

# \$5 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

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### 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)	\$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

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### DEDUCTIBLE OR LIFETIME MAXIMUM

None

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### PROFESSIONAL SERVICES (PLAN PROVIDER OFFICE VISITS)

	YOU PAY
Primary and specialty care visits (includes routine and Urgent Care appointments)	\$5 per visit
Routine preventive physical exams	\$5 per visit
Well-child preventive care visits (0–23 months)	No charge
Family planning visits	\$5 per visit
Scheduled prenatal care and first postpartum visit	No charge
Routine preventive refraction exams	\$5 per visit
Routine preventive hearing tests	\$5 per visit
Physical, occupational, and speech therapy visits	\$5 per visit

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### OUTPATIENT SERVICES

	YOU PAY
Outpatient surgery	\$5 per procedure
Allergy injection visits	No charge
Allergy testing visits	\$5 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	\$5 per visit
Group educational programs	No charge

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### HOSPITALIZATION SERVICES

	YOU PAY
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	No charge

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### EMERGENCY HEALTH COVERAGE

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

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**AMBULANCE SERVICES**

Ambulance Services

**YOU PAY**

\$75 per trip

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**PRESCRIPTION DRUG COVERAGE**

Most covered outpatient items in accord with our drug formulary guidelines from Plan Pharmacies or from our mail-order program:

Generic items

Brand-name items

**YOU PAY**

\$5 for up to a 100-day supply

\$15 for up to a 100-day supply

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**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

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**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**

No charge

\$5 per individual therapy visit

\$2 per group therapy visit

\$2 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*.

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**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**

No charge

\$5 per visit

\$2 per visit

\$100 per admission

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**HOME HEALTH SERVICES**

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

**YOU PAY**

No charge

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**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).