



Individuals and Families Plans

\$1,500 Deductible 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)	\$1,500 / \$3,000
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)	\$30 per visit ¹
Well-child visits from 0 to 23 months	\$30 per visit ¹
Family planning visits	\$30 per visit ¹
Eye exams	\$30 per visit ¹
Hearing tests	\$30 per visit ¹
Physical, occupational, and speech therapy visits	\$30 per visit after deductible
 Outpatient services	
Outpatient surgery	\$250 per procedure after deductible
Allergy injection visits	\$5 per visit after deductible
Vaccines (immunizations)	No charge ¹
Most X-rays and lab tests	\$10 per encounter after deductible
 Health education	
Individual visits	\$30 per visit ¹
Group visits	No charge ¹
 Hospitalization services	
Room and board, surgery, anesthesia, X-rays, lab tests, and medications	\$500 per day after deductible

Emergency health coverage

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

Emergency ambulance services	\$150 per trip after deductible
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Prescription drug coverage

Covered items in accord with our drug formulary when obtained at Plan pharmacies

Generic drugs	\$10 up to a 30-day supply
Brand-name drugs	\$35 up to a 30-day supply
Mail-order program	\$20 generic/\$70 brand for 100-day supply for most maintenance drugs

Durable medical equipment (DME)

DME used in the home in accord with our DME formulary	30% coinsurance
Prosthetic and orthotic devices	No charge

Mental health services**Inpatient psychiatric care**

Inpatient psychiatric care	\$500 per day after deductible (up to 10 days per calendar year)
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Outpatient visits

Individual visits	\$30 per individual visit (deductible does not apply) up to a total of 10 individual and group visits per calendar year
Group therapy visits	\$15 per group visit (deductible does not apply)

apply) up to a total of 10 individual and group visits per 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, Deductibles, Copayments, and Coinsurance” section of the *Membership Agreement*.

Chemical dependency services

Inpatient detoxification	\$500 per day after deductible
Outpatient individual therapy visits	\$30 per visit after deductible
Outpatient group therapy visits	\$5 per visit after deductible
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

Home health care (up to 100 two-hour visits per calendar year)	No charge ¹
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Other

Skilled nursing facility care	\$50 per day after deductible (up to 60 days per benefit period)
Hospice care	No charge ¹

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(1) These services not subject to the deductible.

(2) When prescribed by American Specialty Health (ASH) Plans practicing chiropractor and authorized by ASH Plan.

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