Plan A- GOLD

Quick Reference Summary
$1,750 80%/50% OV: $35/$55 Rx: $10/$25/$50
Point of Service (Open Access)

JEFF DAVIS HOSPITAL

Schedule of Benefits

Deductibles, Coinsurance and Maximums	In-Network Benefit	Out-of-Network Benefit
Calendar Year Deductible – Individual – Family	 $1,750 $3,500	 $3,500 $7,000
Coinsurance	**Plan pays 80% after deductible**	Plan pays 50% after deductible
Lifetime Maximum	Unlimited	Unlimited
Out-of-Pocket Calendar Year Maximum – Individual – Family	 $3,500 $7,000	 Unlimited Unlimited

- ***Compared to other "Gold Level" healthcare plans, a policyholder can expect Plan A to cover approximately 80% of your medical expenses in a given year.**
- **100% of co-pays, co-insurance, and out-of-pocket expenses are applied towards the individual and family deductibles.**
- **Out of pocket expenses are capped at $3,500 per individual and $7,000 per family annually.**
- **All out-of-network co-pays, co-insurance, and out-of-pocket expenses are applied towards the in-network maximum limits.**
- **In-network out-of-pocket expenses are not applied toward the out-of-network, out-of-pocket maximum limits.**
- **Per the Affordable Care Act, a Summary of Benefits and Coverage (SBC) form summarizes health plan information and provides estimated costs of commonly used services for this plan.**

Primary network hospitals:
regional hospitals: JDH, Coffee Regional Medical Center & Memorial Health Partners. It is important that every member clearly understands that if a service is available at JDH then that is the only option. If you do utilize another hospital and the services could have been performed at JDH, the charges will not be covered at all. The provider network for hospital utilization will only include JDH, Coffee Regional Medical Center and Memorial Hospital. **The hospitals must be used in that order** and you may not proceed to the next hospital when the services you need are available at that hospital.

Covered Services	In-Network Benefit **** Member Pays ****	Out-of-Network Benefit **** Member Pays ****
Preventive Care and Services Preventive Care Services are those that meet the requirements of federal and state law, including certain screenings, immunizations, and physician visits.		
• Well-child care, immunizations, vaccines	No cost	Member pays deductible then 50%
• Annual adult health examinations and physicals	No cost	Member pays deductible then 50%
• Annual gynecology examination and mammograms	No cost	Member pays deductible then 50%
• Annual prostate screening	No cost	Member pays deductible then 50%
Primary Care Physician (PCP) Services Services performed AND billed in a physician's office		
• Office Visit (including diagnostic x-rays and laboratory performed in physician's office)	$35 Co-pay	Member pays deductible then 50%
• **Specialist Office Visit** (including diagnostic x-rays and laboratory performed in physician's office)	$55 Co-pay	Member pays deductible then 50%
• Surgery in a physician's office	Member pays deductible then 20%	Member pays deductible then 50%
• Allergy care (testing, serum, and allergy shots)	Member pays deductible then 20%	Member pays deductible then 50%
• Maternity physician services (prenatal, delivery, postpartum)	Member pays deductible then 20%	Member pays deductible then 50%
Emergency Room Services		
• Life-threatening illness or serious accidental injury	Member pays deductible then $225 Co-pay (waived if admitted) & 20% co-insurance	Same as In-network benefits
• Non-emergency use of the emergency room	Not a covered service	Not a covered service
Inpatient Hospital Services		
• Daily room, board and general nursing care at semi-private room rate; ICU/CCU; other medically necessary hospital charges such as diagnostic x-ray and lab services; newborn nursery care	Member pays deductible then $225 co-pay per inpatient hospital admittance & 20% co-insurance	Member pays deductible then $600 co-pay per admittance & 50% co-insurance
• Physician services (surgeon, anesthesiologist, radiologist, pathologist)	Member pays deductible then 20%	Member pays deductible then 50%
Outpatient Services		
• Surgery facility / hospital charges	Member pays deductible then 20%	Member pays deductible then 50%
• Diagnostic X-ray and lab services	Member pays deductible then 20%	Member pays deductible then 50%
• Physician services (surgeon, anesthesiologist, radiologist, pathologist)	Member pays deductible then 20%	Member pays deductible then 50%
• Outpatient Dialysis Treatment: (In-Network and Out of Network)- 100% of the lesser of (i) the Usual, Customary, and Reasonable Outpatient Dialysis Charge as defined in "Outpatient Dialysis Treatment" Section in the Plan Document, (ii) the maximum allowable charge after all applicable deductibles and cost-sharing; and (iii) such charge as is negotiated between the Plan Administrator and the provider of Outpatient Dialysis Treatment.	Member pays deductible then 20% of Usual, Customary and Reasonable Charge	Member pays deductible then 50% of Usual and Customary Charge

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Covered Services	In-Network Benefit	Out-of-Network Benefit
Therapy Services **Calendar year maximums are combined between in-network and out-of-network**		
• Speech therapy (25 visit limit annually)	Member pays deductible then 20%	Member pays deductible then 50%
• Physical therapy, occupational therapy, and services of athletic trainers (25 visit limit each, annually)	Member pays deductible then 20%	Member pays deductible then 50%
• Chiropractic Care (20 visit limit annually)	Member pays deductible then 20%	Member pays deductible then 50%
• Pulmonary/Cardiac therapy	Member pays deductible then 20%	Member pays deductible then 50%
• Radiation therapy and chemotherapy	Member pays deductible then 20%	Member pays deductible then 50%
Mental Health / Substance Abuse **Services must be authorized by calling 1-888-741-2673**		
• Inpatient (facility and physician fee)	Member pays deductible then 20%	Member pays deductible then 50%
• Inpatient Substance Abuse Detoxification (facility and physician fee)	Member pays deductible then 20%	Member pays deductible then 50%
• Partial Hospitalization Program (facility and physician fee)	Member pays deductible then 20%	Member pays deductible then 50%
• Intensive Outpatient Program (facility and physician fee)	Member pays deductible then 20%	Member pays deductible then 50%
• Professional Outpatient Services	Member pays deductible then 20%	Member pays deductible then 50%
Other Services **Calendar year maximums are combined between in-network and out-of-network**		
• Urgent Care Center	$75 Co-pay	$75 copayment Member pays deductible then 50%
• Skilled Nursing Facility (30-day maximum cap)	Member pays deductible then 20%	Member pays deductible then 50%
• Home Health Care (120-day calendar year maximum)	Member pays deductible then 20%	Member pays deductible then 50%
• Hospice Care	Member pays deductible then 20%	Member pays deductible then 50%
• Ambulance (Ground)	Member pays deductible then 20%	Member pays deductible then 50%
• Ambulance (Air)	Member pays deductible then 20%	Member pays deductible then 50%
• Durable Medical Equipment (DME)	Member pays deductible then 20%	Member pays deductible then 50%
• Orthotics • Prosthetics	Member pays deductible then 20%	Member pays deductible then 50%
PRESCRIPTION CO-PAYS (The greater of the flat-dollar co-payment or coinsurance)	**RETAIL PHARMACY** (30-day supply only)	**MAIL ORDER** (60, 90-day supply)
Generic	$10	$25
Preferred	$25 or 25%, whichever is greater. ($100 Max)	$50 or 25%, whichever is greater. ($200 Max)
Non-Preferred	$50 or 50%, whichever is greater. ($300 Max)	$100 or 50% whichever is greater. ($600 Max)
Specialty Drug Co-pay		
Generic	$50	NA
Preferred	20% ($1,000 max)	NA
Non-Preferred	50% ($1,500 max)	NA
EXCLUDED SERVICES AND PROCEDURES	• Genetic testing, Gastric bypass surgery, and Cosmetic procedures • All non-FDA approved procedures and services • Services that do not meet *Medical Necessity* designation	

This Schedule of Benefits is part of your Certificate of Insurance but does not replace it. Many words are defined elsewhere in the Certificate, and other limitations or exclusions may be listed in other sections of your Certificate. Reading this Schedule by itself could give you an inaccurate impression of the terms of your coverage. This Schedule must be read with the rest of your Certificate.

- **Prior authorization may be required for specific services.**
- **Payment to Out-of-Network providers is based on the Out-of-Network Rate (ONR).**
- **Preventative Services must qualify as such as specified in your contract and the PPACA in order to be exempt from applicable deductibles.**
- **Physician services are limited to one Copay per Member, per provider, per date of service and per place of service.**