

## Health Plan Benefits and Coverage Matrix (\$50 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) .....	\$3,500 per calendar year
For any one Member in a Family of two or more Members .....	\$3,500 per calendar year
For an entire Family of two or more Members .....	\$7,000 per calendar year

<b>Deductible for Certain Drugs</b>	<b>\$250 per Member per calendar year</b>
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<b>Deductible for All Other Services or Lifetime Maximum</b>	<b>None</b>
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<b>Professional Services (Plan Provider office visits)</b>	<b>You Pay</b>
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Most primary and specialty care consultations, exams, and treatment .....	\$50 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 .....	\$50 per visit
Physical, occupational, and speech therapy.....	\$50 per visit

<b>Outpatient Services</b>	<b>You Pay</b>
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Outpatient surgery and certain other outpatient procedures .....	\$250 per procedure
Allergy injections (including allergy serum).....	\$5 per visit
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

<b>Hospitalization Services</b>	<b>You Pay</b>
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Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs .....	\$500 per day
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<b>Emergency Health Coverage</b>	<b>You Pay</b>
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Emergency Department visits .....	\$150 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)

<b>Ambulance Services</b>	<b>You Pay</b>
Ambulance Services .....	\$300 per trip
<b>Prescription Drug Coverage</b>	<b>You Pay</b>
Covered outpatient items in accord with our drug formulary guidelines at Plan Pharmacies or through our mail-order service:	
Most generic items .....	\$10 for up to a 100-day supply
Most brand-name items .....	\$35 for up to a 100-day supply after \$250 drug Deductible
<b>Durable Medical Equipment</b>	<b>You Pay</b>
The durable medical equipment items for home use listed in the <i>EOC</i> in accord with our durable medical equipment formulary guidelines (most durable medical equipment is <b>not covered</b> ) .....	
	50% Coinsurance
<b>Mental Health Services</b>	<b>You Pay</b>
Inpatient psychiatric hospitalization .....	\$500 per day
Individual outpatient mental health evaluation and treatment.....	\$50 per individual visit
Group outpatient mental health treatment .....	\$25 per group visit
<b>Chemical Dependency Services</b>	<b>You Pay</b>
Inpatient detoxification .....	\$500 per day
Individual outpatient chemical dependency evaluation and treatment .....	\$50 per visit
Group outpatient chemical dependency treatment .....	\$5 per visit
<b>Home Health Services</b>	<b>You Pay</b>
Home health care (up to 100 visits per calendar year) .....	No charge
<b>Other</b>	<b>You Pay</b>
Skilled nursing facility care (up to 100 days per benefit period) .....	No charge
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the <i>EOC</i> (most external prosthetic and orthotic devices are <b>not covered</b> ) .....	
	No charge
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).