Summary of Benefits - Medical

Basic 10600

Benefit	In-Network	Out-of-Network
Customer Success Phone Number	Pending	
Benefit Period	Calendar Year	
Individual Deductible Per Plan Year	$10,600	$31,800
Family Deductible Per Plan Year	$21,200	$63,600
Benefits are payable for an individual once the Individual Deductible is met. Each time an individual within the family pays toward his or her individual deductible, that amount is also credited toward the family deductible. Once the family deductible is met, benefits are payable for all family members even if their individual deductibles are not met. In network deductible and Out of network deductible do not cross accumulate.		
Member Pays - Payment based on the plan allowance	20% After the Deductible	50% After the Deductible
Total Maximum Out of Pocket - Individual	$10,600	$31,800
Total Maximum Out of Pocket - Family	$21,200	$63,600
Benefits are payable at 100% without any cost share for an individual once the Individual Out-of-Pocket Maximum is met. Each time an individual within the family pays toward his or her individual Out-of-Pocket Maximum, that amount is also credited toward the family Out-of-Pocket Maximum. Once the family Out-of-Pocket Maximum is met, benefits are payable for all family members even if their individual deductibles are not met. In network Out-of-Pocket and Out of Network do not cross accumulate		
Physician Office Services		
Services Rendered in a Physicians Office	Patient Responsibility	Patient Responsibility
Primary Care Physician/Provider (office only, Virtual Primary Care is $0 through Vitable)	$50 copay per visit	Deductible then 50% coinsurance
Specialty Care Physician/ Provider (office, home, virtual , phone)	$100 copay per visit	Deductible then 50% coinsurance
Lab & X-ray Services and Diagnostic Tests	Included in office visit copay if no same day office visit subject to deductible and 20% coinsurance	Deductible then 50% coinsurance
Advanced Imaging (MRI/MRA, CT Scans, PET Scans, Nuclear Medicine)	$200 copay per service	Deductible then 50% coinsurance
Injections (Physician & Medication)	Included in office visit copay if no same day office visit subject to deductible and 20% coinsurance	Deductible then 50% coinsurance
Office Surgery	Deductible and 20% coinsurance	Deductible then 50% coinsurance
Allergy Injections	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Preventive Care		
Service	Patient Responsibility	Patient Responsibility
Routine Pediatric/Adolescent Physical Exams	No Cost Share	Deductible then 50% coinsurance
Routine Adult Physical Exams	No Cost Share	Deductible then 50% coinsurance
Adult, Pediatric and Adolescent Immunizations	No Cost Share	Deductible then 50% coinsurance
Routine Gynecological Exams, including a Pap Test	No Cost Share	Deductible then 50% coinsurance
Preventive Contraceptive Management	No Cost Share	Deductible then 50% coinsurance
Routine Screening Services	No Cost Share	Deductible then 50% coinsurance

Benefit	In-Network	Out-of-Network
Routine Colonoscopy	No Cost Share	Deductible then 50% coinsurance
Routine PSA	No Cost Share	Deductible then 50% coinsurance
Routine Vision	No Cost Share	Deductible then 50% coinsurance
Preventive/Well Care is covered as defined in the Patient Protection and Affordable Care Act, as amended and as described by the Health Resources and Services Administration (HRSA)		
Diagnostic Testing (Independent Lab & Freestanding Facility		
Service	Patient Responsibility	Patient Responsibility
Lab & X-ray Services and Diagnostic Tests	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Advanced Imaging (MRI/MRA, CT Scans, PET	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Scans, Nuclear Medicine)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Sleep Study (Freestanding Facility)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Sleep Study (Home)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Emergency Services		
Service	Patient Responsibility	Patient Responsibility
Emergency Room (Including Facility, ER Physician, Radiologist, & Pathologist)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Urgent Care Office Visit Charge	$100 copay per visit	Deductible then 50% coinsurance
Ambulance and other medically necessary transportation	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Non Emergent Air Ambulance	Not Covered	Not Covered
Surgery		
Service	Patient Responsibility	Patient Responsibility
Surgery Facility	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Surgeon	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Assistant Surgeon	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Anesthesiologist	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Pathologist/Radiologist	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Cochlear Implants	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Preadmission Testing	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Transplant Services (Designated Facility Only)	Not Covered	Not Covered
Bariatric Surgery	Not Covered	Not Covered
Gender Reassignment	Not Covered	Not Covered
Abortion (Only covered when medically necessary or if rape or incest)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Medical Inpatient Services (Hospital, Medical Rehab, Skilled Nursing Facility)		
Service	Patient Responsibility	Patient Responsibility
Inpatient Facility	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Inpatient Physician	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Inpatient Physician Services (Including Path and Radiology)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Inpatient Surgery (Includes Surgeon, Assistant, Anesthesiologist, Radiologist, Pathologist	Deductible then 20% coinsurance	Deductible then 50% coinsurance

Benefit	In-Network	Out-of-Network
Post Hospitalization Medical Rehab Facility	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Skilled Nursing Facility	Not Covered	Not Covered
Medical Outpatient Hospital Services		
Service	Patient Responsibility	Patient Responsibility
Outpatient Hospital Facility	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Outpatient Hospital Observation	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Lab & X-ray Services and Diagnostic Tests	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Advanced Imaging (MRI/MRA, CT Scans, PET)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Scans, Nuclear Medicine)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Chemotherapy	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Radiation Therapy	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Infusion Therapy	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Cardiac Rehabilitation (35 visit limit per plan year)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Physical Therapy (Combined limit of 35 visits per plan year with PT, OT,RT & ST, including Autism Spectrum Disorder)	$50 copay per visit	Deductible then 50% coinsurance
Speech, and Occupational Therapy (Combined limit of 35 visits per plan year with PT, OT,RT & ST, including Autism Spectrum Disorder)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Pulmonary Rehab/Respiratory Therapy (Combined limit of 35 visits per plan year with PT, OT,RT & ST, including Autism Spectrum Disorder)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Applied Behavior Analysis for Autism Spectrum Disorder (Combined limit of 35 visits per plan year with PT, OT,RT & ST, including Autism Spectrum Disorder)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Maternity Services		
Service	Patient Responsibility	Patient Responsibility
Prenatal Care - Physician Office Visits	No Cost Share	Deductible then 50% coinsurance
Inpatient Facility (Mother)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Facility Nursery (Newborn)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Physician - Global Delivery	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Physician - Newborn	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Nurse Midwife	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Birthing Center	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Lactation Counseling & Equipment	No Cost Share	Deductible then 50% coinsurance
*Precertification required if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section		
Therapy and Rehabilitation Services - Office		
Service	Patient Responsibility	Patient Responsibility
Acupuncture Treatment	Not Covered	Not Covered
Applied Behavior Analysis for Autism Spectrum Disorder (Combined limit of 35 visits per plan year with PT, OT,RT & ST, including Autism Spectrum Disorder)	Deductible then 20% coinsurance	Deductible then 50% coinsurance

Biofeedback	Not Covered	Not Covered

Benefit	In-Network	Out-of-Network
Cardiac Rehabilitation (Limit 35 visits per plan year)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Chemotherapy	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Chiropractic Care/Spinal Manipulations (Limit 18 Visits per plan year)	$50 copay per visit	Deductible then 50% coinsurance
Dialysis	Not Covered	Not Covered
Holistic or Homeopathic Medicine	Not Covered	Not Covered
Hyperbaric Treatment	Not Covered	Not Covered
Infusion Therapy	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Infusion Specialty Medications	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Massage Therapy	Not Covered	Not Covered
Physical Therapy (Combined limit of 35 visits per plan year with PT, OT,RT & ST, including Autism Spectrum Disorder)	$50 copay per visit	Deductible then 50% coinsurance
Speech, and Occupational Therapy (Combined limit of 35 visits per plan year with PT, OT,RT & ST, including Autism Spectrum Disorder)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Pulmonary Rehab/Respiratory Therapy (Combined limit of 35 visits per plan year with PT, OT,RT & ST, including Autism Spectrum Disorder)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Radiation Therapy	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Mental Health Services		
Service	Patient Responsibility	Patient Responsibility
Office Visit - Mental Health	$50 copay per visit	Deductible then 50% coinsurance
Inpatient Mental Health Services (Facility)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Inpatient Mental Health Services (Physician)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Inpatient Lab, X-ray, Diagnostic Testing	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Outpatient Mental Health Services (Facility)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Outpatient Mental Health Services (Physician)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Mental Health Residential Treatment (Facility & Physician)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Mental Health Residential Treatment (Facility & Physician)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Mental Health Partial Hospitalization (Facility & Physician)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Substance Abuse		
Service	Patient Responsibility	Patient Responsibility
Office Visit - Substance Abuse	$50 copay per visit	Deductible then 50% coinsurance
Inpatient Detox - Facility	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Inpatient Lab, X-ray, Diagnostic Testing	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Outpatient Hospital Detox Services - Facility	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Outpatient Hospital Detox Services - Physician	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Inpatient Substance Abuse Rehab - Facility	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Inpatient Substance Abuse Rehab - Physician	Deductible then 20% coinsurance	Deductible then 50% coinsurance

Outpatient Hospital Substance Abuse - Facility	Deductible then 20% coinsurance	Deductible then 50% coinsurance

Outpatient Hospital Substance Abuse - Physician	Deductible then 20% coinsurance	Deductible then 50% coinsurance

Benefit	In-Network	Out-of-Network
Substance Abuse Residential Treatment - Facility & Physician	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Substance Abuse Partial Hospitalization - Facility & Physician	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to Accidental Injury	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Dental Oral Surgery	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Diabetic Supplies	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Diabetic Nutritional Counseling & Education	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Durable Medical Equipment and Prosthetics	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Genetic Counseling	Not Covered, except as required for preventive care	Not Covered
Genetic Testing	Not Covered, except as required for preventive care	Not Covered
Cataract Surgery and Lenses (One set)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Hearing Aids & Exams (Limit $3,000 per ear every 2 plan years)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Home Health Care (Limit 60 days per plan year)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Hospice	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Infertility Diagnosis & Treatment of underlying cause	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Medical Supplies	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Nutritional Counseling	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Private Duty Nursing	Not Covered	Not Covered
Prostate Exam	No Cost Share	Deductible then 50% coinsurance
Sexual Function (Diagnostic and Surgical if medically necessary)	Not Covered	Not Covered
Temporomandibular Joint Disorder (TMJ)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Wigs (hair loss due to cancer treatment or alopecia related to a medical condition) (Limit $1,000 every 2 plan years)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Prescription Drugs - Retail		
Tier	Preferred Pharmacy - 30 Day Supply	Preferred Pharmacy 31-90 Day Supply
Prescription Drug Deductible Individual/Family		
Preventive Drugs	No Cost Share	No Cost Share
Preferred Generic (free with Vitable)	$5 copay per prescription	$15 copay per prescription
Preferred Brand	$30 copay per prescription	$90 copay per prescription
Non-Preferred Brand	$100 copay per prescription	$300 copay per prescription
Specialty Drugs	$250 copay per prescription	Not Covered

Prescription Drugs - Mail Order		
Tier	Preferred Pharmacy 31-90 Day Supply	

Benefit	In-Network	Out-of-Network
Prescription Drug Deductible Individual/Family		
Preventive Drugs	No Cost Share	
Preferred Generic (free with Vitable)	$15 copay per prescription	
Preferred Brand	$90 copay per prescription	
Non-Preferred Brand	$300 copay per prescription	
Specialty Drugs	Not Covered	