

Health Plan Benefits and Coverage Matrix (\$5 Copayment Plan)

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 of 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 Services, 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 if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:

For self-only enrollment (a Family of one Member)	\$1,500 per calendar year
For any one Member in a Family of two or more Members	\$1,500 per calendar year
For an entire Family of two or more Members	\$3,000 per calendar year

Deductible or Lifetime Maximum

None

Professional Services (Plan Provider office visits)

You Pay

Most primary and specialty care consultations, exams, and treatment	\$5 per visit
Routine physical maintenance exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling	No charge
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge
Eye exams for refraction	No charge
Hearing exams	No charge
Urgent care consultations, exams, and treatment	\$5 per visit
Physical, occupational, and speech therapy	\$5 per visit

Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures	\$5 per procedure
Allergy injections (including allergy serum)	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	\$10 per encounter
Preventive X-rays, screenings, and laboratory tests as described in the <i>EOC</i> ...	No charge
MRI, most CT, and PET scans	\$50 per procedure
Health education:	
Covered individual health education counseling	No charge
Covered health educational programs	No charge

Hospitalization Services

You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
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Emergency Health Coverage

You Pay

Emergency Department visits	\$100 per visit
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Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing)

Ambulance Services		You Pay
Ambulance Services		\$75 per trip
Prescription Drug Coverage		You Pay
Covered outpatient items in accord with our drug formulary guidelines at Plan Pharmacies or through our mail-order service:		
Most generic items		\$5 for up to a 100-day supply
Most brand-name items		\$15 for up to a 100-day supply
Durable Medical Equipment		You Pay
Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines up to a \$2,000 calendar year benefit limit as described in the <i>EOC</i>		
		20% Coinsurance
Mental Health Services		You Pay
Inpatient psychiatric hospitalization		No charge
Individual outpatient mental health evaluation and treatment.....		\$5 per individual visit
Group outpatient mental health treatment		\$2 per group visit
Chemical Dependency Services		You Pay
Inpatient detoxification		No charge
Individual outpatient chemical dependency evaluation and treatment		\$5 per visit
Group outpatient chemical dependency treatment		\$2 per visit
Home Health Services		You Pay
Home health care (up to 100 visits per calendar year)		No charge
Other		You Pay
Eyewear purchased at Plan Medical Offices or plan optical sales offices every 24 months		Amount in excess of \$150 Allowance
Skilled nursing facility care (up to 100 days per benefit period)		No charge
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies		No charge
All covered Services related to infertility treatment.....		50% Coinsurance
Hospice care		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).