Gold 1000

Individual Plan Benefit Summary

Plan Features	In-Network Member is responsible for:	Out-of-Network Member is responsible for:
Essential Health Benefits	Unlimited	
Lifetime Maximum Benefit	Unlimited	
Deductible		
Per Covered Person	$1,000	$2,000
Per Family	$2,000	$4,000
Annual Maximum Out-of-Pocket *(includes all deductibles, copays and coinsurance)*		
Per Covered Person	$6,000	$20,000
Per Family	$12,000	$40,000
Physician Services		
Primary Care Physician (PCP)	$20 copay	50%** U&C*
Specialty Care Physician (SCP)	$40 copay	50%** U&C*
Physician eVisit	$10 copay	50%** U&C*
Physician Services not received in an office setting	20%**	50%** U&C*
Preventive Health Services		
Services recommended by the U.S. Preventive Services Task Force as mandated by PHSA Section 2713	$0	50%** U&C*
Additional preventive services or treatments not mandated by PHSA Section 2713	20%**	50%** U&C*
Preventive Services for Children and Adolescents		
Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration	$0	50%** U&C*
Physician office visits and laboratory tests associated with preventive checkups	$0	50%** U&C*
Preventive Services for Adults		
Preventive care and screenings for women supported by the Health Resources and Services Administration	$0	50%** U&C*
Immunizations Ages 0 to Adult *(per immunization)*		
As recommended by Advisory Committee on Immunization Practices of the CDC as mandated by PHSA Section 2713	$0	$12 copay
Additional immunizations not mandated by PHSA Section 2713	$12 copay	$12 copay
Inpatient Hospital Services		
Physician Services	20%**	50%** U&C*
Hospitalization	20%**	50%** U&C*
Maternity and Newborn Care	20%**	50%** U&C*
Human Organ Transplant	20%**	50%** U&C*
Transportation and Lodging	20%**	Not Covered
Unrelated Donor Search	20%**	
Skilled Nursing Services - Inpatient	20%**	50%** U&C*
	90 Inpatient days per Benefit Year	
Physical Medicine and Rehabilitation	20%**	50%** U&C*
	60 Inpatient days per Benefit Year	
Outpatient Services		
Emergency Services	$200 copay	$200 copay
Urgent Care Services	$75 copay	50%** U&C*
Outpatient Surgery & Procedures	20%**	50%** U&C*
Rehabilitation and Habilitative		
*Physical Therapy and Manipulation Therapy (not including Chiropractic Services)****	20%**	50%** U&C*
	20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)	
Occupational Therapy	20%**	50%** U&C*
	20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)	

Speech Therapy	20%**	50%** U&C*
	Unlimited	
Cardiac Rehabilitation	20%**	50%** U&C*
	36 visits per Benefit Year	
Pulmonary Rehabilitation	20%**	50%** U&C*
	20 visits per Benefit Year	
Chiropractic Services	20%**	50%** U&C*
	26 visits per Benefit Year without prior approval	
Diagnostic Laboratory, Imaging and Radiology	20%**	50%** U&C*
Home Health Care	20%**	50%** U&C*
	90 visits per Benefit Year	
Private Duty Nursing	20%**	50%** U&C*
Hospice	20%**	50%** U&C*
Ambulance Services	20%**	20%**
Educational Services	20%**	50%** U&C*
Durable Medical Equipment	20%**	50%** U&C*
Hearing Aids (newborns only)	20%**	50%** U&C*
Orthotics	20%**	50%** U&C*
Disposable Medical Supplies	20%**	50%** U&C*
Prosthetics	20%**	50%** U&C*
Mental Health Services		
Mental Health Office Visit	$20 copay	50%** U&C*
Mental Health Services not received in an office setting	20%**	50%** U&C*
Hospital Inpatient / Residential Treatment	20%**	50%** U&C*
Substance Abuse		
Outpatient Annual Maximum Benefit (unlimited)	20%**	50%** U&C*
Inpatient/Residential Annual Maximum (unlimited)	20%**	50%** U&C*
Medical or Social Setting Detox Annual Max (unlimited)	20%**	50%** U&C*
Applied Behavior Analysis (ABA)		
Applied Behavior Analysis *(dependent children through age 18) Requires prior authorization*	20%**	50%** U&C*
Dental Services *(only related to accidental injury or for certain members requiring general anesthesia)*	20%**	50%** U&C*
Pediatric Dental *(dependent children through age 18)*		
Dental Exam	20%**	
Basic Dental Care	20%**	
Major Dental Care	20%**	
Orthodontia (requires prior authorization)	20%**	
Pediatric Vision *(dependent children through age 18)*		
Routine Eye Exam (1 visit per Benefit Year)	20%**	
Eye Glasses (1 pair of glasses, lenses and frames, per Benefit Year)	20%**	
Pharmacy Services		
Deductible	$0	
Generic (most), Tier 1 (30 day supply)	$15	50%** U&C*
Preferred Brand, Tier 2 (30 day supply)	$45	50%** U&C*
Other Brand / Non-Formulary, Tier 3 (30 day supply)	$75	50%** U&C*
Specialty Formulary Brand / Non-Formulary, Tier 4 (30 day supply)	$100	N/A
Mail Order (90 day supply)	2.5x	N/A

*U&C is used as an abbreviation for Usual and Customary.
**Coinsurance applies after Deductible is met.
***Co-pays/Coinsurance for Physical Therapy will not exceed the physician office visit once the deductible is met.
This is only a brief summary of benefits, which is not intended to be comprehensive.
Your Individual Health Plan Policy is the governing document for benefit information.

All Plans Are Qualified Health Plans

(Plans Available Beginning: 1/1/2016)