| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Other Practitioner Visits** | | |
| **Routine Maternity Care** (P enatal and Po tnatal)<br>*In-Network routine pren t l office vi it nd ot er preventive pren t l c re nd creening re covered t 100 .* | 10 coin u ance afte medical deductible i met | 0 coin u ance afte medical deductible i met |

| Covered Medical Benefits |
| --- |
| **Outpatient Mental Health and Substa** |
| Facility Fee |
| Docto Se vice |
| **Outpatient Surgery** |
| **Facility Fees** |
| Ho pital |
| Ambulato y Su ical Cente |
| **Docto** |
| H |
| **Hospital (Including Maternity, Men** |

| Covered Medical Benef | | | |
|---|---|---|---|
| **Rehabilitation services**<br>*Benefit limit doe not pply*<br>*doe not pply w en perfor*<br><br>Office<br><br>Outp | | | |
| **Habilitation services**<br>*Benefit limit doe not pply to Ap*<br>*doe not pply w en performed*<br><br>Office<br><br>Outp | | | |
| **Chemo/Radiation Therapy**<br><br>Office<br><br>Outp | | | |
| **Dialysis/Hemodialysis**<br><br>Office<br><br>Outp | medical deductible i met | medical ded met | |
| **Cardiac rehabilitation** | | | |

| Covered Medical Benefits | Cost if you use an |
| --- | --- |

| Covered Prescription Drug Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
| --- | --- | --- |
| **Pharmacy Deduc** | | |

| Covered Vision Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
| --- | --- | --- |

*T i i brief outline of your vi ion cover ge. To receive t e In-Network benefit you m*

th lu Cross a d lu hi ld is th t ad a o th alth Pl s o ai , I c. I d d t lic s o th lu Cross a d lu hi ld ssociatio . ® NT E
is a ist d t ad a o th I su a c Co a i s, I c. Th lu Cross a d lu

p and infor at on n your angu

n nterpreter, ca

o our l ngu ge ssist n e progr e ke do ents ll