Patriot Plans
Blue

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
Teladoc	The Teladoc program, while not insurance, is a convenient standalone service that provides access by web, phone, or mobile app to qualified doctors who can treat many common medical conditions.	$0 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.	$20 Copay $40 Copay $20 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.	$20 Copay
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).	$60 Copay $60 Copay
Vision	Any optometrist; member must submit claim for reimbursement. Copay waived for children under 5.	$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).	$40 Copay
Emergency Services Hospital Emergency Room Urgent Care/Physician Ambulance	ER copayment waived if admitted; $250 penalty for non-emergency use of a hospital emergency room. Urgent Care copayments do not include charges for diagnostic, surgical, or medical procedures.	$200 Copay $20 Copay $40 Copay
Allergy Treatment Testing & Injections Serum		$20 Copay $150 Copay
Prescription Drug Coverage Generics Preferred Brand Non-Preferred Brand Expensive Specialty & Injectables	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.	$0 Copay $20 Copay $75 Copay $150 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.	$1,000 Deductible $2,000 Deductible
Deductible & Coinsurance Maximum Individual Family	Copays do not apply to the deductible and coinsurance maximum. However, copays combined with the deductible and coinsurance maximum do apply to an In Network Out of Pocket maximum of $7,000 for those with individual coverage and $14,000 for those with dependents covered.	$4,500 per Individual $9,000 per Family
Inpatient Hospitalization Medical Services & Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Use Disorder		30% after the Deductible 30% after the Deductible 30% after the Deductible
Home Health Care & Skilled Nursing Facilities		30% after the Deductible
Durable Medical Equipment		30% after the Deductible

PPO Provisions. Benefit Reduction for Non-Network Providers - when receiving care from non-network providers, all benefits are subject to the deductible and an additional 20% coinsurance and an increased out of pocket maximum. Other limits may apply. Out of Network Expense: 50% after the deductible. Maximum Out of Pocket Expense: $9,000/$18,000. Please refer to the Summary Plan Description (SPD) for details. The SPD is the final determination of all benefits. Out-of-Network benefits are subject to usual and customary limitations.