Freedom Plans (QHDHP)

Glory EZ

Schedule of Benefits

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.	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	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 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 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)

Stars

Schedule of Benefits

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.	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	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 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 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

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.	No Deductible, No Copay
Plan Year Deductible	An individual within family coverage will only be required to meet the indicated individual deductible amount before coinsurance benefits begin.	
Individual		$6,650 per Individual
Family		$13,300 per Family
Out of Pocket Maximum	All in network covered cost sharing including copays, deductible and coinsurance combine to meet this OOP maximum.	
Individual		$6,650 per Individual
Family		$13,300 per Family
Professional Outpatient Office Visits		
Primary Care		0% after the Deductible
Specialist		0% after the Deductible
Mental Health & Substance Use Disorder		0% after the Deductible
Office Based Diagnostic Tests, Labs & X-Ray		0% after the Deductible
Outpatient Surgical, Diagnostic & Therapeutic Procedures		
Medical Services		0% after the Deductible
Facility Charges		0% after the Deductible
Vision	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	$250 penalty for non-emergency use of a hospital emergency room.	
Hospital Emergency Room		0% after the Deductible
Urgent Care/Physician		0% after the Deductible
Ambulance		0% after the Deductible
Allergy Treatment		
Testing & Injections		0% after the Deductible
Serum		0% after the Deductible
Prescription Drug Coverage		
Generics		0% after the Deductible
Preferred Brand		0% after the Deductible
Non-Preferred Brand		0% after the Deductible
Expensive Specialty & Injectables		0% after the Deductible
Inpatient Hospitalization		
Medical Services & Facility		0% after the Deductible
Anesthesiologist & Surgeon Fees		0% after the Deductible
Mental Health & Substance Use Disorder		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.

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