

Prenatal Plus 2

Summary of Health Plan Benefits Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERED BENEFITS AND IS A SUMMARY ONLY. THE BENEFIT DESCRIPTION SECTION SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERED BENEFITS AND LIMITATIONS.

Benefit	Description of Services & Limitations	Co-Payment
Inpatient Hospital Services	Room and board, nursing care, and all medically necessary ancillary services.	No copayment
Outpatient Hospital Services	Diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility.	No copayment
Durable Medical Equipment	Medical equipment appropriate for use in the home which primarily serves a medical purpose, is intended for repeated use, and is generally not useful to a person in the absence of illness or injury.	No copayment
Medical Transportation Services	Emergency ambulance transportation and non-emergency transportation to transfer a member from a hospital to another hospital or facility, or facility to home.	No copayment
Emergency Health Care Services	Emergency services are covered both in and out of the plan's service area and in and out of the plan's participating facilities.	No copayment
Professional Services	<p>Services and consultations by a physician or other licensed health care provider.</p> <p>Periodic health examinations for subscribers, routine diagnostic testing and laboratory services immunizations, and services for the detection of asymptomatic diseases.</p>	<ul style="list-style-type: none"> • No copayment for hospital inpatient professional services • No copayment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments
Health Education	Includes education regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services.	No copayment
Nutrition Services	Direct patient care nutrition services	No copayment

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Prescription Drug Program	Drugs prescribed by a licensed practitioner.	No copayment <ul style="list-style-type: none"> • No copayment for prescription drugs provided in an inpatient setting. • No copayment for drugs administered in the doctor's office or in an outpatient facility. • No copayment for FDA-approved contraceptive drugs and devices.
Reconstructive Surgery	Performed on abnormal structures of the body caused by congenital defects, developmental anomalies, trauma, infection, tumors, or disease and are performed to improve function or create a normal appearance.	No copayment
Organ Transplants	Coverage for organ transplants and bone marrow transplants which are not experimental or investigational.	No copayment
Maternity Care	Professional and hospital services relating to maternity care.	No copayment
Family Planning Services	Voluntary family planning services	No copayment
Diagnostic, X-Ray and Laboratory Services	Laboratory services, and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, and treat members.	No copayment
Home Health Care Services	Services provided at the home by health care personnel.	No copayment
Physical, Occupational, and Speech Therapy	Therapy may be provided in a medical office or other appropriate outpatient setting.	No copayment No copayment-inpatient therapy

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Blood and Blood Products	Includes processing, storage, and administration of blood and blood products in inpatient and outpatient settings.	No copayment
Cataract Spectacles and Lenses	Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery.	No copayment
Skilled Nursing Care	Services provided in a licensed skilled nursing facility.	No copayment Benefit is limited to a maximum of 100 days per benefit year
Hospice	For members who are diagnosed with a terminal illness and who elect hospice care instead of traditional health care services.	No copayment
Orthotics and Prosthetics	Original and replacement devices as prescribed by a licensed practitioner.	No copayment
Inpatient Mental Health Services	Confinement in a participating hospital is covered.	No copayment Benefit is limited to 30 days per benefit year for mental health illnesses that do not meet criteria for SMI.
Outpatient Mental Health Services	Mental health care is covered when services are ordered and performed by a Plan mental health professional.	No copayment Benefit is limited to 20 visits per benefit year, except for the treatment of severe mental illnesses
Inpatient Alcohol / Drug Abuse Services	Hospitalization to remove toxic substances from the system.	No copayment
Outpatient Alcohol / Drug Abuse Services	Crisis intervention and treatment of alcoholism or drug abuse.	No copayment Benefit is limited to 20 visits per benefit year

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Diabetic Care	Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without prescription.	No copayment
Phenylketonuria (PKU)	Testing and treatment of PKU.	No copayment
Clinical Cancer Trials	Coverage for a member's participation in a cancer clinical trial, phase I through IV, when the member's physician has recommended participation in the trial, and member meets certain requirements.	No copayment No copayment for prescriptions as described in the "Prescription Drug Program" Section
Chiropractic	Does not require referral from the member's provider but services must be obtained from a plan provider.	No copayment Benefit is limited to 20 visits per benefit year
Acupuncture	Does not require referral from the member's provider but services must be obtained from a plan provider.	No copayment Benefit is limited to 20 visits per benefit year
Lactation Services	Pregnant women or women with new babies can meet with a special teacher called a "Certified Lactation Educator" who will help them with breastfeeding. Does not require referral from the member's provider but services must be obtained from a plan provider.	No copayment
Deductibles	No deductibles will be charged for covered benefits	
Lifetime Maximums	No lifetime maximum limits on benefits apply under this plan	

* Benefits are provided only for services which are medically necessary.