PLAN FINDER

I WANT LOWER MONTHLY RATES AND A FIXED COPAYMENT for preventive care services. I'm willing to have a **deductible** and pay for most services when I actually need them.

DEDUCTIBLE PLANS

Lower monthly rate
Higher out-of-pocket costs

$1,500 Deductible Plan

- Annual out-of-pocket maximum: $3,500/individual or $7,000/family
- Medical calendar-year deductible: $1,500/individual or $3,000/family
- Preventive care office visit:[1] $30 per visit
- Nonpreventive office visit: $30 per visit
- Most lab and X-rays: $10 per encounter after deductible
- Hospital care: $500 per day after deductible
- Emergency services: $150 per visit after deductible
- Prescription drugs:
  - $10 generic
  - $35 brand

Moderate monthly rate
Moderate out-of-pocket costs

New!

$1,000 Deductible Plan

- Annual out-of-pocket maximum: $1,500/individual or $3,000/family
- Medical calendar-year deductible: $1,000/individual or $2,000/family
- Preventive care office visit:[1] $25 per visit
- Nonpreventive office visit: $25 per visit
- Most lab and X-rays: $10 per encounter after deductible
- Hospital care: $250 per day after deductible
- Emergency services: $100 per visit after deductible
- Prescription drugs:
  - $10 generic
  - $35 brand

Higher monthly rate
Moderate out-of-pocket costs

$500 Deductible Plan

- Annual out-of-pocket maximum: $2,500/individual or $5,000/family
- Medical calendar-year deductible: $500/individual or $1,000/family
- Preventive care office visit:[1] $20 per visit
- Nonpreventive office visit: $20 per visit
- Most lab and X-rays: $10 per encounter after deductible
- Hospital care: $100 per day after deductible
- Emergency services: $100 per visit after deductible
- Prescription drugs:
  - $10 generic
  - $35 brand

[1]Preventive care office visits are not subject to the deductible. Preventive care services include well-child visits from 0 to 23 months, scheduled prenatal care, and vaccines (immunizations).

DEDUCTIBLE PLANS – FEATURES AT A GLANCE

This is a summary of the most frequently asked-about benefits and their copayments and coinsurance. For more information on benefits, copayments, and coinsurance, please refer to the *Disclosure Form* enclosed with this booklet. Detailed information about your plan is included in the *Membership Agreement*, which will be mailed to you upon acceptance.

FEATURES	$1,500 DEDUCTIBLE PLAN	$1,000 DEDUCTIBLE PLAN	$500 DEDUCTIBLE PLAN
Medical calendar-year deductible			
Individual	$1,500	$1,000	$500
Family	$3,000	$2,000	$1,000
Annual out-of-pocket maximum			
Individual	$3,500	$1,500	$2,500
Family	$7,000	$3,000	$5,000
Lifetime benefit maximum	None	None	None
PROFESSIONAL SERVICES (PLAN PROVIDER OFFICE VISITS)			
Primary and specialty care visits (includes routine and urgent care appointments)	$30 per visit[1]	$25 per visit[1]	$20 per visit[1]
Well-child visits from 0 to 23 months	$30 per visit[1]	$10 per visit[1]	No charge[1]
Family planning visits	$30 per visit[1]	$25 per visit[1]	$20 per visit[1]
Eye exams	$30 per visit[1]	$25 per visit[1]	$20 per visit[1]
Hearing tests	$30 per visit[1]	$25 per visit[1]	$20 per visit[1]
Physical, occupational, and speech therapy visits	$30 per visit after deductible	$25 per visit after deductible	$20 per visit after deductible
OUTPATIENT SERVICES			
Outpatient surgery	$250 per procedure after deductible	$150 per procedure after deductible	$50 per procedure after deductible
Allergy injection visits	$5 per visit after deductible	$5 per visit after deductible	$5 per visit after deductible
Vaccines (immunizations)	No charge[1]	No charge[1]	No charge[1]
Most X-rays and lab tests	$10 per encounter after deductible	$10 per encounter after deductible	$10 per encounter after deductible
Health education			
Individual visits	$30 per visit[1]	$25 per visit[1]	$20 per visit[1]
Group visits	No charge[1]	No charge[1]	No charge[1]
HOSPITALIZATION SERVICES			
Room and board, surgery, anesthesia, X-rays, lab tests, and medications	$500 per day after deductible	$250 per day after deductible	$100 per day after deductible
EMERGENCY HEALTH COVERAGE			
Emergency Department visits	$150 per visit after deductible (waived if admitted directly to the hospital)	$100 per visit after deductible (waived if admitted directly to the hospital)	$100 per visit after deductible (waived if admitted directly to the hospital)
AMBULANCE SERVICES			
Emergency ambulance services	$150 per trip after deductible	$150 per trip after deductible	$150 per trip after deductible

[1]These services are not subject to the deductible.

DEDUCTIBLE PLANS – FEATURES AT A GLANCE

FEATURES	$1,500 DEDUCTIBLE PLAN	$1,000 DEDUCTIBLE PLAN	$500 DEDUCTIBLE PLAN
PRESCRIPTION DRUG COVERAGE			
Covered items in accord with our drug formulary when obtained at Plan pharmacies			
Generic drugs	$10 up to a 30-day supply	$10 up to a 30-day supply	$10 up to a 30-day supply
Brand-name drugs	$35 up to a 30-day supply	$35 up to a 30-day supply	$35 up to a 30-day supply
Mail-order program	$20 generic/$70 brand for 100-day supply for most maintenance drugs	$20 generic/$70 brand for 100-day supply for most maintenance drugs	$20 generic/$70 brand for 100-day supply for most maintenance drugs
DURABLE MEDICAL EQUIPMENT (DME)			
DME used in the home in accord with our DME formulary	30% coinsurance	20% coinsurance up to a $1,000 calendar-year benefit limit[1]	20% coinsurance up to a $2,000 calendar-year benefit limit[1]
Prosthetic and orthotic devices	No charge	No charge	No charge
MENTAL HEALTH SERVICES			
Inpatient psychiatric care	$500 per day after deductible (up to 10 days per calendar year)	$250 per day after deductible (up to 10 days per calendar year)	$100 per day after deductible (up to 30 days per calendar year)
Outpatient visits			
Individual visits	$30 per visit after deductible (up to a total of 10 individual/ group visits per calendar year)	$25 per visit after deductible (up to a total of 10 individual/ group visits per calendar year)	$20 per visit after deductible (up to a total of 20 individual/ group visits per calendar year)
Group visits	$15 per visit after deductible (up to a total of 10 individual/ group visits per calendar year)	$12 per visit after deductible (up to a total of 10 individual/ group visits per calendar year)	$10 per visit after deductible (up to a total of 20 individual/ group visits per calendar year)
Note: Visit and day limits do not apply to severe mental illness and serious emotional disturbances of children as described in the "Benefits and Cost Sharing" section of the *Membership Agreement*.	Up to 30 additional group therapy visits that meet Medical Group criteria in the same calendar year	Up to 30 additional group therapy visits that meet Medical Group criteria in the same calendar year	Up to 30 additional group therapy visits that meet Medical Group criteria in the same calendar year
CHEMICAL DEPENDENCY SERVICES			
Inpatient detoxification	$500 per day after deductible	$250 per day after deductible	$100 per day after deductible
Outpatient individual therapy visits	$30 per visit after deductible	$25 per visit after deductible	$20 per visit after deductible
Outpatient group therapy visits	$5 per visit after deductible	$5 per visit after deductible	$5 per visit after deductible
Transitional residential recovery services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission after deductible	$250 per admission after deductible	$100 per admission after deductible
HOME HEALTH SERVICES			
Home health care (up to 100 two-hour visits per calendar year)	No charge[1]	No charge[1]	No charge[1]
OTHER			
Skilled nursing facility care	$50 per day after deductible (up to 60 days per benefit period)	No charge after deductible (up to 100 days per benefit period)	No charge after deductible (up to 100 days per benefit period)
Hospice care	No charge[1]	No charge[1]	No charge[1]

[1]These services are not subject to the deductible.