

Silver 3500

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		
<i>Per Covered Person</i>	\$3,500	\$7,000
<i>Per Family</i>	\$7,000	\$14,000
Annual Maximum Out-of-Pocket (including deductible and co-pay)		
<i>Per Covered Person</i>	\$4,000	\$20,000
<i>Per Family</i>	\$8,000	\$40,000
Physician Services		
<i>Primary Care Physician (PCP)</i>	20%**	50%** U&C*
<i>Specialty Care Physician (SCP)</i>	20%**	50%** U&C*
<i>Physician eVisit</i>	20%**	50%** U&C*
<i>Physician Telehealth Visit</i>	\$45	50%** U&C*
<i>Physician Services not received in an office setting</i>	20%**	50%** U&C*
Preventive Health Services		
<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*
Preventive Services for Children and Adolescents		
<i>Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration</i>	\$0	50%** U&C*
Physician office visits and laboratory tests associated with preventive checkups		
<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*
Immunizations Ages 0 to Adult (per immunization)		
<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
Inpatient Hospital Services		
<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*
		<i>150 Inpatient days per Benefit Year Combined</i>
Outpatient Services		
<i>Emergency Services</i>	20%**	20%**
<i>Urgent Care Services</i>	20%**	50%** U&C*
<i>Outpatient Surgery & Procedures</i>	20%**	50%** U&C*
Rehabilitation and Habilitative		
<i>Physical Therapy and Manipulation Therapy (not including Chiropractic Services)***</i>	20%**	50%** U&C*
		<i>20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)</i>
<i>Occupational Therapy</i>	20%**	50%** U&C*
		<i>20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)</i>

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*
Mental Health Services			
Mental Health Office Visit	20%**		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*
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%**	
Autism Services Benefits are based on the setting in which Covered Services are received****			
Applied Behavior Analysis (ABA) (dependent children through age 18) Requires prior authorization	20%**		50%** U&C*
Pharmacy Services			
Deductible		Subject to Medical Deductible and Co-insurance	
Generic (most), Tier 1 (30 day supply)	20%**		50%** U&C*
Preferred Brand, Tier 2 (30 day supply)	20%**		50%** U&C*
Other Brand / Non-Formulary, Tier 3 (30 day supply)	20%**		50%** U&C*
Specialty Formulary Brand / Non-Formulary, Tier 4 (30 day supply)	20%**		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)