Fleet Plans
2500/80

Schedule of Benefits

		You Pay
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.	No Deductible, No Copay
Telemedicine Services As provided by your Revolution Health Plan. See enrollment materials for details.	This convenient standalone service provides access by web, phone, or your Revolution Health Plans benefits app to qualified doctors who can treat many common medical conditions.	No Deductible, No Copay
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Use Disorder	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 $50 Copay $30 Copay
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
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
Urgent Care / Physician	Urgent Care copayments do not include charges for diagnostic, surgical, or medical procedures.	$30 Copay
Prescription Drug Coverage Tier 1 Tier 2 Tier 3 Tier 4	Up to a 34-day supply may be purchased at retail for the listed copay. Up to a 90-day supply may be purchased at retail or by mail order for 2 copays.	$10 Copay $30 Copay $75 Copay 50% up to $400 Max Copay
	EXPENSES ABOVE THIS LINE NOT SUBJECT TO DEDUCTIBLE	
Plan Year Deductible Individual Family	An individual within family coverage will only be required to meet the indicated individual deductible amount before coinsurance benefits begin.	$2,500 per Individual $5,000 per Family
Out of Pocket Maximum Individual Family	All in network covered cost sharing including copays, deductible and coinsurance combine to meet this OOP maximum.	$8,000 per Individual $16,000 per Family
Outpatient Surgical, Diagnostic & Therapeutic Procedures Medical Services Facility Charges	Includes outpatient services, such as miscellaneous medical procedures and supplies, diagnostic and therapeutic procedures and surgery at a physician's office, freestanding surgical center or hospital (when approved).	20% after the Deductible 20% after the Deductible
Vision Annual Exam Only	Any optometrist; member must submit claim for reimbursement. Copay waived for children under 5.	20% after the Deductible
Emergency Services Hospital Emergency Room Ambulance	$250 penalty for non-emergency use of a hospital emergency room.	20% after the Deductible 20% after the Deductible
Allergy Testing, Injections & Serum		20% after the Deductible
Inpatient Hospitalization Medical Services & Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Use Disorder		20% after the Deductible 20% after the Deductible 20% after the Deductible
Home Health Care & Skilled Nursing Facilities		20% after the Deductible
Durable Medical Equipment		20% after the Deductible

PPO Provisions. When receiving care from non-network providers, all benefits are subject to the deductible and 40% coinsurance for the member and an increased out of pocket maximum. Other limits may apply. Maximum Out of Pocket Expenses are increased to $10,000 for individual and $20,000 for coverage with dependents. Please refer to the Summary Plan Descriptions (SPD) for details. The SPD is the final determination of all benefits. Out-of-Network benefits are subject to usual and customary limitations.