SECTION A. Summary of Benefits

This Summary is part of your Benefit Handbook. It states the Cost Sharing amounts that you must pay for Covered Benefits and some important limitations on your coverage. It also identifies any supplemental medical benefits included in your Plan.

For complete information on Covered Benefits, including limitations on your coverage, you must refer to Section C of the Benefit Handbook. For information on how the Plan works, please see Section B of the Benefit Handbook.

Covered Benefits:	Your Cost Sharing:
Outpatient Professional Services	
▪ Ambulance Transport, Non-Emergency	Nothing
▪ Cardiac Rehabilitation	Nothing
▪ Diagnostic Laboratory and X-rays	Nothing
▪ Dialysis	Nothing
▪ Early Intervention Services - $3,200 per calendar year, up to $9,600 per lifetime	$10 Copayment
▪ Formulas and Low Protein Foods	Nothing
▪ Home Care and Hospice	Nothing
▪ Physical therapy - limited to 24 visits per calendar year. Occupational therapy - limited to 24 visits per calendar year.	$5 Copayment
▪ Physician Services, except the three services listed below	$10 Copayment
Prenatal and Postpartum Care	Nothing
Allergy Injections	$5 Copayment
Preventive Care, including: - Well child visits and immunizations - Routine physical exams (including vision and hearing screenings) - Annual gynecological exam (including family planning) - Nutritional counseling and health education - Mammograms, pap smears, lead screening, prostatic specific antigen (PSA) screening	Nothing
▪ House Calls	$10 Copayment
▪ Speech therapy - limited to 24 visits per calendar year	$5 Copayment
▪ Surgical Day Care	Nothing
▪ Urgent Care Services	$25 (50% of your Emergency Room Care Copayment)
▪ Vision Hardware for Special Conditions	Nothing

Covered Benefits:	Your Cost Sharing:
Emergency Services	
▪ Ambulance Transport, Emergency	Nothing
▪ Emergency Dental Care - in a professional office within 72 hours of injury	$10 Copayment
▪ Emergency Room Care	$50 Copayment This Copayment is waived if admitted directly to the hospital from the emergency room
Inpatient Services	
▪ Acute Hospital Care ▪ Maternity Care ▪ Rehabilitation Hospital Care - limited to 60 days per calendar year ▪ Skilled Nursing Facility Care - limited to 100 days per calendar year	Nothing
Mental Health Services	
Important Note: Benefit limits do not apply to care for Serious Mental Illnesses. See Section C.5.a for details.	
▪ Inpatient Care - limited to 15 days per calendar year	Nothing
▪ Outpatient Care - limited to 20 visits per calendar year	
Group Therapy	$10 Copayment
Individual Therapy	$10 Copayment
▪ Psychological Testing	$10 Copayment

Covered Benefits:	Your Cost Sharing:
Drug and Alcohol Rehabilitation Services	
▪ Inpatient Care - limited to 30 days per calendar year	Nothing
▪ Outpatient Care - limited to 20 visits per calendar year	
Group Therapy	$10 Copayment
Individual Therapy	$10 Copayment
▪ Inpatient Detoxification	Nothing
▪ Outpatient Detoxification	$10 Copayment
Durable Medical Equipment and Prosthetic Devices	
▪ Limited to $2,500 per calendar year for all covered equipment. This limit does not apply to the five items listed below.	Nothing
Blood Glucose Monitors, Insulin Pumps and Infusion Devices	Nothing
Breast Prostheses, including Replacements and Mastectomy Bras	Nothing
Medical Equipment and Supplies for Diabetes Treatment	Nothing
Oxygen and Respiratory Equipment	Nothing
Prosthetic Arms and Legs	Nothing
Other Health Services	
▪ Annual Eye Exam	$5 Copayment
▪ Chiropractic Care	$10 Copayment
▪ Hearing Aids - limited to 2 per calendar year	Nothing