Benefits

#2393 – Giles Farm Services

Calendar Year Deductible			$250.00
Out-of-pocket limit on expenses			$500.00
Common Medical Event	Service Type		Member Cost Share
	Benefits		**Interplan/Healthsmart Network (outpatient services – office visit, lab, x-ray, urgent care visits and Free Standing Facilities for MRI, CT and PET scans)** **Services provided outside of the Interplan/Healthsmart network for outpatient services are not covered by this plan**
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness		$10 co-pay- member Plan pays 100% of allowed
	Specialist visit		$40 co-pay – member Plan pays 100% of allowed
	Urgent Care Facility/Service		$40 co-pay – member Plan pays 100% of allowed
	Preventive care/screening/ immunization		No cost share – member Plan pays 100% of allowed
Tests	Diagnostic test (x-ray, blood work) Free Standing Facilities **Subject to Deductible**		Plan pays 75% of allowed
	Imaging (CT/PET scans, MRIs) at a Free Standing Imaging Center, if performed in a hospital on an outpatient basis not covered **Subject to Deductible**		Not Covered
Outpatient Mental health, Behavioral Health, or Substance abuse needs	Mental/Behavioral health outpatient service		Not Covered
	Substance use disorder outpatient services **Subject to Deductible** **12 visit maximum**		Not Covered
Outpatient surgery	Facility fee (e.g., ASC)		Not Covered
	Physician/surgeon fees		Not Covered
Need immediate attention	Emergency room services (waived if admitted)		Not Covered
	Emergency medical transportation		Not Covered
Hospital stay	Facility fee (e.g., hospital room)		Not Covered
	Physician/surgeon fee		Not Covered
Inpatient Mental health, Behavioral Health, or Substance abuse needs	Mental/Behavioral health inpatient Services		Not Covered
	Substance use disorder inpatient Services		Not Covered
Pregnancy	Delivery and all Inpatient services	Professional Hospital	Not Covered
Help recovering or other special health needs	Home health care (60 days per calendar year)		Not Covered
	Rehabilitation services Subject to deductible		$20 co-pay – member Plan pays 100% of allowed
	Habilitation services		Not Covered
	Skilled nursing facility (60 days per calendar year) Immediately following an in-patient stay.		Not Covered
	Chemotherapy/Radiation		Not Covered
	Dialysis		Not Covered
	Durable medical equipment ($2500 per benefit period)		Not Covered
	Hospice service ($2,500 calendar year max benefit)		Not Covered
Child needs Child oral care Ages 0-11 mos, 1-4yrs, 5-10 yrs.	Eye Exam		No cost share
	Glasses ($150 max benefit)		Not Covered
	Dental check-up – Preventive and Diagnostic Services		Not Covered
	Dental Basic Services ($1,000 calendar year max)		Not Covered
Drugs to treat illness or condition	Generic Drugs – Mandatory Generic		$5 co-pay
	Brand Name Available only when generic is not available		Not Covered Not Covered
	Specialty Medication		Not Covered