

Health Plan Benefits and Coverage Matrix (\$40/\$2,000 Deductible 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, plus all your Deductible payments, add up to one of the following amounts:

For self-only enrollment (a Family of one Member)	\$4,500 per calendar year
For any one Member in a Family of two or more Members	\$4,500 per calendar year
For an entire Family of two or more Members	\$9,000 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 of one Member)	\$2,000 per calendar year
For any one Member in a Family of two or more Members	\$2,000 per calendar year
For an entire Family of two or more Members	\$4,000 per calendar year

Lifetime Maximum

None

Professional Services (Plan Provider office visits)

You Pay

Most primary and specialty care consultations, exams, and treatment	\$40 per visit (Deductible doesn't apply)
Routine physical maintenance exams	No charge (Deductible doesn't apply)
Well-child preventive exams (through age 23 months).....	No charge (Deductible doesn't apply)
Family planning counseling.....	No charge (Deductible doesn't apply)
Scheduled prenatal care exams and first postpartum follow-up consultation and exam.....	No charge (Deductible doesn't apply)
Eye exams for refraction	No charge (Deductible doesn't apply)
Hearing exams	No charge (Deductible doesn't apply)
Urgent care consultations, exams, and treatment	\$40 per visit (Deductible doesn't apply)
Physical, occupational, and speech therapy.....	\$40 per visit after Deductible

Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures	30% Coinsurance after Deductible
Allergy injections (including allergy serum).....	\$5 per visit after Deductible
Most immunizations (including the vaccine)	No charge (Deductible doesn't apply)
Most X-rays and laboratory tests	\$10 per encounter after Deductible
Preventive X-rays, screenings, and laboratory tests as described in the <i>EOC</i>	No charge (Deductible doesn't apply)
MRI, most CT, and PET scans	\$50 per procedure after Deductible
Health education:	
Covered individual health education counseling	No charge (Deductible doesn't apply)
Covered health educational programs	No charge (Deductible doesn't apply)

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	30% Coinsurance after Deductible
Emergency Health Coverage	You Pay
Emergency Department visits	30% Coinsurance after Deductible
Ambulance Services	You Pay
Ambulance Services	\$100 per trip after Deductible
Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy.....	\$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 (Deductible doesn't apply)
Most generic refills through our mail-order service	\$10 for up to a 30-day supply or \$20 for a 31- to 100-day supply (Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy.....	\$35 for up to a 30-day supply, \$70 for a 31- to 60-day supply, or \$105 for a 61- to 100-day supply (Deductible doesn't apply)
Most brand-name refills through our mail-order service	\$35 for up to a 30-day supply or \$70 for a 31- to 100-day supply (Deductible doesn't apply)
Durable Medical Equipment	You Pay
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 not covered)	30% Coinsurance (Deductible doesn't apply)
Mental Health Services	You Pay
Inpatient psychiatric hospitalization	30% Coinsurance after Deductible
Individual outpatient mental health evaluation and treatment.....	\$40 per individual visit (Deductible doesn't apply)
Group outpatient mental health treatment	\$20 per group visit (Deductible doesn't apply)
Chemical Dependency Services	You Pay
Inpatient detoxification	30% Coinsurance after Deductible
Individual outpatient chemical dependency evaluation and treatment	\$40 per visit (Deductible doesn't apply)
Group outpatient chemical dependency treatment	\$5 per visit (Deductible doesn't apply)
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)	30% Coinsurance after Deductible
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the <i>EOC</i> (most external prosthetic and orthotic devices are not covered).....	No charge (Deductible doesn't apply)
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).