Greater Johnstown School D

Carrier	CDPHP HMO 10	MVP HMO CoPlan 10+	EMPIRE PPO B (Fulmont Health Trust)
Benefit			
Deductible	**$0**	**$0**	**Inn: $0 Oon: $750/$1,500**
Medical			
Physician and Other Health Professional Services			
Office/ Home Visits *PCP *Specialist	**$10**	**$10**	**Inn: $20** **Oon: Ded. Then 30% Coinsurance**
Routine Physical Exam (1 Per year Per Member)	**Covered in Full**	**Covered in Full**	**Inn: $0** **Oon: $0**
Adult Immunizations	**Not Covered**	**Not Covered**	**Inn:$20** **Oon: Not Covered**
Radiation Therapy	**$10**	**$10**	**Inn: Covered in Full** **Oon: Ded. Then 30% Coinsurance**
Diagnostic Hearing Exam	**$10**	**$10**	**Inn: $20** **Oon: Ded. Then 30% Coinsurance**
Podiatry	**$10 Routine Footcare Not Covered**	**$10 Routine Footcare Not Covered**	**Inn: $20** **Oon: Ded. Then 30% Coinsurance**
Emergency Room (Waived if Admitted to Hospital)	**$50**	**$35**	**Inn: $200** **Oon: $200**
Ambulance	**$50**	**$0**	**Inn: Covered in Full** **Oon: Ded. Then 30% Coinsurance**
Ambulette	**$50**	**$0**	**Inn: Covered in Full** **Oon: Ded. Then 30% Coinsurance**

Urgent Care	**$50**	**$35**	**Inn: $25** **Oon: $25**
Preventative Services Continued			
Bone Mass Measurement	**Covered in Full**	**Covered in Full**	**Inn: Covered in Full** **Oon: Not Covered**
Mammogram Screening	**Covered in Full**	**Covered in Full**	**Inn: Covered in Full** **Oon: Not Covered**
Mammogram Diagnostic	**Covered in Full**	**Covered in Full**	**Inn: Covered in Full** **Oon: Not Covered**
Pap Smear (Routine)	**Covered in Full**	**Covered in Full**	**Inn: Covered in Full** **Oon: Not Covered**
Pelvic Exam Routine; Additional Pelvic Exam	**Covered in Full**	**Covered in Full**	**Inn: Covered in Full** **Oon: Not Covered**
Hospital Inpatient	**Covered in Full**	**Covered in Full**	**Inn: Covered in Full** **Oon: Ded. Then 30% Coinsurance**
Ambulatory Surgery	**$10**	**$10**	**Inn: Covered in Full** **Oon: Ded. Then 30% Coinsurance**
Skilled Nursing Facility	**Covered in Full**	**Covered in Full**	**Inn: Covered in Full** **Oon: Ded. Then 30% Coinsurance**
Kidney dialysis	**Covered in Full**	**Covered in Full**	**Inn: Covered in Full** **Oon: Ded. Then 30% Coinsurance**
Diagnostic Testing Non-Lab (ie EKG)			

Laboratory Testing	**$10(Waived at Preferred Laboratory)**	**Covered in Full**	**Inn: Covered in Full Oon: Ded. Then 30% Coinsurance**
X-Rays	**$10(Waived at Preferred Laboratory)**	**$10**	**Inn: Covered in Full Oon: Ded. Then 30% Coinsurance**
Diagnostic Testing Non-Lab (ie EKG)	**$10(Waived at Preferred Laboratory)**	**$10**	**Inn: Covered in Full Oon: Ded. Then 30% Coinsurance**
Laboratory and X-Ray Services Continued			
MRI/MRA	**$10(Waived at Preferred Laboratory)**	**$10**	**Inn: Covered in Full Oon: Ded. Then 30% Coinsurance**
Mental Health/Substance Avuse			
Mental Health (Inpatient)	**Covered in Full**	**Covered in Full**	**Inn: Covered in Full Oon: Ded. Then 30% Coinsurance**
Mental Health (Outpatient)	**$10**	**$10**	**Inn: Covered in Full Oon: Ded. Then 30% Coinsurance**
Alcohol Substance Abuse (Inpatient)	**Covered in Full**	**Covered in Full**	**Inn: Covered in Full Oon: Ded. Then 30% Coinsurance**
Alcohol Substance Abuse (Outpatient)	**$10**	**$10**	**Inn: Covered in Full Oon: Ded. Then 30% Coinsurance**
Supplies, Equipment, Devices and Education			
Durable Medical Equipment	**20% Coinsurance**	**20% Coinsurance**	**Inn: Covered in Full Oon: Ded. Then 30% Coinsurance**

Prosthetics	**20% Coinsurance**	**20% Coinsurance**	**Inn: Covered in Full Oon: Ded. Then 30% Coinsurance**
Diabetic Supplies	**$10**	**$10**	**Inn: $5 Oon: Ded. Then 30% Coinsurance**
Diabetic Education & Training	**$10**	**$10**	**Inn: Covered in Full Oon: Ded. Then 30% Coinsurance**
Rehabilitation Services			
Home Health Care	**$10**	**Covered in Full**	**Inn: $20 Oon: Ded. Then 30% Coinsurance**
Physical Therapy	**$10**	**$10**	**Inn: $20 Oon: Ded. Then 30% Coinsurance**
Occupational Therapy	**$10**	**$10**	**Inn: $20 Oon: Ded. Then 30% Coinsurance**
Speech Therapy	**$10**	**$10**	**Inn: $20 Oon: Ded. Then 30% Coinsurance**
Chiropractic Care	**$10**	**$10**	**Inn: $20 Oon: Ded. Then 30% Coinsurance**
Rehabilitation Services Continued			
Cardiac Rehabilitation	**Covered in Full**	**Covered in Full**	**Inn: $20 Oon: Ded. Then 30% Coinsurance**
Vision Care			
Routine Eye Exam	**$10**	**$10**	**Inn: $10 Oon: $40 Allowance**
Medical Exam	**$10**	**$10**	**Inn: $20 Oon: Ded. Then 30% Coinsurance**

Frames	**Not Covered**	**Not Covered**	**Inn: $150 Allowance, then 20% off balance Oon: $45 Allowance**
Lenses:			
Single Vision	**Not Covered**	**Not Covered**	**$0 Inn Only**
Bifocal	**Not Covered**	**Not Covered**	**$0 Inn Only**
Trifocal	**Not Covered**	**Not Covered**	**$0 Inn Only**
Prescription Drugs			
Prescription Drug Rx (30 Day)	**$5/$25/$40**	**$10$25$40**	**Low : $10/$25/$40 High : $5/$15/$30**
Mail Order (90 Day Supply)	**$12.50/$62.50/$100**	**$20/$50/$80**	**Low : $20/$50/$80 High : $10/$30/$60**

If you utilize Out of Network Benefits, you will be responsible for paying any amount above the Allowed Amo coinsurance amounts.

******This is a benefit summary only, and is subject to the terms, conditions, limitations, and exclusions set for comparisons for benefit details.**