

# Gold 1000

## Individual Plan Benefit Summary



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

Speech Therapy	20%**	Unlimited	50%** U&C*
Cardiac Rehabilitation	20%**	36 visits per Benefit Year	50%** U&C*
Pulmonary Rehabilitation	20%**	20 visits per Benefit Year	50%** U&C*
Chiropractic Services	20%**	26 visits per Benefit Year without prior approval	50%** U&C*
Diagnostic Laboratory, Imaging and Radiology	20%**		50%** U&C*
Home Health Care	20%**	100 visits per Benefit Year	50%** U&C*
Private Duty Nursing	20%**	82 visits per Benefit Year, 164 visits Lifetime Maximum	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*
<b>Mental Health Services</b>			
Mental Health Office Visit	\$20 co-pay		50%** U&C*
Mental Health Services not received in an office setting	20%**		50%** U&C*
Hospital Inpatient / Residential Treatment	20%**		50%** U&C*
<b>Substance Abuse</b>			
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*
<b>Dental Services</b> (only related to accidental injury or for certain members requiring general anesthesia)	20%**		50%** U&C*
<b>Pediatric Dental</b> (dependent children through age 18)			
Dental Exam		20%**	
Basic Dental Care		20%**	
Major Dental Care		20%**	
Orthodontia (requires prior authorization)		20%**	
<b>Pediatric Vision</b> (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%**	
<b>Autism Services</b> Benefits are based on the setting in which Covered Services are received****			
<b>Applied Behavior Analysis (ABA)</b> (dependent children through age 18) Requires prior authorization	20%**		50%** U&C*
<b>Pharmacy Services</b>			
<b>Deductible</b>		\$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. \*\*Co-insurance applies after Deductible is met.

\*\*\*Co-pays/Co-insurance for Physical Therapy will not exceed the physician office visit once the deductible is met.

\*\*\*\*Coverage for the diagnosis and treatment of Autism Spectrum Disorders will not be subject to any greater Deductible/Co-pay/Co-insurance than is applicable to other physical health care services covered by this Plan.

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: 1/1/2017)