

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

Routine preventive care:

Physical exams	\$5 per visit
Well-child visits (through age 23 months)	\$5 per visit
Family planning visits	\$5 per visit
Scheduled prenatal care visits and first postpartum visit	\$5 per visit
Eye refraction exams	\$5 per visit
Hearing tests	\$5 per visit
Primary and specialty care visits	\$5 per visit
Urgent care visits.....	\$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 injection visits	No charge
Allergy testing visits.....	\$5 per visit
Vaccines (immunizations).....	No charge
X-rays and lab tests	No charge
Health education:	
Individual visits.....	\$5 per visit
Group educational programs	No charge

Hospitalization Services

You Pay

Room and board, surgery, anesthesia, X-rays, lab tests, and drugs..... No charge

Emergency Health Coverage

You Pay

Emergency Department visits

\$5 per visit (does not apply if admitted directly to the hospital as an inpatient)

Ambulance Services

You Pay

Ambulance Services

No charge

Prescription Drug Coverage

You Pay

Most covered outpatient items in accord with our drug formulary guidelines from Plan Pharmacies or from our mail-order service.....

\$5 for up to a 100-day supply

Mental Health Services

You Pay

Inpatient psychiatric hospitalization and intensive psychiatric treatment programs (up to 30 days per calendar year)

No charge

Outpatient visits:

Up to a total of 20 individual and group visits per calendar year.....

\$5 per individual visit
\$2 per group visit

Up to 20 additional group visits that meet the Medical Group criteria in the same calendar year

\$2 per group visit

Note: Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the "Benefits and Cost Sharing" section.

