Freedom Plans (QHDHP)

STRIPES

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
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.	 $6,650 per Individual $13,300 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.	 $6,650 per Individual $13,300 per Family
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Use Disorder		 0% after the Deductible 0% after the Deductible 0% after the Deductible
Office Based Diagnostic Tests, Labs & X-Ray		0% after the Deductible
Outpatient Surgical, Diagnostic & Therapeutic Procedures Medical Services Facility Charges		 0% after the Deductible 0% after the Deductible
Vision Annual Exam Only	Any optometrist; member must submit claim for reimbursement. Copay waived for children under 5.	0% after the Deductible
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).	0% after the Deductible
Emergency Services Hospital Emergency Room Urgent Care/Physician Ambulance	$250 penalty for non-emergency use of a hospital emergency room.	 0% after the Deductible 0% after the Deductible 0% after the Deductible
Allergy Treatment Testing & Injections Serum		 0% after the Deductible 0% after the Deductible
Prescription Drug Coverage Tier 1 Tier 2 Tier 3 Tier 4		 0% after the Deductible 0% after the Deductible 0% after the Deductible 0% after the Deductible
Inpatient Hospitalization Medical Services & Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Use Disorder		 0% after the Deductible 0% after the Deductible 0% after the Deductible
Home Health Care & Skilled Nursing Facilities		0% after the Deductible
Durable Medical Equipment		0% 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. 20% after the deductible. Maximum Out of Pocket Expense are increased to $8,650 for individual and $17,300 for coverage with dependents. 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.