Quick Reference Summary
Plan C – SILVER*
$2,000 80%/50% OV: $40/$60 Rx: $10/$30/$60
Point of Service (Open Access)

Schedule of Benefits

Deductibles, Coinsurance and Maximums	In-Network Benefit	Out-of-Network Benefit
Calendar Year Deductible – Individual – Family	 $2,000 $5,000	 $5,000 $10,000
Coinsurance	Plan pays 80% after deductible	Plan pays 50% after deductible
Lifetime Maximum	Unlimited	Unlimited
Out-of-Pocket Calendar Year Maximum – Individual – Family	 $5,000 $10,000	 Unlimited Unlimited

- ***Compared to other "Silver Level" healthcare plans, a policyholder can expect Plan C 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 $5,000 per individual and $10,000 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: 16 regional hospitals located in a 29-county area, EXCLUDING EAST GA REGIONAL MC.**
- **In-network Primary Care and Specialty Care providers: All members of the Core Community Care Managed Care Network**

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-childcare, 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) (See Mental Health for separate co-pay information)	$40 Co-pay	Member pays deductible then 50%
• **Specialist Office Visit** (including diagnostic x-rays and laboratory performed in physician's office) (See Mental Health for separate co-pay information)	$60 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 $200 Co-pay (waived if admitted) Deductible & 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 $400 Co-pay per admittance, then deductible & 20% Co-insurance	Member pays $1200 Co-pay per admittance then deductible & 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%

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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 (20 visit limit annually)	Member pays deductible then 20%	Member pays deductible then 50%
• Physical, occupational therapy, chiropractic care and services of athletic trainers (20 visit limit combined 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%
• Mental Health OFFICE VISITS	$30 Co-pay (waiving deductible)	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 calendar year maximum)	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	$30 or 20% ($100 Max)	$60 or 20% ($200 Max)
Non-Preferred	$60 or 50% ($300 Max)	$120 or 50% ($600 Max)
Specialty Drug Co-Pay		
Generic	10% ($100)	NA
Preferred	20% ($1,000 max)	NA
Non-Preferred	50% ($1,500 max)	NA

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.**

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