SCHEDULE OF COPAYMENTS & LIMITATIONS
Standard Medical Plan

BENEFIT	COPAYMENT
Primary Care Physician & Specialist:	
Office Visit to Primary Care Physician (PCP):	$10
Home Visit by (PCP)	$10
After Hours Visit to (PCP)	$10
Office Visit to Specialist	$15
Hearing Exam Visit	$15
Emergency & Urgent Care:	
Visit to Emergency Room (Facility)*	$40
Urgently Needed Care Visit	$10- $40
Outpatient:	
Outpatient Rehabilitation Service Visit**	$15
Outpatient Mental Health Visit	$25
Outpatient Substance Abuse Visit	$15

BENEFIT	COPAYMENT
Inpatient Admission:	
Inpatient Hospital**	N/A
Inpatient Skilled Nursing Care Facility**	N/A
Inpatient Rehabilitation Service**	N/A
Inpatient Mental Health**	N/A
Inpatient Substance Abuse**	N/A
Inpatient Non-Hospital Substance Abuse**	N/A
Detoxification Service**	N/A

BENEFIT	LIMITATION
SKILLED NURSING FACILITY SERVICES**	100 days per Medicare benefit period
REHABILITATION THERAPY SERVICES** (Physical, Occupational, and Speech Therapy)	Copayment does not apply to services performed during inpatient hospitalization, skilled nursing facility or at home.
MENTAL HEALTH CARE**	
Inpatient Mental Health Facility Days	190 day Lifetime† Benefit Maximum in a Medicare approved Mental Health Facility
Inpatient Acute Care Hospital Days	Unlimited
SUBSTANCE ABUSE TREATMENT/DETOXIFICATION**	
Inpatient Substance Abuse Facility Days	190 day Lifetime† Benefit Maximum in a Medicare approved Substance Abuse Facility
Inpatient Non-Hospital Substance Abuse Days	90 day Lifetime Benefit Maximum for care provided in a Medicare approved Substance Abuse Treatment Facility
Inpatient Acute Care Hospital Days	Unlimited
HEARING AID BENEFIT	You are covered up to $500 allowance for hearing aids every three (3) calendar years.

*This Copayment will be waived if the Member is admitted to the Hospital as an inpatient immediately following the Emergency room visit, or if the Member is Referred to the Emergency room because of the need for Covered Services that could have been provided by the Primary Care Physician. †190 day Lifetime Maximum includes Mental Health and Substance Abuse Treatment received in a Medicare Approved Psychiatric Hospital. **Precertification required.

SCHEDULE OF COPAYMENTS & LIMITATIONS

DENTAL CARE benefits

BENEFIT	**COPAYMENT/LIMITATION**
Dental Visits	
Dental Office Visit	$10 per visit

THE FOLLOWING SERVICES ARE COVERED SUBJECT TO THE $10 OFFICE VISIT COPAYMENT WHEN PROVIDED BY THE PRIMARY DENTIST.

DENTAL PREVENTIVE

Oral Examination & Diagnosis	Once every 6 months
Prophylaxis (teeth cleaning)	Once every 6 months

VISION CARE BENEFITS

Vision Examination

Each Member may have one (1) routine eye exam and refraction every two (2) calendar years. These services must be provided by a Plan (in-network) Provider. A list of Providers is available through the Member Services Department.

Check the Specialist Office Visit Copay in the Schedule of Copayments & Limitations to determine the applicable copayment.

Prescription Lenses and Frames from a Plan (in-network) Provider

Each Member is entitled to the following benefits for vision frames and prescription lenses once every two (2) calendar years when provided by a Plan (in-network) Provider.

(1) one (1) pair of frames from a select group of frames; and

(2) one (1) set of eyeglass lenses that may be plastic or glass, single, bifocal, or trifocal lenses, lenticular lenses, and/or oversized lenses, including glass grey #3 prescription sunglasses and tinting.

Benefits are provided for prescription contact lenses in lieu of eyeglasses for up to $100 every two (2) calendar years. Additional services are available at a discount through the Plan (in-network) Provider.

Reimbursement for Prescription Lenses and frames from a Non-Plan (out-of-network) Provider

Each Member is entitled to a reimbursement for the cost of corrective lenses including prescription contact lenses and eyeglass frames. The reimbursement amount is stated below and will be paid when a properly receipted bill is submitted. Instructions for reimbursement may be obtained from the Member Services Department.

Reimbursement Amount	$100 every two (2) calendar years