



Fulmont Trust High Option  
\$5 Copay / \$0 Deductible



	In-Network	Out-of-Network
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**Benefit**

• Coinsurance	100%	100%
• Copayment	\$5	None
• Deductible Levels	\$0	\$0
• Coinsurance Maximum	None	

**Hospital/Facility Benefits**

**Hospital - Inpatient**

• Unlimited Days Semi-private Room & Board*	Covered in Full	Covered in Full
• Maternity Care*	Covered in Full	Covered in Full
• Routine Newborn Nursery Care	Covered in Full	Covered in Full

**Hospital/Facility Outpatient**

• Ambulatory Surgery	Covered in Full	Covered in Full
• Pre-admission Testing	Covered in Full	Covered in Full
• Kidney Dialysis	Covered in Full	Covered in Full

**Professional And Additional Health Benefits**

**Physician:**

• Office Visit/Consultation	OV Copay	Covered in Full
• Chiropractic Services	OV Copay	Covered in Full
• Routine Pap Smear	Covered in Full	Covered in Full
• Routine Mammography Screening	Covered in Full	Covered in Full
• Allergy Testing	OV Copay	Covered in Full
• Allergy Injections	Covered in Full	Covered in Full
• Second Surgical Opinion/Second Medical Opinion	OV Copay	Covered in Full
• Pre/Post Natal Care	Covered in Full	Covered in Full
• In-Hospital/In-Facility Physician Services/Consultation	Covered in Full	Covered in Full
• Anesthesia	Covered in Full	Covered in Full
• Gynecological Visits	OV Copay	Covered in Full

**Preventive:**

• Annual Routine Physical (1 per year)	OV Copay	Not Covered
• Well-Child Care Visits/Immunizations Up To Age 19	Covered in Full	Covered in Full
• Routine Gynecological Exam (1 per year)	Covered in Full	Covered in Full
• Routine Eye Exam (1 per year)	\$35 allowance	Not Covered

**Alcohol/Substance Abuse/Mental Health:**

- Inpatient Detoxification – Effective 7/1/10 No Limit/Prior - 7 days
- Inpatient Rehabilitation – Effective 7/1/10 No Limit/Prior - 30 days
- Inpatient Mental Health – Effective 7/1/10 No Limit/Prior - 30 days
- Inpatient Mental Health Professional Services – Effective 7/1/10 No Limit/Prior - 30 Visits - \$25 Copay
- Inpatient Mental Health Professional Services – Effective 1/1/10 No Limit/Prior – 30 Visits – 50% Coinsurance
- Alcohol/Substance Abuse – Effective 7/1/10 No Limit/Prior – 60 Visits/20 Family - Covered in Full
- Outpatient Mental Health – Effective 7/1/10 No Limit/Prior – 30 Visits Per Year - Covered in Full

**General Services:**

• Diagnostic Machine Test	Covered in Full	Covered in Full
• Diagnostic X-Ray	Covered in Full	Covered in Full



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• Diagnostic Laboratory	Covered in Full	Covered in Full
• Chemotherapy/Radiation	Covered in Full	Covered in Full
• Ambulance (ground)	Covered in Full	Covered in Full
• Ambulance (air)	Covered in Full	Covered in Full
• Diabetes, Education, Equipment & Supplies	OV Copay	Covered in Full
• Hospice (210 days)	Covered in Full	Covered in Full
• Home Health Care (365 visits)*	Covered in Full	Covered in Full
• MRI/MRA	Covered in Full	Covered in Full
• Infusion Therapy*	Covered in Full	Covered in Full
• Skilled Nursing Facility (120 days*)	Covered in Full	Covered in Full
• DME and Prosthetic Devices*	Covered in Full	Covered in Full
• Short Term Therapies PT, OT, ST, Cardiac Rehab, Pulmonary Therapy	OV Copay	Covered in Full
<b>Emergency Services:</b>		
• Medical Emergency/Accidental Injury	\$25 Copay per visit	Covered in Full
<b>Other:</b>		
• Eye Glasses, Frames, Contact Lenses		
Frames .....		\$50 allowance
Lenses: Single Vision .....		\$30 allowance
Bifocal .....		\$40 allowance
Trifocal .....		\$50 allowance
Contact Lenses.....		\$60 allowance
• Student dependent coverage to age 25		

**Prescription Drugs:**

- \$4 Generic/\$10 Brand, MO \$0 \$5 Diabetic

This is a summary of benefits to be used for comparison only.  
Please refer to the BluePreferred-PPO contract for a complete description of available benefits.

**PPO-Z1\$5-\$0**