

\$30/\$1,000 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)	\$1,000 per calendar year
For any one Member in a Family Unit of two or more Members	\$1,000 per calendar year
For an entire Family Unit of two or more Members	\$2,000 per calendar year

DEDUCTIBLE FOR CERTAIN DRUGS

\$250 per Member per calendar year

LIFETIME MAXIMUM

None

PROFESSIONAL SERVICES (PLAN PROVIDER OFFICE VISITS)

Primary and specialty care visits
(includes routine and Urgent Care appointments)
Routine preventive physical exams
Well-child preventive care visits (0–23 months)
Family planning visits
Scheduled prenatal care and first postpartum visit
Voluntary termination of pregnancy
Routine preventive refraction exams
Routine preventive hearing tests
Physical, occupational, and speech therapy visits

YOU PAY

\$30 per visit (Deductible doesn't apply)
\$30 per visit (Deductible doesn't apply)
No charge (Deductible doesn't apply)
\$30 per visit (Deductible doesn't apply)
No charge (Deductible doesn't apply)
\$30 per procedure after Deductible
\$30 per visit (Deductible doesn't apply)
\$30 per visit (Deductible doesn't apply)
\$30 per visit after Deductible

OUTPATIENT SERVICES

Outpatient surgery
Allergy injection visits
Allergy testing visits
Vaccines (immunizations)
X-rays and lab tests

YOU PAY

\$250 per procedure after Deductible
\$5 per visit after Deductible
\$30 per visit (Deductible doesn't apply)
No charge (Deductible doesn't apply)
\$10 per encounter after Deductible (except the Deductible doesn't apply to preventive screenings as described in the *EOC*)
\$50 per procedure after Deductible

MRI, CT and PET

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).