$30/$1,500 DEDUCTIBLE PLAN

HEALTH PLAN BENEFITS AND COVERAGE MATRIX

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

The Services described below are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside your Home Region Service Area, except where specifically noted to the contrary in the *Evidence of Coverage (EOC)* for authorized referrals, hospice care, Emergency Care, Post-stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

ANNUAL OUT-OF-POCKET MAXIMUM FOR CERTAIN SERVICES	
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year after the Copayments and Coinsurance you pay for those Services, plus all your Deductible payments (except prescription drugs), add up to one of the following amounts:	
For self-only enrollment (a Family Unit of one Member)	$3,500 per calendar year
For any one Member in a Family Unit of two or more Members	$3,500 per calendar year
For an entire Family Unit of two or more Members	$7,000 per calendar year
Deductible for Certain Services as specified below You must pay Charges for Services you receive in a calendar year until you reach one of the following Deductible amounts:	
For self-only enrollment (a Family Unit of one Member)	$1,500 per calendar year
For any one Member in a Family Unit of two or more Members	$1,500 per calendar year
For an entire Family Unit of two or more Members	$3,000 per calendar year
DEDUCTIBLE FOR CERTAIN DRUGS	$250 per Member per calendar year
LIFETIME MAXIMUM	None

PROFESSIONAL SERVICES (PLAN PROVIDER OFFICE VISITS)	**YOU PAY**
Primary and specialty care visits (includes routine and Urgent Care appointments)	$30 per visit (Deductible doesn’t apply)
Routine preventive physical exams	$30 per visit (Deductible doesn’t apply)
Well-child preventive care visits (0–23 months)	No charge (Deductible doesn’t apply)
Family planning visits	$30 per visit (Deductible doesn’t apply)
Scheduled prenatal care and first postpartum visit	No charge (Deductible doesn’t apply)
Voluntary termination of pregnancy	$30 per procedure after Deductible
Routine preventive refraction exams	$30 per visit (Deductible doesn’t apply)
Routine preventive hearing tests	$30 per visit (Deductible doesn’t apply)
Physical, occupational, and speech therapy visits	$30 per visit after Deductible

OUTPATIENT SERVICES	**YOU PAY**
Outpatient surgery	$250 per procedure after Deductible
Allergy injection visits	$5 per visit after Deductible
Allergy testing visits	$30 per visit (Deductible doesn’t apply)
Vaccines (immunizations)	No charge (Deductible doesn’t apply)
X-rays and lab tests	$10 per encounter after Deductible (except the Deductible doesn’t apply to preventive screenings as described in the *EOC*)
MRI, CT and PET	$50 per procedure after Deductible

Health education:	
Individual visits	$30 per visit (Deductible doesn't apply)
Group educational programs	No charge (Deductible doesn't apply)
HOSPITALIZATION SERVICES	**YOU PAY**
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	$500 per day after Deductible
EMERGENCY HEALTH COVERAGE	**YOU PAY**
Emergency Department visits	$100 per visit after Deductible
AMBULANCE SERVICES	**YOU PAY**
Ambulance Services	$75 per trip after Deductible
PRESCRIPTION DRUG COVERAGE	**YOU PAY**
Most covered outpatient items in accord with our drug formulary guidelines from Plan Pharmacies or from our mail-order program:	
Generic items	$10 for up to a 100-day supply (Deductible doesn't apply)
Brand-name items	$35 for up to a 100-day supply after $250 drug Deductible
DURABLE MEDICAL EQUIPMENT (DME)	**YOU PAY**
The DME items for home use listed in the *EOC* in accord with our DME formulary guidelines (most DME items are not covered)	30% Coinsurance (Deductible doesn't apply)
MENTAL HEALTH SERVICES	**YOU PAY**
Inpatient psychiatric care (up to 30 days per calendar year)	$500 per day after Deductible
Outpatient visits:	
Up to a total of 20 individual and group therapy visits per calendar year	$30 per individual therapy visit (Deductible doesn't apply) $15 per group therapy visit (Deductible doesn't apply)
Up to 20 additional group therapy visits that meet the Medical Group criteria in the same calendar year	$15 per group therapy visit (Deductible doesn't apply)
Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *EOC*.	
CHEMICAL DEPENDENCY SERVICES	**YOU PAY**
Inpatient detoxification	$500 per day after Deductible
Outpatient individual therapy visits	$30 per visit (Deductible doesn't apply)
Outpatient group therapy visits	$5 per visit (Deductible doesn't apply)
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission after Deductible
HOME HEALTH SERVICES	**YOU PAY**
Home health care (up to 100 visits per calendar year)	No charge (Deductible doesn't apply)
OTHER	**YOU PAY**
Skilled nursing facility care (up to 60 days per benefit period)	$50 per day after Deductible
Hospice care	No charge (Deductible doesn't apply)

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the EOC. Please note that we provide all benefits required by law (for example, diabetes testing supplies).