



Individuals and Families Plans

\$50 Copayment Plan

This is a summary of the most frequently asked-about benefits and their copayments and coinsurance. For information on benefits, copayments, and coinsurance, please refer to the *Disclosure Form*. Detailed information about your plan is included in the *Membership Agreement*, which will be provided to you upon acceptance.

Features	Member pays
Medical calendar-year deductible (Individual/Family)	None/None
Annual out-of-pocket maximum (Individual/Family)	\$3,500 / \$7,000
Lifetime benefit maximum	None
Professional services (plan provider office visits)	
Primary and specialty care visits (includes routine and urgent care appointments)	\$50 per visit
Well-child visits from 0 to 23 months	\$15 per visit
Family planning visits	\$50 per visit
Scheduled prenatal care and first postpartum visit	\$15 per visit
Eye exams	\$50 per visit
Hearing tests	\$50 per visit
Physical, occupational, and speech therapy visits	\$50 per visit
Outpatient services	
Outpatient surgery	\$250 per procedure
Allergy injection visits	\$5 per visit
Vaccines (immunizations)	No charge
Most X-rays and lab tests	\$10 per encounter
Health education	
Individual visits	\$50 per visit
Group visits	No charge
Hospitalization services	
Room and board, surgery, anesthesia, X-rays, lab tests, and medications	\$500 per day

Emergency health coverage

Emergency Department visits	\$150 per visit (waived if admitted directly to the hospital)
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Ambulance services

Emergency ambulance services	\$300 per trip
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Prescription drug coverage

Most prescription drugs are not covered

Durable medical equipment (DME)

DME used in the home in accord with our DME formulary	Not covered
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Prosthetic and orthotic devices	No charge
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Mental health services**Inpatient psychiatric care**

Inpatient psychiatric care	\$500 per day (up to 30 days per calendar year)
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Outpatient visits

Individual visits	\$50 per visit (up to 20 individual/group visits per calendar year)
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Group therapy visits	\$25 per visit (up to 20 individual/group visits per calendar year)
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Up to 20 additional group therapy visits that meet Medical Group criteria in the same calendar year

Note: Visit and day limits do not apply to severe mental illness and serious emotional disturbances of children as described in the "Benefits, Copayments, and Coinsurance" section of the *Membership Agreement*.

Chemical dependency services

Inpatient detoxification	\$500 per day
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Outpatient individual therapy visits	\$50 per visit
Outpatient group therapy visits	\$5 per visit
Transitional residential recovery services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	\$100 per admission

Home health services

Home health care (up to 100 two-hour visits per calendar year)	No charge
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Other

Skilled Nursing Facility care	No charge (up to 100 days per benefit period)
Hospice care	No charge

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