

Deductible plans—features at a glance

This is a summary of the most frequently asked-about benefits and their copayments and coinsurance. For 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	\$250 Deductible Plan
Medical calendar-year deductible		
Individual	\$1,500	\$250
Family	\$3,000	\$500
Pharmacy calendar-year deductible		
	\$250 for brand-name drugs	\$250 for brand-name drugs
Annual out-of-pocket maximum		
Individual	\$3,500	\$2,500
Family	\$7,000	\$5,000
Lifetime benefit maximum		
	None	None
PROFESSIONAL SERVICES (PLAN PROVIDER OFFICE VISITS)		
Primary and specialty-care visits (includes routine and urgent-care appointments)	\$30 per visit after deductible	\$20 per visit after deductible
Well-child visits to age 2	\$30 per visit*	No charge*
Family planning visits	\$30 per visit*	\$20 per visit*
Scheduled prenatal care and first postpartum visit	\$30 per visit*	No charge*
Eye exams	\$30 per visit*	\$20 per visit*
Hearing tests	\$30 per visit*	\$20 per visit*
Chiropractic office visits†	\$15 per visit (up to 20 visits per calendar year)	Not covered
Physical, occupational, and speech therapy visits	\$30 per visit after deductible	\$20 per visit after deductible
OUTPATIENT SERVICES		
Outpatient surgery	\$250 per procedure after deductible	\$50 per procedure after deductible
Allergy injection visits	\$5 per visit after deductible	\$5 per visit after deductible
Immunizations	No charge*	No charge*
X-rays and lab tests	\$10 per encounter after deductible	\$10 per encounter after deductible
Health education:		
Individual visits	\$30 per visit*	\$20 per visit*
Group visits	No charge	No charge
HOSPITALIZATION SERVICES		
Room and board, surgery, anesthesia, X-rays, lab tests, and medications	\$500 per day after deductible	\$100 per day after deductible
EMERGENCY HEALTH COVERAGE		
Emergency Department visits	\$100 per visit after deductible (\$100 copayment is waived if admitted directly to the hospital)	\$100 per visit after deductible (\$100 copayment is waived if admitted directly to the hospital)
AMBULANCE SERVICES		
Emergency ambulance services	\$150 per trip after deductible	\$75 per trip after deductible
PRESCRIPTION DRUG COVERAGE		
Covered items in accord with our drug formulary when obtained at Plan pharmacies	Brand-name items and compounded products are subject to a \$250 drug deductible; see the “Outpatient Prescription Drugs, Supplies and Supplements” section of the <i>Membership Agreement</i> for details.	Brand-name items and compounded products are subject to a \$250 drug deductible; see the “Outpatient Prescription Drugs, Supplies and Supplements” section of the <i>Membership Agreement</i> for details.
Generic drugs	\$10 up to a 100-day supply	\$10 up to a 100-day supply
Brand-name drugs	\$35 up to a 100-day supply after \$250 drug deductible	\$35 up to a 100-day supply after \$250 drug deductible

Fold out facing page for more deductible plan features and rates

Features	\$1,500 Deductible Plan	\$250 Deductible Plan
DURABLE MEDICAL EQUIPMENT (DME)		
DME used in the home in accord with our DME formulary	Not covered	20% coinsurance up to a \$2,000 calendar year benefit limit*
MENTAL HEALTH SERVICES		
Inpatient psychiatric care	\$500 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)	\$20 per visit after deductible (up to a total of 20 individual/group visits per calendar year)
Group therapy visits	\$15 per visit after deductible (up to a total of 10 individual/group visits per calendar year) Up to 30 additional group therapy visits that meet medical group criteria in the same calendar year	\$10 per visit after deductible (up to a total of 20 individual/group visits per calendar year) Up to 20 additional group therapy visits that meet medical group criteria in the same 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, Deductibles, Copayments, and Coinsurance” section of the <i>Membership Agreement</i> .		
CHEMICAL DEPENDENCY SERVICES		
Inpatient detoxification	\$500 per day after deductible	\$100 per day after deductible
Outpatient individual therapy visits	\$30 per visit after deductible	\$20 per visit after deductible
Outpatient group therapy visits	\$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 5-year period)	\$100 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*	No charge*
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)
Hospice care	No charge*	No charge*

*These services are not subject to the deductible.

†When prescribed by an American Specialty Health Plans (ASH Plans) participating chiropractor and authorized by ASH Plans.