## Health Care Services

### Benefit Period, Annual Deductible, and Annual Co-insurance Maximum:

<table>
<thead>
<tr>
<th>Benefit Period</th>
<th>Annual Deductible</th>
<th>Co-insurance (amount member pays)</th>
<th>Annual Co-insurance Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year</td>
<td>None</td>
<td>None</td>
<td>NA</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

### Preventive Services Limitations:

- **Preventive Office Visit / Physical Exam**: Covered
- **Well Baby Office Visit**: Covered up to 24 months
- **Routine Hearing Exam**: Covered
- **Routine Eye Exam**: Covered
- **Immunizations**: Covered
- **Related Laboratory and Radiology Services**: 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**: $20 Copay

### Outpatient & Physician Services Limitations:

- **Chiropractic Office Visit and Related Services**: Up to 35 visits per benefit period

### 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 Services and Supplies**: Covered
- **Bariatric Surgery & Related Services**: $1,000 Copay

### Maternity Services:

- **Initial Prenatal Office Visit**: Covered
- **Subsequent Prenatal Office Visits**: Covered
- **Postnatal Office Visits**: $20 Copay
- **Labor, Delivery and Newborn Care**: Covered

### Mental Health:

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

### Chemical Dependency:

- **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**: Covered
- **Physical, Occupational, and Speech Therapy (PT/OT/ST)**: Covered
- **Voluntary Sterilizations**: Covered
- **Voluntary Termination of Pregnancy**: Not Covered

### Inpatient Hospital Services Limitations:

- **Bariatric Surgery & Related Services**: One procedure per lifetime
- **Labor, Delivery and Newborn Care**: Up to 210 days per lifetime

### Outpatient & Physician Services Limitations:

- **Personal Care Physician Office Visit**: See PT/OT/ST Coverage
- **Specialty Physician Office Visit**: Up to 210 days per lifetime
- **Gynecology Office Visit**: Covered
- **Audiology Office Visit**: Covered
- **Eye Exam Office Visit**: Covered
- **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**: Up to 35 visits per benefit period

### Maternity Services Limitations:

- **Initial Prenatal Office Visit**: Covered
- **Subsequent Prenatal Office Visits**: Covered
- **Postnatal Office Visits**: $20 Copay
- **Labor, Delivery and Newborn Care**: Covered

### Chemical Dependency Limitations:

- **Inpatient Services**: Up to 60 combined visits per benefit period - May be rendered at home
- **Outpatient Services**: See PT/OT/ST Coverage

### Pharmacy:

- **Generic / Preferred Brand / Non-Preferred Brand**: $5 / $25 / $50 Copay

### Benefit Riders:

- **012,013,073,118,124,133,203,313,573,599,920

---

* 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.