

Benefit Highlights

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call our Member Service Call Center.

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.....	\$25 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	\$25 per visit
Physical, occupational, and speech therapy.....	\$25 per visit

Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures	\$100 per procedure
Allergy injections (including allergy serum).....	\$5 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests.....	No charge
Health education:	
Covered individual health education counseling.....	No charge
Covered health education programs.....	No charge

Hospitalization Services

You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs .	\$100 per admission
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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.....	No charge
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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
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
Most brand-name items at a Plan Pharmacy	\$25 for up to a 30-day supply, \$50 for a 31- to 60-day supply, or \$75 for a 61- to 100-day supply
Most brand-name refills through our mail-order service.....	\$25 for up to a 30-day supply or \$50 for a 31- to 100-day supply

Durable Medical Equipment	You Pay
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	No charge
Mental Health Services	You Pay
Inpatient psychiatric hospitalization.....	\$100 per admission
Individual outpatient mental health evaluation and treatment.....	\$25 per visit
Group outpatient mental health treatment	\$12 per visit
Chemical Dependency Services	You Pay
Inpatient detoxification.....	\$100 per admission
Individual outpatient chemical dependency evaluation and treatment	\$25 per visit
Group outpatient chemical dependency treatment	\$5 per visit
Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge
Other	You Pay
Hearing aid(s) every 36 months	Amount in excess of \$500 Allowance per aid
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 Services related to covered 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 "Benefits and Cost Sharing" and "Exclusions, Limitations, Coordination of Benefits, and Reductions" sections.