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## Redington-Fairview General Hospital

### Higher Out-of-Pocket Option Benefit Overview

#### April 1, 2025

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

<b>Services</b>	<b>Preferred (Redington-Fairview General Hospital)</b>	<b>Anthem Network Member Pays</b>	<b>Non-Network Member Pays</b>
<b>PREVENTIVE CARE, SCREENINGS and IMMUNIZATIONS</b>  <i>To include annual routine eye exams, preventive screening colonoscopies, mammograms, immunizations, etc.</i>	100% Covered	100% Covered	50%, after deductible
<b>PROFESSIONAL SERVICES</b>  <b>Sick Care / Surgical Office Visits</b> <b>Diagnostic Tests</b>  <b>MATERNITY CARE</b> <b>Pre and postnatal</b> <b>Delivery</b>  <b>FAMILY PLANNING</b> <b>Office Visit</b> <b>Female Contraceptive services and devices**</b>	100% Covered 100% Covered  100% Covered 100% Covered  100% Covered 100% Covered	\$30 copay, no deductible* 30%, after deductible  100%, no deductible 30%, after deductible  \$30 copay, no deductible* 100% Covered	50%, after deductible 50%, after deductible  50%, after deductible 50%, after deductible  50%, after deductible 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.			
<b>Services</b>	<b>Preferred (Redington-Fairview General Hospital)</b>	<b>Anthem Network Member Pays</b>	<b>Non-Network Member Pays</b>
<b>ADDITIONAL BENEFITS</b> <b>Physical Manipulations/Adjustments</b> <i>– limited to 40 visits per calendar year. The manipulation copayment applies to manipulations only</i>	100% Covered	\$30 copay, no deductible	50%, after deductible
<b>Physical, Occupational, and Speech Therapy – limited to 60 combined visits per calendar year</b>	100% Covered	30%, no deductible	50%, after deductible

<b>Durable Medical Equipment</b>	100% Covered	30%, no deductible	50%, after deductible
<b>Prosthetics</b>	100% Covered	20%, no deductible	50%, after deductible
<b>Hearing Aids:</b> Dependents through age 18: <i>One hearing aid per ear every 36 months, with no dollar limit.</i>  Members age 19+: <i>Limited to \$3,000 per ear every 36 months</i>	100% Covered	30%, no deductible	50%, after deductible
<b>Ambulance</b>	100% Covered	100%, no deductible	100%, no deductible
<b>Smoking Cessation</b> <i>Smoking Cessation Education Program</i>  <i>Physician Follow-up Visits</i>  <i>Select prescription and over the counter medications for smoking cessation*</i>  *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
<b>PRESCRIPTION DRUGS</b> <i>(Includes Contraceptives)</i>  <b>Drug Card Copayment</b> (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
<b>MENTAL HEALTH/SUBSTANCE ABUSE</b>  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.

**This is not a contract. This Benefit Overview is an outline of your coverage.**  
**Your Summary Plan Description/Plan Document, which includes your Benefit Overview, fully describes the benefits and exclusions.**  
**In the event of a conflict, the terms of the Summary Plan Description/Plan Document prevail.**