Patriot Plans
Independence

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.	$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 Annual Exam Only	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 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.	$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.	$250 Deductible $500 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.	$250 per Individual $500 per Family
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. Out of Network Expense: 20% 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.

Patriot Plans
Red

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.	$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 Annual Exam Only	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 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.	$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.	$250 Deductible $500 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.	$1,500 per Individual $3,000 per Family
Inpatient Hospitalization Medical Services & Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Use Disorder		10% after the Deductible 10% after the Deductible 10% after the Deductible
Home Health Care & Skilled Nursing Facilities		10% after the Deductible
Durable Medical Equipment		10% 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: 30% 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.

Patriot Plans
White

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.	$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 Annual Exam Only	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 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.	$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.	$500 Deductible $1,000 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.	$3,000 per Individual $6,000 per Family
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. 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: 40% 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.

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
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.	$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 Annual Exam Only	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 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.	$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.

Patriot Plans
Navy

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.	$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 Annual Exam Only	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 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.	$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.	$2,500 Deductible $5,000 Deductible
Deductible & Coinsurance Maximum Individual Family	Copays do not apply to the deductible. However, copays and coinsurance combined with the deductible 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.	$7,000 per Individual $14,000 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.

Patriot Plans
Admiral

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.	$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 Annual Exam Only	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 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.	$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.	$3,500 Deductible $7,000 Deductible
Deductible & Coinsurance Maximum Individual Family	Copays do not apply to the deductible. However, copays and coinsurance combined with the deductible do apply to an In Network Out of Pocket Maximum of $8,550 for those with individual coverage and $17,100 for those with dependents covered.	$8,550 per Individual $17,100 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: $10,550/$21,100. 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.

Patriot Plans (HRA EZ)

Washington

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.	$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 Annual Exam Only	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 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.	$0 Copay $20 Copay $75 Copay $150 Copay
EXPENSES ABOVE THIS LINE NOT SUBJECT TO DEDUCTIBLE		
Plan Year Deductible Individual Family	Only one deductible amount applies regardless of dependent status.	$2,500 Deductible $2,500 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 regardless of dependent status.	$2,500 Deductible $2,500 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. Out of Network Expense: 20% after the deductible. Maximum Out of Pocket Expense: $9,000. 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.

Patriot Plans (HRA EZ)

Lincoln

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.	$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 Annual Exam Only	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 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.	$0 Copay $20 Copay $75 Copay $150 Copay
EXPENSES ABOVE THIS LINE NOT SUBJECT TO DEDUCTIBLE		
Plan Year Deductible Individual Family	Only one deductible amount applies regardless of dependent status.	$3,500 Deductible $3,500 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 regardless of dependent status.	$3,500 Deductible $3,500 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. Out of Network Expense: 20% after the deductible. Maximum Out of Pocket Expense: $9,000. 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.

Fleet Plans
1500/80

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.	$1,500 per Individual $3,000 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.

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.

Fleet Plans

3500/80

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.	$3,500 per Individual $7,000 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.

Fleet Plans

5000/80

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.	$5,000 per Individual $10,000 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.

Fleet Plans
7600/80

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.	$40 Copay $70 Copay $40 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.	$40 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).	$70 Copay
Urgent Care / Physician	Urgent Care copayments do not include charges for diagnostic, surgical, or medical procedures.	$40 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 $50 Copay $100 Copay 50% up to $500 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.	$7,600 per Individual $15,200 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.	$8,700 per Individual $17,400 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 $10,700 for individual and $21,400 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.

Freedom Plans (QHDHP)

Glory EZ

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	Only one deductible amount applies regardless of dependent status.	$3,500 per Individual $3,500 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.	$5,000 per Individual $5,000 per Family
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 after the Deductible $40 Copay after the Deductible $20 Copay after the Deductible
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 after the Deductible
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).	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.	$30 Copay 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).	$40 Copay after the Deductible
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 after the Deductible $20 Copay after the Deductible $40 Copay after the Deductible
Allergy Treatment Testing & Injections Serum		$20 Copay after the Deductible $150 Copay after the Deductible
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.	$0 after the Deductible $20 after the Deductible $75 after the Deductible $150 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: $7,000. 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.

Freedom Plans (QHDHP)

Banner

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	Only one deductible amount applies regardless of dependent status.	$5,000 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.	$6,500 per Individual $6,500 per Family
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 after the Deductible $40 Copay after the Deductible $20 Copay after the Deductible
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 after the Deductible
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).	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.	$30 Copay 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).	$40 Copay after the Deductible
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 after the Deductible $20 Copay after the Deductible $40 Copay after the Deductible
Allergy Treatment Testing & Injections Serum		$20 Copay after the Deductible $150 Copay after the Deductible
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.	$0 after the Deductible $20 after the Deductible $75 after the Deductible $150 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: $8,500. 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.

Freedom Plans (QHDHP)

STARS

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	For coverage that includes dependents, the full family deductible must be met before benefits are provided.	 $1,500 per Individual $3,000 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.	 $3,200 per Individual $6,400 per Family
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 after the Deductible $40 Copay after the Deductible $20 Copay after the Deductible
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 after the Deductible
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).	 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.	$30 Copay 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).	$40 Copay after the Deductible
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 after the Deductible $20 Copay after the Deductible $40 Copay after the Deductible
Allergy Treatment Testing & Injections Serum		 $20 Copay after the Deductible $150 Copay after the Deductible
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.	 $0 after the Deductible $20 after the Deductible $75 after the Deductible $150 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 Expenses are increased to $5,200 for individual and $10,400 for coverage with dependents. Please refer to the Summary Plan Description (SPD) for details. The SPD is the final determination of all benefits. The SPD is the final determination of all benefits. Out-of-Network benefits are subject to usual and customary limitations.

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.

Fortress Plans
Concord II

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	No deductible applies to any covered service. Please see applicable copays.	 N/A N/A
Out of Pocket Maximum Individual Family	The maximum out of pocket will be met when the accumulated In-Network copays have reached the maximum amount. In-Network covered services will then be provided at 100%.	 $1,500 in Copays $3,000 in Copays
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
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).	 NOT COVERED NOT COVERED
Vision Annual Exam Only	Any optometrist; member must submit claim for reimbursement. Copay waived for children under 5.	NOT COVERED
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).	$30 Copay
Emergency Services Hospital Emergency Room Urgent Care/Physician Ambulance	$250 penalty for non-emergency use of a hospital emergency room. ER covered services include facility and physician charges only and do not include charges for diagnostic, surgical, or medical procedures. Urgent Care copayments do not include charges for diagnostic, surgical, or medical procedures.	 $500 Copay $30 Copay $100 Copay
Allergy Treatment Testing & Injections Serum		 $50 Copay $100 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.	 $0 Copay for Generics $25 Copay for Preferred NOT COVERED NOT COVERED
Inpatient Hospitalization Medical Services & Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Use Disorder		 NOT COVERED NOT COVERED NOT COVERED
Home Health Care & Skilled Nursing Facilities		NOT COVERED
Durable Medical Equipment		NOT COVERED

Benefit Reduction for Non-Network Providers - when receiving care from non-network providers you are responsible for all expenses except under certain conditions discussed in this Summary Plan Description. THE CONCORD II PLAN PROVIDES IN-NETWORK BENEFITS ONLY. Please refer to the Summary Plan Description (SPD) for details. The SPD is the final determination of all benefits.

Fortress Plans
Minimum Essential Coverage

Preventive Care Only

The Federal Patient Protection and Affordable Care Act has required that certain health plan provisions must apply to all qualified group health plans offered to employees. In accordance with these provisions, our Minimum Essential Coverage plan is designed to provide minimum benefits required under the law. Those required benefits constitute Minimum Essential Coverage containing the lone federally mandated benefit of 100% coverage for Preventive Health Services without any deductibles, copayments, or other cost sharing provisions.

These benefits are categorized into three major categories, based on recipients of preventive health services: Adults, Women, and Children.

Each of these categories has a series of benefits that are offered by this plan when using an in-network provider. Examples of these types of benefits are as follows:

Adult Preventive Services Examples

- Colorectal Cancer Screening for adults over 50
- Blood Pressure Screening for all adults
- Cholesterol Screening for adults of certain ages or at higher risk
- A variety of vaccinations for adults based upon age and population recommendations

Women's Preventive Services Examples

- Contraception FDA approved as prescribed by a physician with certain exclusions
- Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk
- Breast Cancer Mammography Screening every 1 or two years for women over 40
- Cervical Cancer Screening for sexually active women

Children's Preventive Services Examples

- Behavioral Assessments for children of certain ages
- Autism Screening for children at 10 and 24 months
- Developmental screening for children at specifically scheduled ages
- Hearing Screening for all newborns
- Immunizations as recommended

For a complete list of the 63 covered preventive services, please visit https://www.healthcare.gov/preventive-care-benefits

Always remember to refer to your Summary Plan Description (SPD) for benefits, valid on the date of your plan.
You can acquire a copy of your SPD from your employer or health plan administrator.

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***.

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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
TeleMedicine	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 Facility Charges	 Covered in Full Covered in Full	 Deductible & 20% Coinsurance 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 Urgent Care/Physician *(see professional office visit above)* Ambulance	 Covered in Full Covered in Full Covered in Full	 Deductible & 20% Coinsurance Deductible & 20% Coinsurance Deductible & 20% Coinsurance
Allergy Treatment Testing & Injections Serum	 Covered in Full Covered in Full	 Deductible & 20% Coinsurance 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 Anesthesiologist & Surgeon Fees Mental Health & Substance Use Disorder Skilled Nursing Facilities	 Covered in Full Covered in Full Covered in Full Covered in Full	 Deductible & 20% Coinsurance Deductible & 20% Coinsurance Deductible & 20% Coinsurance 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 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.

* 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
TeleMedicine	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
TeleMedicine	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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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
TeleMedicine	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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