# Health Care Services

<table>
<thead>
<tr>
<th>Benefit Period, Annual Deductible, and Annual Co-insurance Maximum:</th>
<th>Coverage</th>
<th>Limitations*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefit Period:</strong></td>
<td>Calendar Year</td>
<td></td>
</tr>
<tr>
<td><strong>Annual Deductible:</strong></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Co-insurance (amount member pays):</strong></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Annual Co-insurance Maximum:</strong></td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum:</strong></td>
<td>$6,600 Individual; $13,200 Family</td>
<td>These values do not accumulate. Premiums, balance-billed charges, health care this plan doesn’t cover. All other cost-sharing accumulates.</td>
</tr>
</tbody>
</table>

## Preventive Services:

- Preventive Office Visit / Physical Exam: Covered
- Well Baby Office Visit: Covered
- Routine Hearing Exam: Covered
- Routine Eye Exam: Covered
- Immunizations: Covered
- Related Laboratory and Radiology Services: Covered
- Pap Smears and Mammograms: Covered

## Outpatient & Physician Services:

- Personal Care Physician Office Visit: $20 Copay
- Specialty Physician Office Visit: $20 Copay
- Gynecology Office Visit: $20 Copay
- Audiology Office Visit: $20 Copay
- Eye Exam Office Visit: $20 Copay
- Allergy Treatment and Injections: Covered
- Laboratory and Radiology Services: Covered
- Dialysis: Covered
- Chemotherapy: Covered
- Radiation Therapy: Covered
- Outpatient Surgery: Covered
- Chiropractic Office Visit and Related Services: Not Covered

## Emergency/Urgent Care:

- Emergency Room Services: $150 Copay
- Urgent Care Facility Services: $20 Copay
- Emergency Ambulance Services: Emergency transport only

## Inpatient Hospital Services:

- Hospital inpatient stay in semi-private room, specialty units as medically necessary, Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital: Covered
- Services and Supplies: $1,000 Copay
- Bariatric Surgery & Related Services: $1,000 Copay
- One procedure per lifetime

## Maternity Services:

- Initial Prenatal Office Visit: Covered
- Subsequent Prenatal Office Visits: Covered
- Postnatal Office Visits: Covered
- Labor, Delivery and Newborn Care: Covered

## Mental/Behavioral Health:

- Inpatient Services: Covered
- Outpatient Services: $20 Copay

## Substance Use Disorder:

- Inpatient Services: Covered
- Outpatient Services: $20 Copay

## Other Services:

- Home Health Care: Covered
- Hospice Care: Covered
- Skilled Nursing Care: Covered
- Durable Medical Equipment: Prosthetic & Orthotics: Not Covered
- Hearing Aid Hardware: Not Covered
- Vision Hardware: Not Covered
- Physical, Occupational, and Speech Therapy: Covered
- Pain Management: Covered
- Voluntary Sterilizations: Covered
- Voluntary Termination of Pregnancy: Covered
- Infertility Services: Covered
- Assisted Reproductive Technologies: Covered

## Pharmacy:

- Generic / Preferred Brand / Non-Preferred Brand: $7 / $20 / $30 Copay

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* Benefit Riders: 573,133,126,124,118,016,K60, MHE, MHP, 440

* Hospital admissions require that HAP be notified within 48 hours of admission. Failure to notify HAP within 48 hours could result in a reduction of benefits, or nonpayment.

* Students away at school are covered for acute illness and injury related services according to HAP criteria. Students away at school are not covered for routine physicals, non-emergency psychiatric care, elective surgeries, obstetrical care, sports medicine and vision care services while at school.

* In cases of conflict between this summary and your HMO Subscriber Contract, the terms and conditions of the HMO Subscriber Contract govern.

* Your employer may have determined that your benefit plan may or may not be grandfathered under health care reform legislation. If you have questions regarding grandfathering, please check with your employer.