

ESSENTIAL CARE CHOICES

Covered Services	Copays
Allergy Services	\$5.00 copay
Cardiology Services	\$5.00 copay
Cardiothoracic Surgery	\$5.00 copay
Dental Services	\$10.00 copay
Dermatology Services	\$5.00 copay
Diagnostic Services	
CT Scan	\$5.00 copay per CT Scan
MRI	\$10.00 copay per MRI
Nuclear Medicine Studies	\$5.00 copay per Nuclear Study
PET Scan	\$20.00 copay per PET Scan
Ultrasound	\$5.00 per Ultrasound
X-rays	\$3.00 per X-ray
Durable Medical Equipment	
Ear, Nose, & Throat Services	\$5.00 copay
Endocrinology Services	\$5.00 copay
Gastroenterology Services	\$5.00 copay
General/Vascular Surgery Services	\$5.00 copay
Gynecology Services	\$5.00 copay
Hematology/Oncology Services	\$5.00 copay
Hospital Services	
Hospital Services - Inpatient	
Hospital Services - Outpatient	
Hospital Services - Emergency Room	\$25.00 per visit unless admission
Infectious Disease Services	\$5.00 copay
Laboratory Services	\$5.00 copay
Nephrology Services	\$5.00 copay
Neurology Services	\$5.00 copay
Neurosurgery Services	\$5.00 copay
Nutritional Counseling (Registered Dietitian)	\$5.00 copay
Ophthalmology Services (Eye Disease and Injury)	\$5.00 copay
Optometry Services	\$5.00 copay
Orthopedic Services	\$5.00 copay
Pain Management Services	\$10.00 copay
Physical Therapy/Occupational Therapy/Speech Therapy	\$5.00 copay
Plastic Surgery (Non-Cosmetic)	\$5.00 copay
Podiatry Services	\$5.00 copay
Prescription Drugs	\$1.00 copay for generic \$5.00 copay for brand
Preventive Screening Services	
Primary Care Services	\$1.00 copay
Pulmonology Services	\$5.00 copay
Rheumatology Services	\$5.00 copay
Specialized Wound Care Services (Hospital)	\$5.00 copay
Transportation Services	\$1.00 one way for each in-network visit \$1.50 one way for each out-of-network visit
Urology Services	\$5.00 copay

Assumption: Prior to service, all services subject to hard limits must be determined to be medically necessary and written Pre-Service Approval must be obtained by the provider unless the service is identified as exempt from Pre-Service Approval in Exhibit B of the provider's contract, the Exemption List Not Requiring Pre-Service Approval.

Assumption: All surgeries, procedures, imaging, and PT/OT will be subject to written Pre-Service Approval unless they are identified in Exhibit B of the provider's contract, the "Exemption List Not Requiring Pre-Service Approval".

Assumption: All services rendered on the same date of service will be counted as one visit, with the exception of labs and x-rays. Providers must obtain Pre-Service Approval subject to Plan rules for purposes of payment.

Assumption: All Hard Limits incorporate and are not in addition to Soft Limit amounts. For a service with a Hard Limit of 6 and a Soft Limit of 3, after the member has used 3 initial visits under the Soft Limit, he gets 3 more visits under the Hard Limit.

ESSENTIAL CARE CHOICES

Covered Services	Soft Limits	Hard Limits	Other Limits
Allergy Services	2 visits	4 visits	
Cardiology Services	2 visits	4 visits	
Cardiothoracic Surgery	3 visits	6 visits	Medical necessity required for all surgeries
Dental Services			1 visit annually (if dental contract cap has not been reached)
Dermatology Services	3 visits	6 visits	
Diagnostic Services			
CT Scans		3 CT Scans per year	
MRI		2 MRIs per year	
PET Scans		2 PET Scans per year	
Ultrasound		2 per body part per year	
X-ray	NA	NA	
Durable Medical Equipment (Post-Surgical Back Brace; Knee Immobilizer; Short Wrist Splint; Air Cast Splint for Ankle; Cam Walker Boot)			1 piece of DME equipment per body part per year
Ear, Nose, & Throat Services	3 visits	6 visits	
Endocrinology Services	2 visits	4 visits	
Gastroenterology Services	2 visits	4 visits	
General/Vascular Surgery Services	4 visits	6 visits	Medical necessity required for all surgeries
Gynecology Services	3 visits	6 visits	One (1) annual well-woman exam
Hematology/Oncology Services	2 visits	4 visits	Chemotherapy & Radiation Therapy are not covered
Hospital Services			
Hospital Services - Inpatient			Limited to 6 days per inpatient hospital admission and 30 days per plan fiscal year
Hospital Services - Outpatient			Limited to 24 hours for surgeries/procedures and up to 48 hours for admissions
Hospital Services - Emergency Room			\$1500 annual cap per member; Emergent condition required to demonstrate medical necessity
Infectious Disease Services	3 visits	6 visits	Hospital Setting Only
Laboratory Services			
Nephrology Services	2 visits	4 visits	
Neurology Services	3 visits	6 visits	
Neurosurgery Services	3 visits	6 visits	
Nutritional Counseling (Registered Dietitian)		1 visit	Conducted by registered dietitian
Ophthalmology Services	2 visits	4 visits	Eye Injury and Disease only; Member should see an optometrist prior to seeing an ophthalmologist
Optometry Services	2 visits	4 visits	Eye Injury and Disease only; Member should see an optometrist prior to seeing an ophthalmologist
Orthopedic Services	3 visits	6 visits	
Pain Management Services	3 visits	6 visits	Subject to Written Prior Authorization
Physical Therapy/Occupational Therapy/Speech Therapy	9 visits per body part per plan fiscal year	36 visits total body per plan fiscal year	Subject to Written Prior Authorization
Plastic Surgery (Non-Cosmetic)	2 visits	4 visits	Non-cosmetic services only (For Wounds and Flaps, Blepharoplasties)
Podiatry Services	2 visits	4 visits	
Prescription Drugs		All drugs provided via plan CVS Caremark formulary	Formulary Drugs Only
Preventive Screening Services			
Primary Care Services	NA	NA	
Pulmonology Services	2 visits	4 visits	
Specialized Wound Care Services (Hospital)		9 visits per body part per year	Hyperbaric treatments, oxygen and wound VACS not covered
Rheumatology Services	3 visits	6 visits	
Transportation Services	\$1.00 in network fee \$1.50 out of network fee		\$1.00 in network fee \$1.50 out of network fee
Urology Services	3 visits	6 visits	

Assumption: All services must be medically necessary and will be subject to written Pre-Service Approval unless they are identified as exempt in Exhibit B of the provider's contract, the "Exemption List Not Requiring Pre-Service Approval".

Assumption: All surgeries, procedures, imaging, and PT/OT will be subject to written Pre-Service Approval unless they are identified in Exhibit B of the provider's contract, the "Exemption List Not Requiring Pre-Service Approval".

Assumption: All services rendered on the same date of service will be counted as one visit, with the exception of labs and x-rays. Providers must obtain Pre-Service Approval subject to Plan rules for purposes of payment.

Assumption: All Hard Limits incorporate and are not in addition to Soft Limit amounts. For a service with a Hard Limit of 6 and a Soft Limit of 3, after the member has used 3 initial visits under the Soft Limit, he gets 3 more visits under the Hard Limit.

CHRONIC CARE CHOICES

Covered Services	Costsharing/Copays
Allergy Services	\$5.00 copay
Cardiology Services	\$3.00 copay
Cardiothoracic Surgery	\$3.00 copay
Dental Services	\$10.00 copay
Dermatology Services	\$5.00 copay
Diagnostic Services	
CT Scan	\$5.00 copay per CT Scan
MRI	\$10.00 copay per MRI
Nuclear Medicine Studies	\$5.00 copay per Nuclear Study
PET Scan	\$20.00 copay per PET Scan
Ultrasound	\$5.00 per Ultrasound
X-rays	\$3.00 per X-ray
Durable Medical Equipment	
Ear, Nose, & Throat Services	\$5.00 copay
Endocrinology Services	\$3.00 copay
Gastroenterology Services	\$5.00 copay
General/Vascular Surgery Services	\$5.00 copay
Gynecology Services	\$5.00 copay
Hematology/Oncology Services	\$3.00 copay
Hospital Services	
Hospital Services - Inpatient	\$0 copay upon admission - Hospital charges above plan limit of 6 days per inpatient hospital admission & 30 days per plan FY may be charged to individual patient.
Hospital Services - Outpatient	
Hospital Services - Emergency Room	\$25.00 per visit unless admission
Infectious Disease Services	\$5.00 copay
Laboratory Services	\$3.00 copay
Nephrology Services	\$3.00 copay
Neurology Services	\$5.00 copay
Neurosurgery Services	\$5.00 copay
Nutritional Counseling (Registered Dietitian)	\$5.00 copay
Ophthalmology Services (Eye Disease and Injury)	\$3.00 copay
Optometry Services	\$5.00 copay
Orthopedic Services	\$5.00 copay
Pain Management Services	\$10.00 copay
Physical Therapy/Occupational Therapy/Speech Therapy	\$3.00 copay
Plastic Surgery (Non-Cosmetic)	\$5.00 copay
Podiatry Services	\$3.00 copay
Prescription Drugs	\$0 copay for generic \$3.00 copay for brand
Preventive Screening Services	
Primary Care Services	\$1.00 copay
Pulmonology Services	\$3.00 copay
Rheumatology Services	\$5.00 copay
Specialized Wound Care Services (Hospital)	\$5.00 copay
Transportation Services	\$1.00 one way for each in-network visit \$1.50 one way for each out-of-network visit
Urology Services	\$5.00 copay

Assumption: All services must be medically necessary and will be subject to written Pre-Service Approval unless (A) they are identified as exempt in Exhibit B of the provider's contract, the Exemption List Not Requiring Pre-Service Approval, or (B) they are services that fall within the Soft Limit.
Assumption: All surgeries, procedures, imaging, and PT/OT will be subject to written Pre-Service Approval unless they are identified in Exhibit B of the provider's contract, the "Exemption List Not Requiring Pre-Service Approval".

Assumption: All services rendered on the same date of service will be counted as one visit, with the exception of labs and x-rays. Providers must obtain Pre-Service Approval subject to Plan rules for purposes of payment.
Assumption: All Hard Limits incorporate and are not in addition to Soft Limit amounts. For a service with a Hard Limit of 6 and a Soft Limit of 3, after the member has used 3 initial visits under the Soft Limit, he gets 3 more visits under the Hard Limit.

CHRONIC CARE CHOICES

Covered Services	Soft Limits	Hard Limits	Other Limits
Allergy Services	2 visits	4 visits	
Cardiology Services	4 visits	9 visits	
Cardiothoracic Surgery	6 visits	9 visits	Medical necessity required for all surgeries
Dental Services			1 visit annually (if dental contract cap has not been reached)
Dermatology Services	5 visits	9 visits	
Diagnostic Services			
CT Scans		3 CT Scans per year	
MRI		2 MRIs per year	
PET Scans		2 PET Scans per year	
Ultrasound		2 per body part per year	
X-ray	NA	NA	
Durable Medical Equipment (Post-Surgical Back Brace; Knee Immobilizer; Short Wrist Splint; Air Cast Splint for Ankle; Cam Walker Boot)			1 piece of DME equipment per body part per year
Ear, Nose, & Throat Services	6 visits	9 visits	
Endocrinology Services	6 visits	9 visits	
Gastroenterology Services	6 visits	9 visits	
General/Vascular Surgery Services	6 visits	9 visits	Medical necessity required for all surgeries
Gynecology Services	6 visits	9 visits	One (1) annual well-woman exam
Hematology/Oncology Services	6 visits	9 visits	Chemotherapy & Radiation Therapy are not covered
Hospital Services			
Hospital Services - Inpatient			Limited to 6 days per inpatient hospital admission and 30 days per plan fiscal year
Hospital Services - Outpatient			Limited to 24 hours for surgeries/procedures and up to 48 hours for admissions
Hospital Services - Emergency Room			\$1500 annual cap per member; Emergent condition required to demonstrate medical necessity
Infectious Disease Services	6 visits	9 visits	Hospital Setting Only
Laboratory Services			
Nephrology Services	6 visits	9 visits	
Neurology Services	6 visits	9 visits	
Neurosurgery Services	3 visits	6 visits	
Nutritional Counseling (Registered Dietitian)	3 visits	6 visits	Conducted by registered dietitian
Ophthalmology Services	6 visits	9 visits	Eye Injury and Disease only; Member should see an optometrist prior to seeing an ophthalmologist
Optometry Services	6 visits	9 visits	Eye Injury and Disease only; Member should see an optometrist prior to seeing an ophthalmologist
Orthopedic Services	6 visits	9 visits	
Pain Management Services	3 visits	6 visits	Subject to Written Prior Authorization
Physical Therapy/Occupational Therapy/Speech Therapy	9 visits per body part per plan fiscal year	36 visits total body per plan fiscal year	Subject to Written Prior Authorization
Plastic Surgery (Non-Cosmetic)	2 visits	4 visits	Non-cosmetic services only (For Wounds and Flaps, Blepharoplasties)
Podiatry Services	4 visits	9 visits	
Prescription Drugs		All drugs provided via plan CVS Caremark formulary	Formulary Drugs Only
Preventive Screening Services			
Primary Care Services	NA	NA	
Pulmonology Services	4 visits	9 visits	
Specialized Wound Care Services (Hospital)		15 visits per body part per year	Hyperbaric treatments, oxygen and wound VACS not covered
Rheumatology Services	6 visits	9 visits	
Transportation Services	\$1.00 in network fee \$1.50 out of network fee		\$1.00 in network fee \$1.50 out of network fee
Urology Services	3 visits	6 visits	

Assumption: All services must be medically necessary and will be subject to written Pre-Service Approval unless they are identified as exempt in Exhibit B of the provider's contract, the "Exemption List Not Requiring Pre-Service Approval".
Assumption: All surgeries, procedures, imaging, and PT/OT will be subject to written Pre-Service Approval unless they are identified in Exhibit B of the provider's contract, the "Exemption List Not Requiring Pre-Service Approval".

Assumption: All services rendered on the same date of service will be counted as one visit, with the exception of labs and x-rays. Providers must obtain Pre-Service Approval subject to Plan rules for purposes of payment.
Assumption: All Hard Limits incorporate and are not in addition to Soft Limit amounts. For a service with a Hard Limit of 6 and a Soft Limit of 3, after the member has used 3 initial visits under the Soft Limit, he gets 3 more visits under the Hard Limit.

COVERED SERVICES

Allergy
 Cardiology Services
 Cardiothoracic Surgery
 Dental Services (Limited to Contract Amount)**
 Dermatology Services
 Diagnostic Services
 CT Scans
 MRI
 PET Scans
 Ultrasound
 X-rays
 Durable Medical Equipment
 Post Surgical Back Brace
 Knee Immobilizer
 Short Wrist Splint
 Air Cast Splint for Ankle
 Cam Walker Boot
 Ear, Nose, & Throat Services
 Endocrinology Services
 Gastroenterology Services
 General/Vascular Surgery Services
 Gynecology Services
 Hematology/Oncology Services
 Hospital Services
 Hospital Services - Inpatient
 Hospital Services - Outpatient
 Hospital Services - Emergency Room
 Infectious Disease Services
 Laboratory Services
 Nephrology Services
 Neurology Services
 Neurosurgery Services
 Nutritional Counseling Services by a Registered Dietitian (chronic conditions - as medically necessary)
 Ophthalmology Services (Eye Disease and Injury) **
 Optometry Services
 Orthopedic Services
 Pain Management Services
 Physical Therapy/Occupational Therapy/Speech Therapy
 Plastic Surgery (Non-Cosmetic Only)
 Podiatry Services
 Prescription Drugs
 Preventive Screening Services
 Pap Smear
 Mammogram Screen
 Prostate Specific Antigen
 Bone Density DexaScan
 Lipid Profile
 Colonoscopy/Sigmoidoscopy
 Primary Care Services
 Pulmonology Services
 Rheumatology Services
 Specialized Wound Care Services (Hospital)
 Transportation Services
 Urology Services

NON-COVERED SERVICES

Ambulance Services
 Allergy Testing or Injections
 AIDS Services
 Alternative Medicine Services
 Behavioral Health Services
 Chemotherapy/Radiation; Drug Enhancers for Advanced Oncology Services
 Chiropractic Services
 Orthodontia & TMJ Services
 Dialysis Procedures
 Hearing Services
 Home Health Services
 Durable Medical Equipment/Supplies (Not covered except listed exceptions)**
 Hospice Services
 Infertility Services
 Inpatient Rehabilitation Services
 Non-emergent Services in Emergency Room Setting
 Nutritional Services by a Registered Dietitian (routine care)
 Obstetrics/Pregnancy Care
 Ophthalmology/Optometry Services (Eyeglasses/Routine Eye Exams)
 Organ Transplants
 Plastic Surgery (Cosmetic)
 Prosthetic Appliances
 Preventive Screening Services * (not covered except listed exceptions)
 Skilled Nursing Facility Services
 Weight Management Services (surgery and medication)

DISCLAIMER: The benefits plan design may be revised periodically. The latest version will be posted to the Polk HealthCare Plan website.
 EFFECTIVE DATE 1/1/2010