

\$15 COPAYMENT 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 add up to one of the following amounts:

For self-only enrollment (a Family Unit of one Member)	\$3,000 per calendar year
For any one Member in a Family Unit of two or more Members	\$3,000 per calendar year
For an entire Family Unit of two or more Members	\$6,000 per calendar year

DEDUCTIBLE OR LIFETIME MAXIMUM

None

PROFESSIONAL SERVICES (PLAN PROVIDER OFFICE VISITS)

	YOU PAY
Primary and specialty care visits (includes routine and Urgent Care appointments)	\$15 per visit
Routine preventive physical exams	\$15 per visit
Well-child preventive care visits (0–23 months)	No charge
Family planning visits	\$15 per visit
Scheduled prenatal care and first postpartum visit	No charge
Voluntary termination of pregnancy	\$15 per procedure
Routine preventive refraction exams	\$15 per visit
Routine preventive hearing tests	\$15 per visit
Physical, occupational, and speech therapy visits	\$15 per visit

OUTPATIENT SERVICES

	YOU PAY
Outpatient surgery	\$100 per procedure
Allergy injection visits	\$5 per visit
Allergy testing visits	\$15 per visit
Vaccines (immunizations)	No charge
X-rays and lab tests	\$10 per encounter
MRI, CT and PET	\$50 per procedure
Health education: Individual visits	\$15 per visit
Group educational programs	No charge

HOSPITALIZATION SERVICES

	YOU PAY
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	\$200 per day

EMERGENCY HEALTH COVERAGE

	YOU PAY
Emergency Department visits	\$100 per visit (does not apply if admitted directly to the hospital as an inpatient)

AMBULANCE SERVICES

	YOU PAY
Ambulance Services	\$75 per trip

PRESCRIPTION DRUG COVERAGE

Most covered outpatient items in accord with our drug formulary guidelines:

Generic items from a Plan Pharmacy

Generic refills from our mail-order program
Brand-name items from a Plan Pharmacy

Brand-name refills from our mail-order program

YOU PAY

\$10 for up to a 30-day supply,
\$20 for a 31 to 60-day supply, or
\$30 for a 61 to 100-day supply

\$20 for up to a 100-day supply
\$25 for up to a 30-day supply,
\$50 for a 31 to 60-day supply, or
\$75 for a 61 to 100-day supply
\$50 for up to 100-day supply

DURABLE MEDICAL EQUIPMENT (DME)

Most covered DME for home use in accord with our DME formulary guidelines up to a \$2,000 calendar year benefit limit as described in the *EOC*

YOU PAY

20% Coinsurance

MENTAL HEALTH SERVICES

Inpatient psychiatric care (up to 30 days per calendar year)

Outpatient visits:

Up to a total of 20 individual and group therapy visits per calendar year

Up to 20 additional group therapy visits that meet the Medical Group criteria in the same calendar year

YOU PAY

\$200 per day

\$15 per individual therapy visit
\$7 per group therapy visit

\$7 per group therapy visit

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

Inpatient detoxification

Outpatient individual therapy visits

Outpatient group therapy visits

Transitional residential recovery Services

(up to 60 days per calendar year, not to exceed 120 days in any five-year period)

YOU PAY

\$200 per day

\$15 per visit

\$5 per visit

\$100 per admission

HOME HEALTH SERVICES

Home health care (up to 100 visits per calendar year)

YOU PAY

No charge

OTHER

Eyewear purchased from Plan Optical Sales Offices every 24 months

Skilled nursing facility care (up to 100 days per benefit period)

All covered Services related to infertility treatment

Hospice care

YOU PAY

Amount in excess of \$150 Allowance

No charge

50% Coinsurance

No charge

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).