

Benefit Highlights

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
Annual Wellness Visit and the Welcome to Medicare Exam.....	No charge
Family planning counseling	\$25 per visit
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	\$5 per visit
Eye exams for refraction and glaucoma screening	\$25 per visit
Hearing exams.....	\$25 per visit
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	\$25 per procedure
Allergy injections (including allergy serum).....	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays, annual mammograms, and laboratory tests	No charge
Manual manipulation of the spine	\$20 per visit
Health education:	
Most individual health education counseling	\$25 per visit
Covered health education programs	No charge

Hospitalization Services

You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs .	\$250 per admission
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Emergency Health Coverage

You Pay

Emergency Department visits	\$50 per visit
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Note: This Cost Sharing does not apply if admitted to the hospital as an inpatient within 24 hours for the same condition for covered Services or if you are admitted directly to the hospital as an inpatient (see "Hospitalization Services" for inpatient Cost Sharing).

Ambulance Services

You Pay

Ambulance Services	\$50 per trip
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Prescription Drug Coverage

You Pay

Most covered outpatient items in accord with our drug formulary guidelines	\$10 for up to a 100-day supply
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Durable Medical Equipment

You Pay

Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	20 percent Coinsurance
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Mental Health Services

You Pay

Inpatient psychiatric hospitalization.....	\$250 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.....	\$250 per admission
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Chemical Dependency Services	You Pay
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 (part-time, intermittent)	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
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
External prosthetic devices, orthotic devices, and ostomy and urological supplies	20 percent Coinsurance
Hospice care for Members without Medicare Part A	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.