

Copayment plans

PLAN HIGHLIGHTS

FEATURES	MOST POPULAR PLAN				
	\$50 PLAN MEMBER PAYS	\$30 PLAN MEMBER PAYS	\$20 PLAN MEMBER PAYS	\$15 PLAN MEMBER PAYS	\$5 PLAN MEMBER PAYS
MEDICAL CALENDAR-YEAR DEDUCTIBLE	\$0	\$0	\$0	\$0	\$0
PHARMACY CALENDAR-YEAR DEDUCTIBLE	\$250 for brand prescriptions	\$250 for brand prescriptions	\$0	\$0	\$0
ANNUAL OUT-OF-POCKET MAXIMUM¹ Individual/Family	\$3,500/\$7,000	\$3,500/\$7,000	\$3,000/\$6,000	\$3,000/\$6,000	\$1,500/\$3,000
IN THE MEDICAL OFFICE					
Office visits	\$50	\$30	\$20	\$15	\$5
Preventive exams	\$50	\$30	\$20	\$15	\$5
Maternity/prenatal care ²	\$15	\$0	\$0	\$0	\$0
Well-child preventive care visits ³	\$15	\$0	\$0	\$0	\$0
Vaccines (immunizations)	\$0	\$0	\$0	\$0	\$0
Allergy injections	\$5	\$5	\$5	\$5	\$5
Infertility services	Not covered	Not covered	Not covered	50%	50%
Occupational, physical, and speech therapy	\$50	\$30	\$20	\$15	\$5
Most labs and imaging	\$10	\$10	\$10	\$10	\$10
MRI/CT/PET	\$50	\$50	\$50	\$50	\$50
Outpatient surgery	\$250	\$200	\$150	\$100	\$5
EMERGENCY SERVICES					
Emergency Department visits (waived if admitted directly to hospital)	\$150	\$100	\$100	\$100	\$100
Ambulance	\$300	\$75	\$75	\$75	\$75
PRESCRIPTIONS⁴	(up to a 100-day supply)	(up to a 100-day supply)	(up to a 30-day supply)	(up to a 30-day supply)	(up to a 100-day supply)
Generic	\$10 ⁵	\$10 ⁵	\$10 ⁵	\$10 ⁵	\$5 ⁵
Brand	\$35 (after pharmacy deductible)	\$35 (after pharmacy deductible)	\$30 ⁵	\$25 ⁵	\$15 ⁵
HOSPITAL CARE					
Physicians' services, room and board, tests, medications, supplies, therapies	\$500 per day	\$400 per day	\$300 per day	\$200 per day	\$0
Skilled nursing facility care (up to 100 days per benefit period)	\$0	\$0	\$0	\$0	\$0
MENTAL HEALTH SERVICES⁶					
In the medical office (up to 20 visits per calendar year)	\$50 individual \$25 group	\$30 individual \$15 group	\$20 individual \$10 group	\$15 individual \$7 group	\$5 individual \$2 group
In the hospital (up to 30 days per calendar year)	\$500 per day	\$400 per day	\$300 per day	\$200 per day	\$0
CHEMICAL DEPENDENCY SERVICES					
In the medical office	\$50 individual	\$30 individual	\$20 individual	\$15 individual	\$5 individual
In the hospital (detoxification only)	\$500 per day	\$400 per day	\$300 per day	\$200 per day	\$0
OTHER					
Certain durable medical equipment (DME) DME used in the home in accord with our DME formulary	Not covered ⁷	Not covered ⁷	20% (\$2,000 maximum)	20% (\$2,000 maximum)	20% (\$2,000 maximum)
Optical (eyewear)	Not covered	Not covered	Not covered	\$150 allowance ⁸	\$150 allowance ⁸
Vision exam	\$50	\$30	\$20	\$15	\$5
Home health care (up to 100 two-hour visits per calendar year)	\$0	\$0	\$0	\$0	\$0
Hospice care	\$0	\$0	\$0	\$0	\$0

¹The annual out-of-pocket maximum is the limit to the total amount that an individual or family must pay for certain services in a calendar year (as discussed in the *Evidence of Coverage*).

²Scheduled prenatal visits and the first postpartum visit

³23 months or younger

⁴Prescription drugs are covered in accord with our formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copayments; please refer to the *Evidence of Coverage* for detailed information about prescription drug copayments.

⁵This service is not subject to a deductible.

⁶Visit or day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage*.

⁷Please refer to the *Evidence of Coverage* for more information; most DME is not covered.

⁸Allowance toward the cost of eyeglass lenses, frames, and contact lenses fitting and dispensing every 24 months

Deductible plans PLAN HIGHLIGHTS

FEATURES	\$30/\$1,500 PLAN MEMBER PAYS	\$30/\$1,000 PLAN MEMBER PAYS
MEDICAL CALENDAR-YEAR DEDUCTIBLE Individual/Family	\$1,500/\$3,000	\$1,000/\$2,000
PHARMACY CALENDAR-YEAR DEDUCTIBLE	\$250 for brand prescriptions	\$250 for brand prescriptions
ANNUAL OUT-OF-POCKET MAXIMUM¹ Individual/Family	\$3,500/\$7,000	\$3,500/\$7,000
IN THE MEDICAL OFFICE		
Office visits	\$30 (after deductible)	\$30 (after deductible)
Preventive exams	\$30 ²	\$30 ²
Maternity/prenatal care ³	\$0 ²	\$0 ²
Well-child preventive care visits ⁴	\$0 ²	\$0 ²
Vaccines (immunizations)	\$0 ²	\$0 ²
Allergy injections	\$5 (after deductible)	\$5 (after deductible)
Infertility services	Not covered	Not covered
Occupational, physical, and speech therapy	\$30 (after deductible)	\$30 (after deductible)
Most labs and imaging	\$10 (after deductible)	\$10 (after deductible)
MRI/CT/PET	\$50 (after deductible)	\$50 (after deductible)
Outpatient surgery	\$250 (after deductible)	\$250 (after deductible)
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	\$100 (after deductible)	\$100 (after deductible)
Ambulance	\$75 (after deductible)	\$75 (after deductible)
PRESCRIPTIONS⁵	(up to a 100-day supply)	(up to a 100-day supply)
Generic	\$10 ²	\$10 ²
Brand	\$35 (after \$250 pharmacy deductible)	\$35 (after \$250 pharmacy deductible)
HOSPITAL CARE		
Physicians' services, room and board, tests, medications, supplies, therapies	\$500 per day (after deductible)	\$500 per day (after deductible)
Skilled nursing facility care	\$50 per day (after deductible) (up to 60 days per benefit period)	\$50 per day (after deductible) (up to 60 days per benefit period)
MENTAL HEALTH SERVICES⁶		
In the medical office (up to 20 visits per calendar year)	\$30 (after deductible for individual therapy) \$15 (after deductible for group therapy)	\$30 (after deductible for individual therapy) \$15 (after deductible for group therapy)
In the hospital (up to 30 days per calendar year)	\$500 per day (after deductible)	\$500 per day (after deductible)
CHEMICAL DEPENDENCY SERVICES		
In the medical office	\$30 (after deductible for individual therapy)	\$30 (after deductible for individual therapy)
In the hospital (detoxification only)	\$500 per day (after deductible)	\$500 per day (after deductible)
OTHER		
Certain durable medical equipment (DME) ⁸ DME used in the home in accord with our DME formulary	Not covered	Not covered
Optical (eyewear)	Not covered	Not covered
Vision exam	\$30 ²	\$30 ²
Home health care (up to 100 two-hour visits per calendar year)	\$0 ²	\$0 ²
Hospice care	\$0 ²	\$0 ²

Note: The \$30/\$1,500 Deductible Plan is only available if offered with at least one copay plan. This option is available to groups with two or more eligible employees. If the \$30/\$1,500 Deductible Plan is offered with two or more copay plans, regular multiple plan offering rules apply.

¹The annual out-of-pocket maximum is the limit to the total amount that an individual or family must pay for certain services in a calendar year (as discussed in the *Evidence of Coverage*).

²This service is not subject to a deductible.

³Scheduled prenatal visits and the first postpartum visit

⁴23 months or younger

⁵Prescription drugs are covered in accord with our formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copayments; please refer to the *Evidence of Coverage* for detailed information about prescription drug copayments.

⁶Visit or day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage*.

⁷Copay will apply to out-of-pocket maximum.

⁸Please refer to the *Evidence of Coverage* for more information; most DME is not covered.

Deductible plans with HSA option PLAN HIGHLIGHTS

FEATURES	\$30/\$2,700 PLAN WITH HSA MEMBER PAYS
MEDICAL CALENDAR-YEAR DEDUCTIBLE	
Individual/Family	\$2,700/\$5,450
PHARMACY CALENDAR-YEAR DEDUCTIBLE	N/A
ANNUAL OUT-OF-POCKET MAXIMUM¹	
Individual/Family	\$5,250/\$10,500
IN THE MEDICAL OFFICE	
Office visits	\$30 (after deductible)
Preventive exams	\$30 ²
Maternity/prenatal care ³	\$10 ²
Well-child preventive care visits ⁴	\$10 ²
Vaccines (immunizations)	\$0 ²
Allergy injections	\$5 (after deductible)
Infertility services	Not covered
Occupational, physical, and speech therapy	\$30 (after deductible)
Most labs and imaging	\$10 (after deductible)
MRI/CT/PET	\$50 (after deductible)
Outpatient surgery	30% (after deductible)
EMERGENCY SERVICES	
Emergency Department visits (waived if admitted directly to hospital)	30% (after deductible)
Ambulance	\$100 (after deductible)
PRESCRIPTIONS⁵	(up to a 100-day supply)
Generic	\$10 (after deductible)
Brand	\$30 (after deductible)
HOSPITAL CARE	
Physicians' services, room and board, tests, medications, supplies, therapies	30% per admission (after deductible)
Skilled nursing facility care (up to 100 days per benefit period)	30% per admission (after deductible)
MENTAL HEALTH SERVICES⁶	
In the medical office (up to 20 visits per calendar year)	\$30 (after deductible for individual therapy) \$15 (after deductible for group therapy)
In the hospital (up to 30 days per calendar year)	30% per admission (after deductible)
CHEMICAL DEPENDENCY SERVICES	
In the medical office	\$30 (after deductible for individual therapy)
In the hospital (detoxification only)	30% per admission (after deductible)
OTHER	
Certain durable medical equipment (DME) ⁷ DME used in the home in accord with our DME formulary	Not covered
Optical (eyewear)	Not covered
Vision exam	\$30 (after deductible)
Home health care (up to 100 two-hour visits per calendar year)	\$0 (after deductible)
Hospice care	\$0 (after deductible)

¹The annual out-of-pocket maximum is the limit to the total amount that an individual or family must pay for certain services in a calendar year (as discussed in the *Evidence of Coverage*).

²This service is not subject to a deductible.

³Scheduled prenatal visits

⁴23 months or younger

⁵Prescription drugs are covered in accord with our formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copayments; please refer to the *Evidence of Coverage* for detailed information about prescription drug copayments.

⁶Visit or day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage*.

⁷Please refer to the *Evidence of Coverage* for more information; most DME is not covered.