# Health Care Services

| Benefit Period, Annual Deductible, and Annual Co-insurance Maximum: || Coverage || Limitations* |
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**Benefit Period:** Calendar Year  
**Annual Deductible:** None  
**Co-insurance (amount member pays):** None  
**Annual Co-insurance Maximum:** NA

### Preventive Services:

- **Preventive Office Visit / Physical Exam:** $25 Copay  
- **Well Baby Office Visit:** $25 Copay  
- **Routine Hearing Exam:** $25 Copay  
- **Routine Eye Exam:** $25 Copay  
- **Immunizations:** Covered  
- **Related Laboratory and Radiology Services:** Covered  
- **Pap Smears and Mammograms:** Covered

### Outpatient & Physician Services:

- **Personal Care Physician Office Visit:** $25 Copay  
- **Specialty Physician Office Visit:** $25 Copay  
- **Gynecology Office Visit:** $25 Copay  
- **Pregnancy Office Visit:** $25 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:** $100 Copay  
- **Urgent Care Facility Services:** $50 Copay  
- **Emergency Ambulance Services:** Covered (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:** Covered  
- **One procedure per lifetime

### Maternity Services:

- **Initial Prenatal Office Visit:** $25 Copay  
- **Subsequent Prenatal Office Visits:** $25 Copay  
- **Postnatal Office Visits:** $25 Copay  
- **Labor, Delivery and Newborn Care:** Covered

### Mental Health:

- **Inpatient Services:** Covered  
- **Outpatient Services:** Covered

### Chemical Dependency:

- **Inpatient Services:** Covered  
- **Outpatient Services:** Covered

### Other Services:

- **Home Health Care:** Covered  
- **Hospice Care:** Covered (Up to 210 days per lifetime)  
- **Skilled Nursing Care:** Covered  
- **Durable Medical Equipment; Prosthetic & Orthotics:** Covered  
- **Hearing Aid Hardware:** Covered (Coverage provided for approved equipment based on HAP's guidelines)  
- **Vision Hardware:** Covered  
- **Physical, Occupational, and Speech Therapy (PT/OT/ST):** Covered (Up to 60 combined visits per benefit period - May be rendered at home)  
- **Voluntary Sterilizations:** Covered  
- **Voluntary Termination of Pregnancy:** Not Covered  
- **Infertility Services:** Covered  
- **Assisted Reproductive Technologies:** Not Covered

### Pharmacy:

**Generic / Preferred Brand / Non-Preferred Brand:**  
$11 / $35 / $90 Copay

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* 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.