THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE (EOC) AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Accumulation Period

The Accumulation Period for this plan is 01/01/21 through 12/31/21 (Calendar year).

Calendar Year Out-of-Pocket Maximum

You will not pay any more Cost Share during a calendar year if the Copayments and Coinsurance you pay add up to one of the following amounts:

For Self-only enrollment (a Family of one Member)	$2,850 per calendar year
For an entire Family of two or more Members	$5,700 per calendar year

Plan Deductible

You must meet your Plan Deductible before your Cost Share applies (except those services that have "No charge"):

Medical Deductible	$1,400/person or $2,800/family
Pharmacy Deductible	$100/person or $200/family

Lifetime Maximum	None

Professional Services (Plan Provider office visits)	Your Cost Share
Most Primary Care Visits for evaluations and treatment	$15 per visit
Most Specialty Care Visits for consultations, evaluations and treatment	$25 per visit
Other Practitioner Office Visits*	$15 per visit
Routine physical maintenance exams, including well woman exams	No charge
Well-child preventative exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist for Members under age 19	No charge
Hearing exams	No charge
Most Physical, occupational, and speech therapy	$15 per visit
Urgent care consultations, evaluations, and treatment	$15 per visit

Note:

1. Urgent care includes Mental/Behavioral health and Chemical dependency (Substance Use Disorder) crisis intervention services.
2. Telehealth are covered benefits. Your cost-share for telehealth services shall not exceed the cost-share charged for the same services delivered in-person.

Outpatient Services	Your Cost Share
Outpatient surgery facility fee	15% coinsurance per procedure
Outpatient Physician/surgeon fee	15% coinsurance per visit
Outpatient Visit**	15% coinsurance per visit
Most Immunizations (including the vaccine)	No charge
Most X-rays	$40 per encounter
Most Laboratory tests	$20 per encounter
MRI, most CT, and PET scans	$100 per procedure
Rehabilitation/Habilitation services	$15 per visit
Covered individual health education counseling	No charge
Covered health education programs	No charge
Hospitalization Services	**Your Cost Share**
Inpatient stay (facility fee)	15% coinsurance per admission+
Physician/surgeon fee for surgery	15% coinsurance per admission
Emergency Health Coverage	**Your Cost Share**

Emergency room facility fee	$150 per visit
Emergency room physician fee	No charge

Note: Emergency room fees do not apply if admitted directly to the hospital as an inpatient for Covered Services.

Ambulance Services	Your Cost Share
Ambulance Services	$75 per trip

Prescription Drug Coverage		Your Cost Share
Covered outpatient items in accord with our drug formulary guidelines:		
Tier 1	At a Plan Pharmacy or our mail order service	$5 for up to a 30-day supply
Tier 2	At a Plan Pharmacy or our mail order service	$25 for up to a 30-day supply+
Tier 3	At a Plan Pharmacy or our mail order service	$45 for up to a 30-day supply+
Tier 4	Items at a Plan Pharmacy	15% coinsurance for up to $150 per script for up to a 30-day supply+

Drug Tiers	Categories
1	•Most generic drugs and •Low cost preferred brands
2	•Non-preferred generic drugs; •Preferred brand name drugs; and •Any other drugs recommended by plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
3	•Non-preferred brand name drugs or; •Drugs that are recommended by P&T committee based on drug safety, efficacy and cost or; •Generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	• Drugs that are biologics and drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through to specialty pharmacies; • Drugs that requires the enrollee to have special training or, clinical monitoring; • Drugs that cost the health plan (net of rebates) more than six hundred dollars ($600) net of rebates for a one-month supply.

Mental/Behavioral Health (MH) Services	Your Cost Share
Inpatient:	
MH psychiatric hospitalization fee	15% coinsurance per admission+
MH psychiatric physician/surgeon fee	15% coinsurance per admission
MH psychiatric observation	Included in psychiatric hospitalization fee
MH psychological testing	Included in psychiatric hospitalization fee
MH individual and group treatment	Included in psychiatric hospitalization fee
MH individual and group evaluation	Included in psychiatric hospitalization fee
MH crisis residential program	15% coinsurance per admission+
Outpatient:	
MH office visits	$15 per visit
MH monitoring of drug therapy	$15 per visit
MH individual and group treatment	$15 per visit
MH individual and group evaluation	$15 per visit
Outpatient, Other Items and Services:	
Applied behavior analysis and behavioral health treatment	No charge
MH multidisciplinary treatment in an intensive outpatient psychiatric treatment program	No charge

Neuropsychological testing	No charge
MH partial hospitalization	No charge
MH psychological testing	No charge

Note: Telehealth are covered benefits. Your cost-share for telehealth services shall not exceed the cost-share charged for the same services delivered in-person.

Chemical Dependency (Substance Use Disorder) Services	Your Cost Share
Inpatient:	
Chemical dependency hospitalization fee	15% coinsurance per admission+
Chemical dependency physician/surgeon fee	15% coinsurance per admission
Inpatient detoxification	Included in hospitalization fee
Individual and group treatment	Included in hospitalization fee
Individual and group chemical dependency counseling	Included in hospitalization fee
Individual and group evaluation	Included in hospitalization fee
Transitional residential recovery services	15% coinsurance per admission+
Outpatient:	
Chemical dependency office visits	$15 per visit
Chemical dependency individual and group evaluation	$15 per visit
Chemical dependency individual and group counseling	$15 per visit
Methadone Maintenance	$15 per visit
Outpatient, Other Items and Services:	
Chemical dependency intensive outpatient programs	No charge
Chemical dependency day treatment programs	No charge

Note: Telehealth are covered benefits. Your cost-share for telehealth services shall not exceed the cost-share charged for the same services delivered in-person.

Durable Medical Equipment (DME)	Your Cost Share
DME items that are essential health benefits	15% coinsurance
Home Health Services	**Your Cost Share**
Home health care (up to 100 visits per calendar year)	$15 per visit
Other	**Your Cost Share**
Eyeglasses or contact lenses for Members under age 19:	
Eyeglass frame from selected styles per calendar year	No charge
Standard contact lenses per calendar	No charge
Regular eyeglasses lenses per calendar year	No charge
Note: Limited to one pair of glasses per year (contact lenses in lieu of glasses).	
Skilled Nursing Facility care (up to 100 days per benefit period)	15% coinsurance+
Hospice care	No charge
Dental Services	
For associated cost-sharing such as oral exam, preventive cleaning, medically necessary orthodontics, etc. please see Liberty Dentals schedule of benefits with the appropriate cost-amounts.	

Notes:

+ Deductible applies

* Other Practitioner Office Visits include visits not provided by either Primary Care or Specialty Practitioners.

** Outpatient Visit includes but not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of- pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the "Benefits and Cost Share", "Limitations & Exclusions", and "Payment & Reimbursement Responsibility" sections in your EOC.