered           CAT Scans/MR/MRA         20% consurance after deductible         Not Covered           Hospital & Surgical Center         \$40 copay and/or 20% consurance after deductible         Not Covered           Urgent Care         \$40 copay and/or 20% consurance after deductible         Not Covered           Anbulance         20% consurance after deductible         Not Covered           Urgent Care         \$40 copay and/or 20% consurance after deductible         Not Covered           Mation Hospital         20% consurance after deductible         Not Covered           Mutal Health Inpati	centered around you	Effective Date: 01/01/2022	Plan Code: 1089566
Consurance         20% consurance after deductible         Nat Covered           Office Visit Charge (Primary/Specialist)         540 copay         Nat Covered           Office Visit and Related Services         20% consurance after deductible         Nat Covered           Preventive Services         St0 copay         Nat Covered           Deductible and Consurance Limit plus         St1 50 single / St4.300 timly         Nat Covered           Medical and Prescription Copays unless otherwise notes)         St1 50 single / St4.300 timly         Nat Covered           Prescription Drugs, Insulin & Disposable Diabetic Supples         Unless otherwise indicated, genetic co-brand hame drugs can be found in any correctly stable.         Nat Covered           Tier 1         St0 copay         Nat Covered         St0 copay         Nat Covered           Tier 2         St150 copay         Nat Covered         St0 coread         St0 coread         St0 covered	Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Construction         Set Occupation         Set Occupation           Office Visit Charge (Primary/Specialist)         S40 copary         Not Covered           Office Visit and Related Services         20% consurance after deductible         Not Covered           Preventive Services         S0 copary         Not Covered           Deductible and Coinsurance Limit         Not Applicable         Not Covered           Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus)         \$7.59 angle / \$4.300 family         Not Covered           Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus)         Valees otherwise indicated, generic or brand name drugs can be found in any formality interface         Not Covered           Tier 1         \$30 copary         Not Covered         Not Covered           Tier 3         S71 copary         Not Covered         Not Covered           Tier 4         \$100 copary         Not Covered         Not Covered           Diagnostic Services         Not Covered         Not Covered         Not Covered           Diagnostic Services (XraysLabs)         20% coinsurance after deductible         Not Covered           Outpatient Hospital         20% coinsurance after deductible         Not Covered           Inpatient Hospital         20% coinsurance after deductible         Not Covered           Diagnostic Services	Deductible	\$4,000 single / \$8,000 family	Not Covered
Office Visit and Related Services         20% consumme after deductible         Not Covered           Office Visit and Related Services         500 copiny         Not Covered           Preventive Services         500 copiny         Not Covered           Maximum Out-Or-Pocket (Docusible and Coinsurance Limit Puls Medical and Prescription Copurys unless otherwise noted)         \$7.150 single / \$14.300 family         Not Covered           Prescription Drugs, Insulin & Disposable Diabetic Supplies         Unless otherwise indicated, generic or or and name drugs deal         Secondary           Tier 1         \$200 copay         Not Covered         Not Covered           Tier 3         \$70 copay         Not Covered           Tier 4         \$100 copay         Not Covered           Diagnostic Services         Not Covered         Not Covered           Diagnostic Services (Xraya/Labs)         20% consummoe after deductible / 20%         Not Covered           CAT Scans/MR/MRA         20% consummoe after deductible         Not Covered           Hospital & Surgical Center         20% consummoe after deductible         Not Covered           Impaint Hospital         20% consummoe after deductible         Not Covered           Uppert Care         \$40 copay and/or 20% consummoe after deductible         Not Covered           Corered         \$300 copay indiv 70% consummoe after deductib	Coinsurance	20% coinsurance after deductible	Not Covered
Preventive Services         S0 copay         Not Covered           Deductible and Coinsurance Limit         Not Applicable         Not Covered           Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus)         \$7,150 single / \$14.300 family         Not Covered           Prescription Drugs, Insulin & Disposable Diabetic Supplies         Unless otherwise indicated generic or trand name drugs can be found in any trand trans of trand trans of tran	Office Visit Charge (Primary/Specialist)	\$40 copay	Not Covered
Not Applicable         Not Applicable         Not Covered           Medical and Prescription Copays unless otherwise noted)         \$7.150 single / \$14,300 tamly         Not Covered           Prescription Drugs, Insulin & Disposable Diabetic Supplies         Unless otherwise indicated, generic to brand name drugs can be found in any cornular (ter)           Tier 1         \$20 copay         Not Covered           Tier 2         \$45 copay         Not Covered           Tier 3         \$70 copay         Not Covered           Tier 4         \$100 copay         Not Covered           Diagnostic Services         Not Covered         Not Covered           Diagnostic Services (Xrays/Labs)         20% consurance after deductible / 20% consurance after deductible         Not Covered           CAT Scans/MR/MRA         20% consurance after deductible         Not Covered           Hospital & Surgical Center         \$40 copay and/or 20% consurance after deductible         Not Covered           Urgent Care         \$40 copay and/or 20% consurance after deductible         Not Covered           Anbulance         20% consurance after deductible         Not Covered           Urgent Care         \$40 copay and/or 20% consurance after deductible         Not Covered           Mation Hospital         20% consurance after deductible         Not Covered           Mutal Health Inpati	Office Visit and Related Services	20% coinsurance after deductible	Not Covered
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)         S7.150 single / S14.300 family Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier)           Prescription Drugs, Insulin & Disposable Diabetic Supplies         Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier)           Tier 1         \$20 copay         Not Covered           Tier 2         \$45 copay         Not Covered           Tier 3         \$70 copay         Not Covered           Tier 4         \$100 copay         Not Covered           Diagnostic Services         Not Covered         Not Covered           Diagnostic Services (Xrays/Labs)         20% coinsurance after deductible         Not Covered           CAT Scans/MR/MEA         20% coinsurance after deductible         Not Covered           Hospital & Surgical Conter         20% coinsurance after deductible         Not Covered           Urgent Care         \$40 copay and/or 20% coinsurance after deductible         Not Covered           Dugatient Hospital         20% coinsurance after deductible         Not Covered           Care Care         \$400 copay and/or 20% coinsurance after deductible         Not Covered           Urgent Care         \$400 copay and/or 20% coinsurance after deductible         Not Covered           Emergency Keorices (Copay i	Preventive Services	\$0 copay	Not Covered
Medical and Prescription Copays unless otherwise noted)     3.7.190 single 7314-300 terminy     Not Covered       Prescription Drugs, Insultn & Disposable Diabetic Supplies     Unless otherwise indicated, generic or brand name drugs can be found in any formulary dar.       Tier 1     \$20 copay     Not Covered       Tier 3     \$70 copay     Not Covered       Tier 4     \$100 copay     Not Covered       Diagnostic Services     Not Covered     Not Covered       Diagnostic Services (Krays/Labs)     20% coinsurance after deductible / 20% coinsurance after deductible     Not Covered       CAT Scans/MR/MRA     20% coinsurance after deductible     Not Covered       Hospital & Surgical Center     20% coinsurance after deductible     Not Covered       Cupatient Hospital     20% coinsurance after deductible     Not Covered       Outpatient Hospital     20% coinsurance after deductible     Not Covered       Urgent Care     \$40 copay and/or 20% coinsurance after deductible     Not Covered       Emergency Room Services (Copay is waived if admitted)     \$300 copay and/or 20% coinsurance after in network deductible       Other Batter Hospital     20% coinsurance after deductible     Not Covered       Emergency Room Services (Copay is waived if admitted)     \$300 copay and/or 20% coinsurance after in network deductible       Other Batter Hospital     20% coinsurance after deductible     \$300 copay and/or 20% coinsurance after in net	Deductible and Coinsurance Limit	Not Applicable	Not Covered
Prescription Drugs, institut a Disposable Diabetic Supplies         formulary tier)           Tier 1         \$20 copay         Not Covered           Tier 2         \$45 copay         Not Covered           Tier 3         \$70 copay         Not Covered           Tier 4         \$100 copay         Not Covered           Diagnostic Services         Not Covered         Not Covered           Diagnostic Services (Xrays/Labs)         20% consurance after deductible / 20% con	Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	\$7,150 single / \$14,300 family	Not Covered
Tier 2     S46 copay     Not Covered       Tier 3     \$70 copay     Not Covered       Tier 4     \$100 copay     Not Covered       Tier 5     Not Covered     Not Covered       Diagnostic Services     20% coinsurance after deductible / 20%     Not Covered       CAT Scans/MR/MRA     20% coinsurance after deductible / 20%     Not Covered       Hospital 5 Surgical Center     20% coinsurance after deductible     Not Covered       Inpatient Hospital     20% coinsurance after deductible     Not Covered       Outpatient Hospital     20% coinsurance after deductible     Not Covered       Urgent Care     \$40 copay and/or 20% coinsurance after deductible     S00 copay and/or 20% coinsurance after deductible       Emergency Room Services     20% coinsurance after deductible     S00 copay and/or 20% coinsurance after deductible       Mental Health Inpatient     20% coinsurance after deductible     S00 copay and/or 20% coinsurance after deductible       Mental Health Day Treatment Programs     20% coinsurance after deductible     Not Covered       Mental Health Day Treatment Programs     20% coinsurance after deductible     Not Covered       Mental Health Day Treatment Programs     20% coinsurance after deductible     Not Covered       Mental Health Day Treatment Programs     20% coinsurance after deductible     Not Covered       Mental Health Day Treatment Programs     20	Prescription Drugs, Insulin & Disposable Diabetic Supplies		
Tier 3     \$70 copay     Not Covered       Tier 4     \$100 copay     Not Covered       Tier 5     Not Covered     Not Covered       Diagnostic Services     20% coinsurance after deductible / 20%     Not Covered       CAT Scans/MRI/MRA     20% coinsurance after deductible     Not Covered       Hospital & Surgical Center     100     100       Inpatient Hospital     20% coinsurance after deductible     Not Covered       Outpatient Hospital     20% coinsurance after deductible     Not Covered       Care     \$40 copay and/or 20% coinsurance after deductible     Not Covered       Emergency Services     100     20% coinsurance after deductible     Not Covered       Urgent Care     \$40 copay and/or 20% coinsurance after deductible     Not Covered       Emergency Room Services (Copay is waived if admitted)     \$300 copay and/or 20% coinsurance after in network deductible       Ambulance     20% coinsurance after deductible     \$300 copay and/or 20% coinsurance after in network deductible       Other Services     100     20% coinsurance after deductible     \$00 copay and/or 20% coinsurance after in network deductible       Montal Health Day Treatment Programs     20% coinsurance after deductible     Not Covered       Mental Health Day Treatment Programs     20% coinsurance after deductible     Not Covered       Mental Health Dutpatient     \$400 copay per ther	Tier 1	\$20 copay	Not Covered
Tier 4       \$100 copay       Not Covered         Tier 5       Not Covered       Not Covered         Diagnostic Services       20% coinsurance after deductible       20% coinsurance after deductible         CAT Scans/MRI/MRA       20% coinsurance after deductible       Not Covered         Hospital & Surgical Center       10       10         Inpatient Hospital       20% coinsurance after deductible       Not Covered         Outpatient Hospital       20% coinsurance after deductible       Not Covered         Urgent Care       \$40 copay and/or 20% coinsurance after in-network deductible       Not Covered         Emergency Room Services (Copay is waived if admitted)       \$300 copay and/or 20% coinsurance after in-network deductible       20% coinsurance after ideductible         Ambulance       20% coinsurance after deductible       20% coinsurance after in-network deductible       20% coinsurance after in-network deductible         Mental Health Inpatient       20% coinsurance after ideductible       20% coinsurance after in-network deductible         Mental Health Outpatient       20% coinsurance after ideductible       Not Covered         Mental Health Dutpatient       20% coinsurance after ideductible       Not Covered         Mental Health Outpatient       20% coinsurance after deductible       Not Covered         Mental Health Outpatient       20% coinsura	Tier 2	\$45 copay	Not Covered
Tier 5     Not Covered     Not Covered       Diagnostic Services     20% coinsurance after deductible / 20% coinsurance after deductible     Not Covered       CAT Scans/MRI/MRA     20% coinsurance after deductible     Not Covered       Hospital & Surgical Center     1     1       Inpatient Hospital     20% coinsurance after deductible     Not Covered       Outpatient Hospital     20% coinsurance after deductible     Not Covered       Urgent Care     \$40 copay and/or 20% coinsurance after deductible     Not Covered       Emergency Services     1     20% coinsurance after deductible     Not Covered       Urgent Care     \$40 copay and/or 20% coinsurance after innetwork deductible     S300 copay and/or 20% coinsurance after innetwork deductible       Emergency Room Services (Copay is waived if admitted)     \$300 copay and/or 20% coinsurance after innetwork deductible     20% coinsurance after deductible       Ambulance     20% coinsurance after deductible     20% coinsurance after deductible     20% coinsurance after deductible       Mental Health Inpatient     20% coinsurance after deductible     Not Covered       Mental Health Outpatient     \$40 copay     Not Covered       Mental Health Outpatient     \$40 copay per therapy type per day     Not Covered       Physical, Speech & Occupational Therapy     \$40 copay per the	Tier 3	\$70 copay	Not Covered
Diagnostic Services         Not Covered / Not Covered           Diagnostic Services (Xrays/Labs)         20% coinsurance after deductible         Not Covered           CAT Scans/MRI/MRA         20% coinsurance after deductible         Not Covered           Hospital & Surgical Center         1000000000000000000000000000000000000	Tier 4	\$100 copay	Not Covered
Diagnostic Services (Xrays/Labs)         20% coinsurance after deductible / 20% coinsurance after deductible         Not Covered / Not Covered           CAT Scans/MRI/MRA         20% coinsurance after deductible         Not Covered           Hospital & Surgical Center         1         1           Inpatient Hospital         20% coinsurance after deductible         Not Covered           Outpatient Hospital         20% coinsurance after deductible         Not Covered           Inpatient Hospital         20% coinsurance after deductible         Not Covered           Emergency Services         1         1         1           Urgent Care         \$40 copay and/or 20% coinsurance after deductible         \$40 copay and/or 20% coinsurance after innetwork deductible           Emergency Room Services (Copay is waived if admitted)         \$300 copay and/or 20% coinsurance after innetwork deductible         20% coinsurance after deductible         20% coinsurance after deductible           Ambulance         20% coinsurance after deductible         20% coinsurance after deductible         20% coinsurance after deductible         Not Covered           Mental Health Inpatient         20% coinsurance after deductible         Not Covered         Not Covered           Mental Health Outpatient         \$40 copay         Not Covered         Not Covered           Durable Medical Equipment         20% coinsurance after deductible <td>Tier 5</td> <td>Not Covered</td> <td>Not Covered</td>	Tier 5	Not Covered	Not Covered
Didghostic Services (Xrays/Labs)       coinsurance after deductible       Not Covered         CAT Scans/MRI/MRA       20% coinsurance after deductible       Not Covered         Inpatient Hospital       20% coinsurance after deductible       Not Covered         Outpatient Hospital       20% coinsurance after deductible       Not Covered         Emergency Services       20% coinsurance after deductible       Not Covered         Urgent Care       \$40 copay and/or 20% coinsurance after deductible       Solo copay and/or 20% coinsurance after innetwork deductible         Emergency Services       \$300 copay and/or 20% coinsurance after innetwork deductible       \$300 copay and/or 20% coinsurance after innetwork deductible         Emergency Room Services (Copay is waived if admitted)       \$300 copay and/or 20% coinsurance after innetwork deductible       20% coinsurance after deductible         Ambulance       20% coinsurance after deductible       \$000 copay and/or 20% coinsurance after innetwork deductible         Mental Health Inpatient       20% coinsurance after deductible       Not Covered         Mental Health Day Treatment Programs       20% coinsurance after deductible       Not Covered         Durable Medical Equipment       20% coinsurance after deductible       Not Covered         Physical, Speech & Occupational Therapy       \$40 copay per therapy type per day       Not Covered	Diagnostic Services		
Hospital & Surgical Center         Mode           Inpatient Hospital         20% coinsurance after deductible         Not Covered           Outpatient Hospital         20% coinsurance after deductible         Not Covered           Emergency Services             Urgent Care         \$40 copay and/or 20% coinsurance after deductible         \$40 copay and/or 20% coinsurance after in-network deductible           Emergency Room Services (Copay is waived if admitted)         \$300 copay and/or 20% coinsurance after deductible         \$300 copay and/or 20% coinsurance after in-network deductible           Ambulance         20% coinsurance after deductible         \$20% coinsurance after deductible         \$20% coinsurance after deductible           Other Services         20% coinsurance after deductible         20% coinsurance after deductible         Not Covered           Mental Health Inpatient         20% coinsurance after deductible         Not Covered         Not Covered           Mental Health Outpatient         \$40 copay         Not Covered         Not Covered           Durable Medical Equipment         20% coinsurance after deductible         Not Covered           Physical, Speech & Occupational Therapy         \$40 copay per therapy type per day         Not Covered	Diagnostic Services (Xrays/Labs)		Not Covered / Not Covered
Inpatient Hospital       20% coinsurance after deductible       Not Covered         Outpatient Hospital       20% coinsurance after deductible       Not Covered         Emergency Services       20% coinsurance after deductible       Not Covered         Urgent Care       \$40 copay and/or 20% coinsurance after in- network deductible       \$40 copay and/or 20% coinsurance after in- network deductible         Emergency Room Services (Copay is waived if admitted)       \$300 copay and/or 20% coinsurance after in- network deductible       \$300 copay and/or 20% coinsurance after in- network deductible         Ambulance       20% coinsurance after deductible       20% coinsurance after deductible       20% coinsurance after deductible         Other Services       20% coinsurance after deductible       20% coinsurance after deductible       Not Covered         Mental Health Inpatient       20% coinsurance after deductible       Not Covered         Mental Health Outpatient       \$40 copay       Not Covered         Durable Medical Equipment       20% coinsurance after deductible       Not Covered         Physical, Speech & Occupational Therapy       \$40 copay per therapy type per day       Not Covered	CAT Scans/MRI/MRA	20% coinsurance after deductible	Not Covered
Outpatient Hospital       20% coinsurance after deductible       Not Covered         Emergency Services       \$40 copay and/or 20% coinsurance after deductible       \$40 copay and/or 20% coinsurance after in- network deductible         Emergency Room Services (Copay is waived if admitted)       \$300 copay and/or 20% coinsurance after deductible       \$300 copay and/or 20% coinsurance after in- network deductible         Ambulance       20% coinsurance after deductible       20% coinsurance after deductible       20% coinsurance after deductible         Other Services       20% coinsurance after deductible       Not Covered         Mental Health Inpatient       20% coinsurance after deductible       Not Covered         Mental Health Outpatient       \$40 copay       Not Covered         Durable Medical Equipment       20% coinsurance after deductible       Not Covered         Physical, Speech & Occupational Therapy       \$40 copay per therapy type per day       Not Covered	Hospital & Surgical Center		
Emergency Services       S40 copay and/or 20% coinsurance after innetwork deductible         Urgent Care       \$40 copay and/or 20% coinsurance after innetwork deductible         Emergency Room Services (Copay is waived if admitted)       \$300 copay and/or 20% coinsurance after innetwork deductible         Ambulance       20% coinsurance after deductible       \$300 copay and/or 20% coinsurance after innetwork deductible         Other Services       20% coinsurance after deductible       20% coinsurance after deductible         Mental Health Inpatient       20% coinsurance after deductible       Not Covered         Mental Health Outpatient       \$40 copay       Not Covered         Durable Medical Equipment       20% coinsurance after deductible       Not Covered         Physical, Speech & Occupational Therapy       \$40 copay per therapy type per day       Not Covered	Inpatient Hospital	20% coinsurance after deductible	Not Covered
Urgent Care       \$40 copay and/or 20% coinsurance after deductible       \$40 copay and/or 20% coinsurance after in- network deductible         Emergency Room Services (Copay is waived if admitted)       \$300 copay and/or 20% coinsurance after deductible       \$300 copay and/or 20% coinsurance after in- network deductible         Ambulance       20% coinsurance after deductible       20% coinsurance after deductible         Other Services       20% coinsurance after deductible       20% coinsurance after deductible         Mental Health Inpatient       20% coinsurance after deductible       Not Covered         Mental Health Day Treatment Programs       20% coinsurance after deductible       Not Covered         Durable Medical Equipment       20% coinsurance after deductible       Not Covered         Physical, Speech & Occupational Therapy       \$40 copay per therapy type per day       Not Covered	Outpatient Hospital	20% coinsurance after deductible	Not Covered
Orgent Care       And deductible       An network deductible         Emergency Room Services (Copay is waived if admitted)       \$300 copay and/or 20% coinsurance after deductible       \$300 copay and/or 20% coinsurance after in network deductible         Ambulance       20% coinsurance after deductible       20% coinsurance after deductible       20% coinsurance after deductible         Other Services       20% coinsurance after deductible       Not Covered         Mental Health Inpatient       20% coinsurance after deductible       Not Covered         Mental Health Day Treatment Programs       20% coinsurance after deductible       Not Covered         Durable Medical Equipment       20% coinsurance after deductible       Not Covered         Physical, Speech & Occupational Therapy       \$40 copay per therapy type per day       Not Covered	Emergency Services		
Emergency Room Services (Copay is waived if admitted)       Adductible       Adeductible         Ambulance       20% coinsurance after deductible       20% coinsurance after deductible         Other Services       20% coinsurance after deductible       Not Covered         Mental Health Inpatient       20% coinsurance after deductible       Not Covered         Mental Health Day Treatment Programs       20% coinsurance after deductible       Not Covered         Mental Health Outpatient       \$40 copay       Not Covered         Durable Medical Equipment       20% coinsurance after deductible       Not Covered         Physical, Speech & Occupational Therapy       \$40 copay per therapy type per day       Not Covered	Urgent Care		\$40 copay and/or 20% coinsurance after in- network deductible
Other Services       Other Services         Mental Health Inpatient       20% coinsurance after deductible       Not Covered         Mental Health Day Treatment Programs       20% coinsurance after deductible       Not Covered         Mental Health Outpatient       \$40 copay       Not Covered         Durable Medical Equipment       20% coinsurance after deductible       Not Covered         Physical, Speech & Occupational Therapy       \$40 copay per therapy type per day       Not Covered	Emergency Room Services (Copay is waived if admitted)		\$300 copay and/or 20% coinsurance after in- network deductible
Mental Health Inpatient       20% coinsurance after deductible       Not Covered         Mental Health Day Treatment Programs       20% coinsurance after deductible       Not Covered         Mental Health Outpatient       \$40 copay       Not Covered         Durable Medical Equipment       20% coinsurance after deductible       Not Covered         Physical, Speech & Occupational Therapy       \$40 copay per therapy type per day       Not Covered	Ambulance	20% coinsurance after deductible	20% coinsurance after deductible
Mental Health Day Treatment Programs       20% coinsurance after deductible       Not Covered         Mental Health Outpatient       \$40 copay       Not Covered         Durable Medical Equipment       20% coinsurance after deductible       Not Covered         Physical, Speech & Occupational Therapy       \$40 copay per therapy type per day       Not Covered	Other Services		
Mental Health Outpatient     \$40 copay     Not Covered       Durable Medical Equipment     20% coinsurance after deductible     Not Covered       Physical, Speech & Occupational Therapy     \$40 copay per therapy type per day     Not Covered	Mental Health Inpatient	20% coinsurance after deductible	Not Covered
Durable Medical Equipment     20% coinsurance after deductible     Not Covered       Physical, Speech & Occupational Therapy     \$40 copay per therapy type per day     Not Covered	Mental Health Day Treatment Programs	20% coinsurance after deductible	Not Covered
Physical, Speech & Occupational Therapy \$40 copay per therapy type per day Not Covered	Mental Health Outpatient	\$40 copay	Not Covered
	Durable Medical Equipment	20% coinsurance after deductible	Not Covered
Plan Special Features	Physical, Speech & Occupational Therapy	\$40 copay per therapy type per day	Not Covered
	Plan Special Features		

This renewal plan includes prescription drug coverage that is creditable Unless otherwise noted, all benefits are based on a Calendar Year This benefit summary is a highlight of your benefits and should not be relied upon to fully disclose Please review your Member Certificate of Coverage for an exact description of the services and supplies that are covered, excluded, or limited and other terms and conditions of coverage. Your Member Certificate is available at www.prevea360.com.