COPAYS

MEDICAL

In-Plan Benefits	DIAMOND Plan	PLATINUM Plan
Acupuncture Services	$20 per visit	$30 per visit
Allergy Services - Office Visit	$20 per visit	$30 per visit
Allergy Antigen	$1 per antigen	$2 per antigen
Allergy Injections	$5 per injection	$10 per injection
Allergy Testing	$1 per test	$2 per test
Ambulance	20% coinsurance	30% coinsurance
Amniocentesis - Hospital Visit	$125 per test	$250 per test
Amniocentesis - Office Visit	$20 per test	$30 per test
Anesthesia - Outpatient or Inpatient Surgeries, Emergency	$100 per surgical session	$150 per surgical session
Anesthesia - Nerve Blocks/Pain Management	$100 per surgical session	$150 per surgical session
CAT/CT Scans	$50 per test procedure	$75 per test procedure
Chemical Dependency Services - Individual or Group Therapy Sessions	$20 per session (up to $3,000 per calendar year)	$30 per session (up to $3,000 per calendar year)
Chemical Dependency Services - Inpatient Care	$150 per day (maximum $450 per admission/ $9,000 per calendar year)	$300 per day (maximum $900 per admission/ $9,000 per calendar year)
Chemical Dependency Services - Partial Hospitalization & Residential Treatment	$75 per day (maximum $450 per admission/ $9,000 per calendar year)	$150 per day (maximum $900 per admission/ $9,000 per calendar year)
Chemotherapy Services	$20 per visit	$30 per visit
Chiropractic Services	$20 per visit ($50/day cap)	$30 per visit ($50/day cap)
Circumcision, Routine Newborn - Inpatient	$20	$30
Colonoscopies, Virtual/Capsule Endoscopies - Hospital/Facility, Inpatient or Outpatient	$150	$200
Colonoscopies, Virtual/Capsule Endoscopies - Office Visit	$20	$30
Colonoscopies, Virtual/Capsule Endoscopies - Surgeon, Inpatient or Outpatient	$125	$250
Compression Garments	20 percent of allowable amount	30 percent of allowable amount
Diabetic Education Classes	$0	$0
Diagnostic Testing (Laboratory, X-rays, MRIs, etc.) - Inpatient only	$0	$0
Dialysis - Inpatient	$0	$0
Dialysis - Outpatient	$20 per visit	$30 per visit
Dialysis Facility - Inpatient	$0	$0
Dialysis Facility - Outpatient	$20 per visit	$30 per visit
Dialysis Physician - Outpatient	$20 per visit	$30 per visit
Durable Medical Equipment (including anything connected with Sleep Studies)	Participants are responsible for 20% coinsurance	Participants are responsible for 30% coinsurance
Electroconvulsive Therapy (ECT) (Physician)	$75 per treatment	$150 per treatment
Emergency Room	$150 per visit	$300 per visit
Emergency Room - Non-Emergency Visit	$250 per visit	$400 per visit
Facility/Hospital - Inpatient (including Mental Health)	$150 per day (up to $450 per admission)	$300 per day (up to $900 per admission)
Facility - Outpatient (including same-day surgeries)	$150 per surgery	$200 per surgery
Feeding Pump Supplies, Total Parenteral Nutrition (TPN)	20 percent of allowable amount	30 percent of allowable amount
Genetic Testing	$10 per test	$15 per test
Hearing Aid Services	Any amount over $1,000 per ear every 5 years	Not a covered expense
Home Health Care	Participants are responsible for 20% coinsurance	Participants are responsible for 30% coinsurance
Hospice Services - Inpatient and Outpatient	Participants are responsible for 20% coinsurance	Participants are responsible for 30% coinsurance
Hospital Observation	$100 per day	$150 per day
Infusion Drugs	$0	$0
Injected Contraceptives	$20 per drug billed by the physician	$30 per drug billed by the physician
IUD - Device	20 percent of allowable amount	30 percent of allowable amount
IUD - Placement	$20	$30
Laboratory/Pathology - Outpatient, Hospital	$10 per test	$15 per test
Laboratory/Pathology - Outpatient, Office Visits	$0 if performed by Quest Diagnostics or LabCorp, $10 per test if performed by a network physician/provider	$0 if performed by Quest Diagnostics or LabCorp, $15 per test if performed by a network physician/provider
Laboratory/Pathology - Specialty	$0	$0
Mammograms	$0	$0
Mastectomy Supplies	20 percent of allowable amount	30 percent of allowable amount
Mental Health Services - Individual or Group Therapy Session	$20 per session	$30 per session
MRAs and MRIs	$50 per test procedure	$75 per test procedure
Nerve Blocks/Pain Management	$125 per procedure	$250 per procedure
Nerve Conduction Studies/EMG	$10 per nerve	$20 per nerve
Nutritional Consultants	$20 per visit	$30 per visit
OB Care, Routine (Physician)	$150 for all routine office visits and delivery	$300 for all routine office visits and delivery
Observation - Hospital and Physician, Outpatient	$100 per visit	$150 per visit
Office Surgery - Physician Charge	$20 per visit	$30 per visit
Office Visits	$20 per visit	$30 per visit
Orthotics & Prosthetics (includes foot orthotics)	Participants are responsible for 20% coinsurance	Participants are responsible for 30% coinsurance
Ostomy Supplies	20 percent of allowable amount	30 percent of allowable amount
Perinatologist - Delivery	$150	$300
Perinatologist - Hospital Visit	$0	$0
Perinatologist - Office Visit	$20 per visit	$30 per visit
PET Scans	$200 per test procedure	$400 per test procedure
Physicals - Routine Exams and Immunizations	$20 per visit	$30 per visit
Physician Visits - Inpatient	$0	$0
Radiation Services	$0	$0
Skilled Nursing & Rehabilitation Facilities - Inpatient (This is separate from hospital copays.)	$150 per day (up to $450 per admission)	$300 per day (up to $900 per admission)
Skilled Nursing & Rehabilitation Facilities - Outpatient Half-Day or Comprehensive Day Treatment	$20 per day	$30 per day
Sleep Studies - Inpatient	$0	$0
Sleep Studies - Outpatient	$75 per test	$150 per test
Surgeon - Assistant	$0	$0
Surgeon - Inpatient, Outpatient, or Emergency	$125 per surgery	$250 per surgery
Therapy Services	$20 per visit per provider	$30 per visit per provider
Transplant Services - Facility	$1,500 at time of transplant and all other copays apply	$5,000 at time of transplant and all other copays apply
Ultrasound	$10 per test	$20 per test
Urgent Care	$20 per visit	$30 per visit
Wigs	Any amount over the $300 maximum benefit	Any amount over the $300 maximum benefit
X-rays, EKGs, other diagnostic testing	$10 per test	$20 per test

PRESCRIPTIONS

In-Plan Benefits	DIAMOND Plan	PLATINUM Plan
PHARMACY (30-day supply)		
Generic	$0	$0
Preferred Brand Name	$25	$30
Non-Preferred Brand Name	$40	$45
MAIL ORDER (90-day supply)		
Generic	$0	$0
Preferred Brand Name	$50	$60
Non-Preferred Brand Name	$80	$90

DENTAL

In-Plan Benefits	DIAMOND Plan	PLATINUM Plan
Preventive Services	$0	$0
Basic Services	20% coinsurance	20% coinsurance
Major Services	40% coinsurance	40% coinsurance
Orthodontia Services	$0 copay for services until the $1,000.00 lifetime maximum benefit is reached; then you pay any amount in excess of the maximum. This benefit is only available to dependents under 19 who have been on the Diamond Dental plan for two current consecutive years.	**NOT COVERED**

VISION

Vision benefits are provided through Vision Service Plan (VSP).
All services and materials are free if in VSP's selected covered services/materials except the examination copay.

In-Plan Benefits	DIAMOND Plan	PLATINUM Plan
Exam	Exam allowed once per calendar year; $20 copay applies.	Exam allowed once per calendar year; $20 copay applies.
PEC Exam	$20 copay per visit	$20 copay per visit
Lenses	Single vision, lined bifocal, and lined trifocal are fully covered; for lens options, you pay any amount over the price of the aforementioned covered lenses and receive an average 30% discount. Lenses are allowed once every calendar year, only if needed.	Single vision, lined bifocal, and lined trifocal are fully covered; for lens options, you pay any amount over the price of the aforementioned covered lenses and receive an average 30% discount. Lenses are allowed once every calendar year, only if needed.
Frames	$130 allowance; you pay any amount over the allowance at a 20% discounted rate. Frames are allowed once every **other** calendar year.	$130 allowance; you pay any amount over the allowance at a 20% discounted rate. Frames are allowed once every **other** calendar year.
Contact Lenses	$120 allowance for contact lens exam and contacts; you pay any amount over the allowance. (There is a 15% discounted rate for the contact lens exam only.) Contact lenses are allowed once every calendar year.	$120 allowance for contact lens exam and contacts; you pay any amount over the allowance. (There is a 15% discounted rate for the contact lens exam only.) Contact lenses are allowed once every calendar year.