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 Contact 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	None
Lifetime Maximum	None
Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, exams, and treatment	$15 per visit
Routine physical maintenance exams, including well-woman exams	$15 per visit
Well-child preventive exams (through age 23 months)	$15 per visit
Family planning counseling	$15 per visit
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	$15 per visit
Eye exams for refraction	$15 per visit
Hearing exams	$15 per visit
Urgent care consultations, exams, and treatment	$15 per visit
Physical, occupational, and speech therapy	$15 per visit
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$15 per procedure
Allergy injections (including allergy serum)	$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Health education:	
Most individual health education counseling	$15 per visit
Covered health education programs	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit
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
Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary guidelines at Plan Pharmacies or through our mail-order service	$15 for up to a 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	No charge
Individual outpatient mental health evaluation and treatment	$15 per visit
Group outpatient mental health treatment	$7 per visit

Chemical Dependency Services	You Pay
Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment	$15 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**
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
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.