Revolution Health Plans: THE GALAXY SERIES

DIAMOND

EVIDENCE-BASED MEDICINE COMBINED WITH THE FLEXIBILITY OF A PATIENT SPECIFIC QUALITY CARE NETWORK

Say goodbye to massive books of network providers and generic search engine results that lack advice, direction or any measure of quality and performance! Instead, present your healthcare needs to our team and receive real help, including patient advocacy and an Evidence-Based treatment plan. We will provide you with a fully coordinated plan and direct you to the best Guided Network providers in your area for the most appropriate care when you need it most... just ***Call the Nurse***.

Evidence-Based Medicine means that the course of treatment you receive has been scientifically tested, reviewed by medical peers, and confirmed to be safe and effective for a given condition. There is always risk involved in medical treatment, but with Evidence-Based Medicine, experience, data and the power of numbers guide best practices.

THIS INITIATIVE'S GOAL IS TO PROVIDE THE RIGHT PATIENT, WITH THE RIGHT CARE, AT THE RIGHT TIME, IN THE RIGHT PLACE, AND ALL AT THE RIGHT PRICE!

Schedule of Benefits *Guided Network benefits are those directed by your nurse (or basic routine care via your PHCS Provider). Care provided outside of or contradictory to your nurse's direction is considered Out of Network.*	Guided Network *Ask the nurse and follow the Guided Network directions to better health care.*	Out-of-Network *When care is found Out of Network the Deductible and 20% Coinsurance applies.**
Preventive Care Under PPACA | *Charges for preventive care as per PPACA on the effective date of the plan provide for certain benefits to be paid absent of cost sharing.*	Covered in Full	Deductible & 20% Coinsurance
Virtual Care / Telemedicine | *Full Virtual Primary, Urgent and Behavioral Health. With Virtual Primary Care (VPC), members and their families receive access to a dedicated physician. Virtual Preventive, Urgent, and Behavioral Health are covered at a $0 Copay when using a Recuro provider. See enrollment materials for details.*	Covered in Full	Covered in Full
Professional Outpatient Office Visits | *These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical or medical procedures performed by the physician or for diagnostic services billed separately.*	Covered in Full	Deductible & 20% Coinsurance
Office Based Diagnostic Tests, Labs & X-Ray | *Includes diagnostic tests performed in a physician's office and billed by such physician or a freestanding non-hospital billed facility only.*	Covered in Full	Deductible & 20% Coinsurance
Outpatient Surgical, Diagnostic, & Therapeutic Procedure		
Services	Covered in Full	Deductible & 20% Coinsurance
Facility Charges	Covered in Full	Deductible & 20% Coinsurance
Vision | *Annual Eye Exam Only. Any optometrist; member must submit claim for reimbursement.*	Covered in Full	Deductible & 20% Coinsurance
Short Term Rehabilitation Services | *Physical, chiropractic, speech and occupational therapy. (Includes therapies performed in a provider's office or other non-hospital billed facility only).*	Covered in Full	Deductible & 20% Coinsurance
Emergency Services | *ER copayment waived if admitted; $250 penalty for non-emergency use of a hospital emergency room.*		
Hospital Emergency Room	Covered in Full	Deductible & 20% Coinsurance
Urgent Care/Physician *(see professional office visit above)*	Covered in Full	Deductible & 20% Coinsurance
Ambulance	Covered in Full	Deductible & 20% Coinsurance
Allergy Treatment		
Testing & Injections	Covered in Full	Deductible & 20% Coinsurance
Serum	Covered in Full	Deductible & 20% Coinsurance
Plan Year Deductible | *Copays do not apply to deductibles.*	Deductible Waived	$3,000 per Individual $6,000 per Family
Out-of-Pocket Maximum | *When through Guided Network, Only Copays Apply*	$2,500 Individual or Family	$6,000 per Individual $12,000 per Family
Inpatient Hospitalization		
Medical Services & Facility	Covered in Full	Deductible & 20% Coinsurance
Anesthesiologist & Surgeon Fees	Covered in Full	Deductible & 20% Coinsurance
Mental Health & Substance Use Disorder	Covered in Full	Deductible & 20% Coinsurance
Skilled Nursing Facilities	Covered in Full	Deductible & 20% Coinsurance
Home Health Care	Covered in Full	Deductible & 20% Coinsurance
Hospice Care	Covered in Full	Deductible & 20% Coinsurance
Durable Medical Equipment	Covered in Full	Deductible & 20% Coinsurance
Prescription Benefits	No Deductible	All Prescription Benefits are administered through the Pharmacy Manager as indicated in the "Guided Network" column to the left.
Tier 1	$0 Copay	
Tier 2	$20 Copay	
Tier 3	$75 Copay	
Tier 4	$150 Copay	

* Out of Network Reimbursements are subject to Maximum Allowable Charges (MAC). Balance billing may apply.

Revolution Health Plans: THE GALAXY SERIES

RUBY

EVIDENCE-BASED MEDICINE COMBINED WITH THE FLEXIBILITY OF A PATIENT SPECIFIC QUALITY CARE NETWORK

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Preventive Care Under PPACA | *Charges for preventive care as per PPACA on the effective date of the plan provide for certain benefits to be paid absent of cost sharing.*	Covered in Full	Deductible & 30% Coinsurance
Virtual Care / Telemedicine | *Full Virtual Primary, Urgent and Behavioral Health. With Virtual Primary Care (VPC), members and their families receive access to a dedicated physician. Virtual Preventive, Urgent, and Behavioral Health are covered at a $0 Copay when using a Recuro provider. See enrollment materials for details.*	Covered in Full	Covered in Full
Professional Outpatient Office Visits | *These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical or medical procedures performed by the physician or for diagnostic services billed separately.*	$20 Copay for Primary Care Provider $40 Copay for a Specialist	Deductible & 30% Coinsurance
Office Based Diagnostic Tests, Labs & X-Ray | Includes diagnostic tests performed in a physician's office and billed by such physician or a freestanding non-hospital billed facility only.	$20 Copay, then Covered in Full	Deductible & 30% Coinsurance
Outpatient Surgical, Diagnostic, & Therapeutic Procedure Services Facility Charges	 $60 Copay, then Covered in Full $60 Copay, then Covered in Full	 Deductible & 30% Coinsurance Deductible & 30% Coinsurance
Vision | *Annual Eye Exam Only. Any optometrist; member must submit claim for reimbursement.*	$30 Copay, then Covered in Full	Deductible & 30% Coinsurance
Short Term Rehabilitation Services | *Physical, chiropractic, speech and occupational therapy. (Includes therapies performed in a provider's office or other non-hospital billed facility only).*	$40 Copay, then Covered in Full	Deductible & 30% Coinsurance
Emergency Services | *ER copayment waived if admitted; $250 penalty for non-emergency use of a hospital emergency room.* Hospital Emergency Room Urgent Care/Physician *(see professional office visit above)* Ambulance	 $200 Copay, then Covered in Full $20 Copay, then Covered in Full $40 Copay, then Covered in Full	 Deductible & 30% Coinsurance Deductible & 30% Coinsurance Deductible & 30% Coinsurance
Allergy Treatment Testing & Injections Serum	 $20 Copay, then Covered in Full $150 Copay, then Covered in Full	 Deductible & 30% Coinsurance Deductible & 30% Coinsurance
Plan Year Deductible | *Copays do not apply to deductibles.*	**Deductible Waived**	**$5,000 per Individual $10,000 per Family**
Out-of-Pocket Maximum | *When through Guided Network, Only Copays Apply*	**$3,000 Individual or Family**	**$10,000 per Individual $20,000 per Family**
Inpatient Hospitalization Medical Services & Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Use Disorder Skilled Nursing Facilities	 $500 Copay (per confinement)	 Deductible & 30% Coinsurance Deductible & 30% Coinsurance Deductible & 30% Coinsurance Deductible & 30% Coinsurance
Home Health Care	Covered in Full	Deductible & 30% Coinsurance
Hospice Care	Covered in Full	Deductible & 30% Coinsurance
Durable Medical Equipment	Covered in Full	Deductible & 30% Coinsurance
Prescription Benefits Tier 1 Tier 2 Tier 3 Tier 4	**No Deductible** $0 Copay $20 Copay $75 Copay $150 Copay	**All Prescription Benefits are administered through the Pharmacy Manager as indicated in the "Guided Network" column to the left.**

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Revolution Health Plans: THE GALAXY SERIES

EMERALD

EVIDENCE-BASED MEDICINE COMBINED WITH THE FLEXIBILITY OF A PATIENT SPECIFIC QUALITY CARE NETWORK

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Preventive Care Under PPACA | *Charges for preventive care as per PPACA on the effective date of the plan provide for certain benefits to be paid absent of cost sharing.*	Covered in Full	Deductible & 50% Coinsurance
Virtual Care / Telemedicine | *Full Virtual Primary, Urgent and Behavioral Health. With Virtual Primary Care (VPC), members and their families receive access to a dedicated physician. Virtual Preventive, Urgent, and Behavioral Health are covered at a $0 Copay when using a Recuro provider. See enrollment materials for details.*	Covered in Full	Covered in Full
Professional Outpatient Office Visits | *These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical or medical procedures performed by the physician or for diagnostic services billed separately.*	$30 Copay for Primary Care Provider $50 Copay for a Specialist	Deductible & 50% Coinsurance
Office Based Diagnostic Tests, Labs & X-Ray | Includes diagnostic tests performed in a physician's office and billed by such physician or a freestanding non-hospital billed facility only.	$30 Copay, then Covered in Full	Deductible & 50% Coinsurance
Outpatient Surgical, Diagnostic, & Therapeutic Procedure Services Facility Charges	 $80 Copay, then Covered in Full $80 Copay, then Covered in Full	 Deductible & 50% Coinsurance Deductible & 50% Coinsurance
Vision | *Annual Eye Exam Only. Any optometrist; member must submit claim for reimbursement.*	$40 Copay, then Covered in Full	Deductible & 50% Coinsurance
Short Term Rehabilitation Services | *Physical, chiropractic, speech and occupational therapy. (Includes therapies performed in a provider's office or other non-hospital billed facility only).*	$50 Copay, then Covered in Full	Deductible & 50% Coinsurance
Emergency Services | *ER copayment waived if admitted; $250 penalty for non-emergency use of a hospital emergency room.* Hospital Emergency Room Urgent Care/Physician *(see professional office visit above)* Ambulance	 $200 Copay, then Covered in Full $40 Copay, then Covered in Full $40 Copay, then Covered in Full	 Deductible & 50% Coinsurance Deductible & 50% Coinsurance Deductible & 50% Coinsurance
Allergy Treatment Testing & Injections Serum	 $30 Copay, then Covered in Full $150 Copay, then Covered in Full	 Deductible & 50% Coinsurance Deductible & 50% Coinsurance
Plan Year Deductible | *Copays do not apply to deductibles.*	**Deductible Waived**	**$5,000 per Individual $10,000 per Family**
Out-of-Pocket Maximum | *When through Guided Network, Only Copays Apply*	**$4,000 Individual or Family**	**$10,000 per Individual $20,000 per Family**
Inpatient Hospitalization Medical Services & Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Use Disorder Skilled Nursing Facilities	 $1,500 Copay (per confinement)	 Deductible & 50% Coinsurance Deductible & 50% Coinsurance Deductible & 50% Coinsurance Deductible & 50% Coinsurance
Home Health Care	Covered in Full	Deductible & 50% Coinsurance
Hospice Care	Covered in Full	Deductible & 50% Coinsurance
Durable Medical Equipment	Covered in Full	Deductible & 50% Coinsurance
Prescription Benefits Tier 1 Tier 2 Tier 3 Tier 4	**No Deductible** $0 Copay $20 Copay $75 Copay $150 Copay	**All Prescription Benefits are administered through the Pharmacy Manager as indicated in the "Guided Network" column to the left.**

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Revolution Health Plans: THE GALAXY SERIES

HSA Qualified

EVIDENCE-BASED MEDICINE COMBINED WITH THE FLEXIBILITY OF A PATIENT SPECIFIC QUALITY CARE NETWORK

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Virtual Care / Telemedicine | *Full Virtual Primary, Urgent and Behavioral Health. With Virtual Primary Care (VPC), members and their families receive access to a dedicated physician. Virtual Preventive, Urgent, and Behavioral Health are covered at a $0 Copay when using a Recuro provider. See enrollment materials for details.*	Covered in Full	Covered in Full
Professional Outpatient Office Visits | *These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical or medical procedures performed by the physician or for diagnostic services billed separately.*	Deductible then Covered in Full	Deductible & 50% Coinsurance
Office Based Diagnostic Tests, Labs & X-Ray | Includes diagnostic tests performed in a physician's office and billed by such physician or a freestanding non-hospital billed facility only.	Deductible then Covered in Full	Deductible & 50% Coinsurance
Outpatient Surgical, Diagnostic, & Therapeutic Procedure Services Facility Charges	 Deductible then Covered in Full Deductible then Covered in Full	 Deductible & 50% Coinsurance Deductible & 50% Coinsurance
Vision | *Annual Eye Exam Only. Any optometrist; member must submit claim for reimbursement.*	Deductible then Covered in Full	Deductible & 50% Coinsurance
Short Term Rehabilitation Services | *Physical, chiropractic, speech and occupational therapy. (Includes therapies performed in a provider's office or other non-hospital billed facility only).*	Deductible then Covered in Full	Deductible & 50% Coinsurance
Emergency Services | *ER copayment waived if admitted; $250 penalty for non-emergency use of a hospital emergency room.* Hospital Emergency Room Urgent Care/Physician *(see professional office visit above)* Ambulance	 Deductible, then $200 Copay, then Covered in Full Deductible then Covered in Full Deductible then Covered in Full	 Deductible & 50% Coinsurance Deductible & 50% Coinsurance Deductible & 50% Coinsurance
Allergy Treatment Testing & Injections Serum	 Deductible then Covered in Full Deductible then Covered in Full	 Deductible & 50% Coinsurance Deductible & 50% Coinsurance
Plan Year Deductible | *Copays do not apply to deductibles.*	$2,000 per Individual $4,000 per Family	$5,000 per Individual $10,000 per Family
Out-of-Pocket Maximum	$3,500 per Individual $7,000 per Family	$10,000 per Individual $20,000 per Family
Inpatient Hospitalization Medical Services & Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Use Disorder Skilled Nursing Facilities	 Deductible then $500 Copay (per confinement)	 Deductible & 50% Coinsurance Deductible & 50% Coinsurance Deductible & 50% Coinsurance Deductible & 50% Coinsurance
Home Health Care	Deductible then Covered in Full	Deductible & 50% Coinsurance
Hospice Care	Deductible then Covered in Full	Deductible & 50% Coinsurance
Durable Medical Equipment	Deductible then Covered in Full	Deductible & 50% Coinsurance
Prescription Benefits Tier 1 Tier 2 Tier 3 Tier 4	**Deductible, then:** $0 Copay $20 Copay $75 Copay $150 Copay	**All Prescription Benefits are administered through the Pharmacy Manager as indicated in the "Guided Network" column to the left.**

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Revolution Health Plans: THE GALAXY SERIES

Four Important Questions

DO I NEED TO USE A SPECIFIC NETWORK OF MEDICAL PROVIDERS?

First and foremost, you have easy access to a broad range of care through your virtual primary care (VPC) program that will enable you to receive care for you and your covered family members without copayments. Access your VPC by following the instructions that come with your plan! Access to these benefits does not require precertification or a call to the nurse. A dedicated physician, urgent care, mental health, and even some in-home lab tests and more are available at your convenience. Please review the information provided with your plan.

Next, you do have a designated network of care providers for certain out-patient services. But for anything beyond a routine well visit, for the best benefits, we ask that you first *Call the Nurse.* By communicating with the nurse, your care coordinator, you will receive valuable direction toward care, provider selection, and facilities when needed. Your nurse will guide you to an appropriate provider within the terms of the Plan whenever possible for physician, lab, and other health care needs. If you need care beyond that, your nurse will work with you to find the best providers in your area to receive your care in the most appropriate facility in combination with the best quality of providers.

WHAT HAPPENS IF MY NETWORK DOCTOR REFERS ME TO ANOTHER PROVIDER THAT IS NOT IN THE NETWORK?

Any time that your physician refers you to care beyond your routine well visit, you will *Call the Nurse.* Your nurse will coordinate finding you the most appropriate physician, location, and care plan for your medical needs and will assure that you get the very best benefits from your plan. If you go directly to providers without the direction of your nurse coordinator, you will receive out of network benefits which will be considerably higher cost for you.

WHAT IF I NEED TO GO IN THE HOSPITAL OR OTHER HEALTH CARE FACILITY?

It is very important to note that all hospitals are not the same, and no hospital is the best at everything. The most important thing to do is *Call the Nurse.* Your nurse care coordinator will be sure to work with all of the parts of your health plan to help navigate you to the most appropriate care, with quality providers, in facilities well suited for the care you need. It is vital that all hospital, facility, and surgical visits are coordinated with the Plan by calling the nurse. Many facilities will need to work with your care coordinator to maximize your benefits and provide quality care. To prevent your care from being treated as out-of-network care which would have radically higher costs for you... *Call the Nurse!*

WHAT IF I HAVE AN EMERGENCY?

In an emergency the choice is pretty simple. If the problem is serious enough that you should call an ambulance, then do not hesitate, otherwise ask the nurse! It is important especially in times of crisis that you find direction to the nearest appropriate medical provider. So call 911 or *Call the Nurse.* By *Calling the Nurse,* you will find support and direction from a medical professional at a time when you need it most. With professional guidance from your care coordinator you will also preserve the highest level of benefits possible! If you find yourself in a situation where you just can't *Call the Nurse,* then call or have a family member or friend call as soon as the situation allows.

WHAT IF I DON'T CALL THE NURSE OR *CALL THE NURSE* AND MAKE A DIFFERENT DECISION BUT STILL SEE A NETWORK PROVIDER?

If you do not *Call the Nurse* for direction, or you make care decisions contrary to the provided options, then your benefits will be deemed to be Out-of-Network rather than Guided Network. In that case, if you happen to see a Provider that is in the Network you will be receive benefits based on the Out-of-Network schedule but you will not be expected to pay the provider more than the agreed upon charges.

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