



**Plan Change Option 1**

**Plan Change Option 2**

<b>Annual Deductible: Individual / Family per calendar year(s)</b>	None / None	None / None
<b>Maximum Out-Of-Pocket</b>	\$1,500 per member, \$3,000 per family	\$1,500 per member, \$3,000 per family
<b>Maximum Lifetime Benefit</b>	None / None	None / None
<b>Hospital Inpatient (all services rendered while hospitalized)</b>		
	<b>\$250 per admit</b>	<b>\$250 per admit</b>
<b>Outpatient (specialty, routine, eye/hearing exams, and urgent care)</b>		
	<b>\$20 per visit</b>	<b>\$20 per visit</b>
Well-child preventive care visits (23 months or younger)	\$5 per visit	\$5 per visit
Scheduled prenatal care and first postpartum visit	\$5 per visit	\$5 per visit
Outpatient surgery	\$20 per procedure	\$20 per procedure
Allergy Injections / Immunizations	\$3 per visit	\$3 per visit
X-rays and Lab tests	No charge	<b>\$10 per encounter</b>
Ambulance services	\$50 per trip	\$50 per trip
Emergency department visits	\$50 per visit	<b>\$100 per visit</b>
<b>Outpatient Prescription Drugs (pharmacy and mail order)</b>		
	<b>\$10 gen / \$20 brand, \$20 gen / \$40 brand MOI</b>	<b>\$10 gen / \$20 brand, \$20 gen / \$40 brand MOI</b>
Days supply	30 days, 100 days MOI	30 days, 100 days MOI
<b>Mental Health Services</b>		
Inpatient psychiatric care / days per calendar year	\$250 per admit	\$250 per admit
Outpatient individual therapy visits	\$20 per visit	\$20 per visit
Outpatient group therapy visits	\$10 per visit	\$10 per visit
<b>Chemical Dependency Services</b>		
Inpatient detoxification	\$250 per admit	\$250 per admit
Outpatient individual therapy visits	\$20 per visit	\$20 per visit
Outpatient group therapy visits	\$5 per visit	\$5 per visit
Transitional Residential Recovery Services	\$100 per admit	\$100 per admit
<b>Infertility Services</b>		
Covered services related to the diagnosis and treatment of infertility	\$20 per visit	\$20 per visit
<b>Additional Benefits</b>		
Supplemental Durable Medical Equipment	20% per item	20% per item
Skilled Nursing, Home and Hospice Care	No charge	No charge
Optical eyewear (frames, lenses, contact lenses)	\$175 per 24 months	\$175 per 24 months
Hearing aids	Not covered	Not covered
Chiropractic	\$15 per visit to 20 visits	\$15 per visit to 20 visits
Dental	Not covered	Not covered

The information presented in this chart is a summary only. For a complete understanding of benefits, please read this chart in conjunction with the Evidence of Coverage (EOC). The EOC contains a detailed explanation of benefits, exclusions, and limitations.