### 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): $4,500 per calendar year
- For an entire Family of two or more Members: $9,000 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: None
- Pharmacy Deductible: None

### Lifetime Maximum
None

### Professional Services (Plan Provider office visits)

<table>
<thead>
<tr>
<th>Service</th>
<th>Your Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Primary Care Visits for evaluations and treatment</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Most Specialty Care Visits for consultations, evaluations and treatment</td>
<td>$30 per visit</td>
</tr>
<tr>
<td>Other Practitioner Office Visits*</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Routine physical maintenance exams, including well woman exams</td>
<td>No charge</td>
</tr>
<tr>
<td>Well-child preventative exams (through age 23 months)</td>
<td>No charge</td>
</tr>
<tr>
<td>Family planning counseling and consultations</td>
<td>No charge</td>
</tr>
<tr>
<td>Scheduled prenatal care exams</td>
<td>No charge</td>
</tr>
<tr>
<td>Routine eye exams with a Plan Optometrist for Members under age 19</td>
<td>No charge</td>
</tr>
<tr>
<td>Hearing exams</td>
<td>No charge</td>
</tr>
<tr>
<td>Most Physical, occupational, and speech therapy</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Urgent care consultations, evaluations, and treatment</td>
<td>$15 per visit</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Service</th>
<th>Your Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient surgery facility fee</td>
<td>$100 per procedure</td>
</tr>
<tr>
<td>Outpatient Physician/surgeon fee</td>
<td>$25 per visit</td>
</tr>
<tr>
<td>Outpatient Visit**</td>
<td>10% coinsurance per visit</td>
</tr>
<tr>
<td>Most Immunizations (including the vaccine)</td>
<td>No charge</td>
</tr>
<tr>
<td>Most X-rays</td>
<td>$30 per encounter</td>
</tr>
<tr>
<td>Most Laboratory tests</td>
<td>$15 per encounter</td>
</tr>
<tr>
<td>MRI, most CT, and PET scans</td>
<td>$75 per procedure</td>
</tr>
<tr>
<td>Rehabilitation/Habilitation services</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Covered individual health education counseling</td>
<td>No charge</td>
</tr>
<tr>
<td>Covered health education programs</td>
<td>No charge</td>
</tr>
</tbody>
</table>

### Hospitalization Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Your Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient stay (facility fee)</td>
<td>$250 per day up to 5 days per admission***</td>
</tr>
<tr>
<td>Physician/surgeon fee for surgery</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Emergency Health Coverage</strong></td>
<td><strong>Your Cost Share</strong></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Emergency room facility fee</td>
<td>$150 per visit</td>
</tr>
<tr>
<td>Emergency room physician fee</td>
<td>No charge</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th><strong>Ambulance Services</strong></th>
<th><strong>Your Cost Share</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services</td>
<td>$150 per trip</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Prescription Drug Coverage</strong></th>
<th><strong>Your Cost Share</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered outpatient items in accord with our drug formulary guidelines:</td>
<td></td>
</tr>
<tr>
<td>Tier 1 At a Plan Pharmacy or mail order service</td>
<td>$5 for up to a 30-day supply</td>
</tr>
<tr>
<td>Tier 2 At a Plan Pharmacy or mail order service</td>
<td>$15 for up to a 30-day supply</td>
</tr>
<tr>
<td>Tier 3 At a Plan Pharmacy or mail order service</td>
<td>$25 for up to a 30-day supply</td>
</tr>
<tr>
<td>Tier 4 Items at a Plan Pharmacy</td>
<td>10% coinsurance up to $250 per script for up to a 30-day supply</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Drug Tiers</strong></th>
<th><strong>Categories</strong></th>
</tr>
</thead>
</table>
| 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. |

<table>
<thead>
<tr>
<th><strong>Mental/Behavioral Health (MH) Services</strong></th>
<th><strong>Your Cost Share</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient:</strong></td>
<td></td>
</tr>
<tr>
<td>MH psychiatric hospitalization fee</td>
<td>$250 per day up to 5 days per admission***</td>
</tr>
<tr>
<td>MH psychiatric physician/surgeon fee</td>
<td>No charge</td>
</tr>
<tr>
<td>MH psychiatric observation</td>
<td>Included in psychiatric hospitalization fee</td>
</tr>
<tr>
<td>MH psychological testing</td>
<td>Included in psychiatric hospitalization fee</td>
</tr>
<tr>
<td>MH individual and group treatment</td>
<td>Included in psychiatric hospitalization fee</td>
</tr>
<tr>
<td>MH individual and group evaluation</td>
<td>Included in psychiatric hospitalization fee</td>
</tr>
<tr>
<td>MH crisis residential program</td>
<td>$250 per day up to 5 days per admission***</td>
</tr>
<tr>
<td><strong>Outpatient:</strong></td>
<td></td>
</tr>
<tr>
<td>MH office visits</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>MH monitoring of drug therapy</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>MH individual and group treatment</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>MH individual and group evaluation</td>
<td>$15 per visit</td>
</tr>
<tr>
<td><strong>Outpatient, Other Items and Services:</strong></td>
<td></td>
</tr>
<tr>
<td>Applied behavior analysis and behavioral health treatment</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>MH multidisciplinary treatment in an intensive outpatient psychiatric treatment program</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Neuropsychological testing</td>
<td>$15 per visit</td>
</tr>
</tbody>
</table>
### Chemical Dependency (Substance Use Disorder) Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Your Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient:</td>
<td></td>
</tr>
<tr>
<td>Chemical dependency hospitalization fee</td>
<td>$250 per day up to 5 days per admission***</td>
</tr>
<tr>
<td>Chemical dependency physician/surgeon fee</td>
<td>No charge</td>
</tr>
<tr>
<td>Inpatient detoxification</td>
<td>Included in hospitalization fee</td>
</tr>
<tr>
<td>Individual and group treatment</td>
<td>Included in hospitalization fee</td>
</tr>
<tr>
<td>Individual and group chemical dependency counseling</td>
<td>Included in hospitalization fee</td>
</tr>
<tr>
<td>Individual and group evaluation</td>
<td>Included in hospitalization fee</td>
</tr>
<tr>
<td>Transitional residential recovery services</td>
<td>$250 per day up to 5 days per admission***</td>
</tr>
<tr>
<td>Outpatient:</td>
<td></td>
</tr>
<tr>
<td>Chemical dependency office visits</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Chemical dependency individual and group evaluation</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Chemical dependency individual and group counseling</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Methadone Maintenance</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Outpatient, Other Items and Services:</td>
<td></td>
</tr>
<tr>
<td>Chemical dependency intensive outpatient programs</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Chemical dependency day treatment programs</td>
<td>$15 per visit</td>
</tr>
</tbody>
</table>

**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)

<table>
<thead>
<tr>
<th>DME items that are essential health benefits</th>
<th>Your Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10% coinsurance</td>
</tr>
</tbody>
</table>

### Home Health Services

<table>
<thead>
<tr>
<th>Home health care (up to 100 visits per calendar year)</th>
<th>Your Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$20 per visit</td>
</tr>
</tbody>
</table>

### Other

<table>
<thead>
<tr>
<th>Eyeglasses or contact lenses for Members under age 19:</th>
<th>Your Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyeglass frame from selected styles per calendar year</td>
<td>No charge</td>
</tr>
<tr>
<td>Standard contact lenses per calendar</td>
<td>No charge</td>
</tr>
<tr>
<td>Regular eyeglasses lenses per calendar year</td>
<td>No charge</td>
</tr>
</tbody>
</table>

**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):** $150 per day up to 5 days per admission***

**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:

* 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.

*** Stays have no additional cost share after the first 5 days of a continuous stay.

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**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.**