Redington-Fairview General Hospital

Higher Out-of-Pocket Option Benefit Overview

April 1, 2024

	Preferred (Redington-Fairview General Hospital)	Anthem Network Member Pays	Non-Network Member Pays
Deductible:	$0 Individual / $0 Family	$1,500 Individual / $3,000 Family	$2,000 Individual / $4,000 Family
Total Out-of-pocket Limit: *Includes deductible, member coinsurance and copayments*	$0 Individual / $0 Family	$2,500 Individual / $5,000 Family	$4,000 Individual / $8,000 Family
Lifetime Maximum Benefits:	Unlimited	Unlimited	Unlimited

Copayments do not go toward your deductible but do go towards your Out-of-pocket Limit. Limits listed in this overview are per person per calendar year unless otherwise stated. All covered expenses accumulate separately toward the Preferred, Anthem Network and Non-Network Out-of-pocket limit.

Services	Preferred (Redington-Fairview General Hospital)	Anthem Network Member Pays	Non-Network Member Pays
PROVIDER SERVICES			
Hospital Inpatient	100% Covered	30%, after deductible	50%, after deductible
Hospital Outpatient/Diagnostic Tests	100% Covered	30%, after deductible	50%, after deductible
Emergency Care	100% Covered	20% after $75 copay, no deductible	20% after $75 copay, no deductible
Ambulatory Surgical Center	100% Covered	30%, after deductible	50%, after deductible
Skilled Nursing Facility *(150 day limit)*	Not Applicable	30%, no deductible	50%, after deductible
Home Health Care *(100 visits per cal yr)*	Not Applicable	30%, no deductible	50%, after deductible
Hospice Care	Not Applicable	30%, no deductible	50%, no deductible

For all scheduled inpatient admissions (excluding planned cesareans), you must call for a preadmission review.

Services	Preferred (Redington-Fairview General Hospital)	Anthem Network Member Pays	Non-Network Member Pays
PREVENTIVE CARE, SCREENINGS and IMMUNIZATIONS *To include annual routine eye exams, preventive screening colonoscopies, mammograms, immunizations, etc.*	100% Covered	100% Covered	50%, after deductible
PROFESSIONAL SERVICES			
Sick Care / Surgical Office Visits	100% Covered	$30 copay, no deductible*	50%, after deductible
Diagnostic Tests	100% Covered	30%, after deductible	50%, after deductible
MATERNITY CARE			
Pre and postnatal	100% Covered	100%, no deductible	50%, after deductible
Delivery	100% Covered	30%, after deductible	50%, after deductible
FAMILY PLANNING			
Office Visit	100% Covered	$30 copay, no deductible*	50%, after deductible
Female Contraceptive services and devices**	100% Covered	100% Covered	Not Covered

*The office/surgical visit copayment is applied to the office exam charge only.
**Contraceptives: Generic drugs and brand name drugs that don't have a generic equivalent will have no cost share.

Services	Preferred (Redington-Fairview General Hospital)	Anthem Network Member Pays	Non-Network Member Pays
ADDITIONAL BENEFITS **Physical Manipulations/Adjustments** – *limited to 40 visits per calendar year. The manipulation copayment applies to manipulations only*	100% Covered	$30 copay, no deductible	50%, after deductible
Physical, Occupational, and Speech Therapy – *limited to 60 combined visits per calendar year*	100% Covered	30%, no deductible	50%, after deductible

Durable Medical Equipment	100% Covered	30%, no deductible	50%, after deductible
Prosthetics	100% Covered	20%, no deductible	50%, after deductible
Hearing Aids: Dependents through age 18: *One hearing aid per ear every 36 months, with no dollar limit.* Members age 19+: *Limited to $3,000 per ear every 36 months*	100% Covered	30%, no deductible	50%, after deductible
Ambulance	100% Covered	100%, no deductible	100%, no deductible
Smoking Cessation *Smoking Cessation Education Program* *Physician Follow-up Visits* *Select prescription and over the counter medications for smoking cessation** *Tobacco Cessation Products - FDA approved OTC products – Age 18 years and older. Tobacco Cessation Products select generics and brand names without generic alternatives.	100% Covered 100% Covered 100% Covered	100%, no deductible 100%, no deductible 100%, no deductible	20%, after deductible 20%, after deductible 20%, after deductible
Both Network and Non-network services are applied to the calendar year limits for related outpatient services.			

Services	Preferred (Redington-Fairview General Hospital)	Anthem Network Member Pays	Non-Network Member Pays
PRESCRIPTION DRUGS *(Includes Contraceptives)* **Drug Card Copayment** (retail and mail order drugs are two times the copayment for a 31-90 day supply)	Not applicable	$10 Tier 1/per 30 day supply $30 Tier 2/per 30 day supply $50 Tier 3/per 30 day supply $20 Tier 1/per 31-90 day supply $60 Tier 2/per 31-90 day supply $100 Tier 3/per 31-90 day supply	Not Covered
MENTAL HEALTH/SUBSTANCE ABUSE Inpatient Residential Treatment Facilities Outpatient Office visits	 100% Covered Not applicable 100% Covered 100% Covered	 30%, after deductible 30%, after deductible 30%, after deductible $30 copay, no deductible	 50%, after deductible 50%, after deductible 50%, after deductible 50%, after deductible
You must call for preauthorization of all non-emergency inpatient mental health care. If you do not call, your benefits for inpatient services may be reduced by up to $300.			