MEDICAL BENEFITS SCHEDULE

MAXIMUM ANNUAL BENEFIT AMOUNT	$40,000
ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND PROCEDURE BASED MAXIMUM EXPENSE	
DEDUCTIBLE, PER PLAN YEAR	
Per Covered Person	$0
Per Family Unit	$0
COVERED CHARGES	
Hospital Services	
Room and Board	100% after $150 copayment per day up to $750 per stay, subject to plan allowable
	Paid at the facility's semi-private room rate Limited to 6 days per benefit period per Member
Intensive Care Unit	100% after $150 copayment per day up to $750 per stay, subject to plan allowable
	Paid at the Hospital's ICU Charge Limited to 6 days per benefit period per Member
Rehabilitation	Not covered
Surgical Services Includes Physician and Ancillary Services – including Anesthesia	100% after $500 copayment per stay, subject to plan allowable
	Limited to 2 surgery per benefit period per Employee/2 surgeries per benefit period per Family Limited to $2,500 maximum per surgery
Emergency Room Visit	
Emergency Room Copayment waived it admitted Includes Physician and Ancillary Services	100% after $350 copayment per visit, subject to plan allowable
	Limited to 2 visits per benefit period per Member
Observation (less than 24 hours)	100% after $350 copayment per visit, subject to plan allowable
	Limited to 2 visits per benefit period per Member

Outpatient Hospital/ Surgery Center Includes Physician and Ancillary Services – including Anesthesia	100% after $500 copayment per surgery, subject to plan allowable
	Limited to 1 surgery per benefit period per Employee/2 surgeries per benefit period per Family Limited to $2,500 maximum per surgery
Skilled Nursing Facility	Not covered
Urgent Care Services (Includes all charges)	100% after $60 copayment per visit, subject to plan allowable
	Limited to 3 visits per benefit period per Employee/6 visits per benefit period per Family
Physician Services	
Inpatient Physician/Surgeon/Anesthesiologist	100%, subject to plan allowable
Primary Care Physician Office visits (Includes Family practice, General Practitioner, Internist, Pediatrician, OB/GYN, Physician Assistant, or Nurse Practitioner) (Includes: All services billed and performed by the physician except surgery, anesthesia and MRI/CT/PET/ SPECT/MRA)	100% after $20 copayment per visit, subject to plan allowable
	Limited to 6 visits per benefit period per Employee/12 visits per benefit period per Family
Specialist Physician Office visits (Includes: All services billed and performed by the physician except surgery, anesthesia and MRI/CT/PET/ SPECT/MRA)	100% after $40 copayment per visit, subject to plan allowable
	Limited to 6 visits per benefit period per Employee/12 visits per benefit period per Family
SwifMD – Telemedicine	100% after $0 copayment per visit Coverage for Telemedicine only available through SwiftMD
Allergy testing, serum & injections	Not covered
Diagnostic Testing Services (X-Ray and Lab)	100% after $60 copayment per visit, subject to plan allowable

	Limited to 6 visits per benefit period per Employee/12 visits per benefit period per Family
Radiology (CT, PET, MRI, MRA, SPECT)	100% after $150 copayment per visit, subject to plan allowable
	Limited to 2 visits per benefit period per Member
Radiology – Green Imaging (CT, PET, MRI, MRA, SPECT)	100% after $150 copayment per visit, subject to plan allowable
	Limited to 5 visits per benefit period per Member
Home Health Care	Not covered
Hospice Care	Not covered
Ambulance Service – ground/air	100% after $500 copayment per transport, subject to plan allowable
	Limited to 2 visits per benefit period per Member Limited to $1,000 maximum per visit
Physical & Occupational Therapies	Not covered
Speech Therapy	Not covered
Cardiac Rehabilitation Therapy	Not covered
Habilitation services	Not covered
Durable Medical Equipment	75%, subject to plan allowable
	Limited to $1,000 maximum per benefit period
Prosthetics and Orthotics	Not covered
Spinal Manipulation Chiropractic (Does not includes x-rays)	100% after $60 copayment per visit, subject to plan allowable
	Limited to 12 visits per benefit period per Member
Mental Disorders/Substance Abuse/Autism Spectrum Disorder	
Inpatient/Partial Hospitalization	100% after $60 copayment per day, subject to plan allowable

	Paid at the facility's semi-private room rate Limited to 4 days per benefit period per Member
Outpatient	Coverage through SwiftMD
Preventive Care	
Routine Mammogram	100% of plan allowable
	Limited to 1 per benefit period
Routine Colonoscopy	100% of plan allowable
	Limited to 1 per benefit period
Routine Well Adult Care Includes chest x-ray and EKG Covered services include facility charges associated with covered Preventative Care services.	100% of plan allowable
	Annual physical not available until 9 months after effective date. 1 visit per member per plan year
• Abdominal Aortic Aneurysm (Once per lifetime screening for men) • Alcohol Misuse screening/counseling • Aspirin use for men and women of certain ages • Blood Pressure screening • Cholesterol screening for adults of certain ages or at higher risk • Colorectal Cancer screening for adults • Depression screening • Type 2 Diabetes screening for adults with high blood pressure • Diet counseling for adults at higher risk for chronic disease • HIV screening for adults at higher risk • Immunization vaccines: (Doses, ages, and recommended populations vary) Hepatitis A Hepatitis B Herpes Zoster Human Papillomavirus Influenza Measles, Mumps, Rubella Meningococcal Pneumococcal Tetanus, Diphtheria, Pertussis Varicella • Obesity screening and counseling • Sexually Transmitted Infection (STI) prevention counseling for higher risk • Tobacco Use screening • Syphilis screening for higher risk	
Women's Preventive Care Services Covered services include facility charges associated with covered Preventative Care services.	100% of plan allowable
	Annual physical not available until 9 months after effective date 1 visit per member per plan year

• Anemia screening on a routine basis for pregnant women • Bacteriuria urinary tract or other infection screening for pregnant women • BRCA counseling about genetic testing for women with higher risk • Breast cancer Chemoprevention counseling for women at higher risk • Breast Feeding intervention to support and promote breast feeding • Cervical cancer screening for sexually active women • Chlamydia infection screening for younger women and other women at higher risk • Folic Acid supplements for women who may become pregnant • Gonorrhea screening for all women at higher risk • Hepatitis B screening for pregnant women at their first prenatal visit • Osteoporosis screening for women over age 60 depending on risk factors • Rh Incompatibility screening for pregnant women & follow-up testing for women at higher risk • Tobacco Use screening and interventions for all women, and expanded counseling • Syphilis screening for all pregnant women or women at higher risk • Screening for gestational diabetes • Human papillomavirus testing • Counseling for sexually transmitted diseases • Counseling for screening for human immune-deficiency virus • FDA-approved female prescription contraceptive drugs and devices (e.g. diaphragm) • FDA-approved female prescription contraceptive surgical procedures (e.g. IUD's) • FDA-approved emergency contraceptive drugs • Breastfeeding support, supplies and counseling • Screening and counseling for interpersonal and domestic violence	
Routine Well Newborn Care (While hospital confined as a result of birth, limited to ACA covered benefits) Covered services include facility charges associated with covered Preventative Care services.	100% of plan allowable

Routine Well Child Care Covered services include facility charges associated with covered Preventative Care services.	100% of plan allowable Annual physical not available until 9 months after effective date 1 visit per member per plan year
• Alcohol and Drug Use assessments for adolescents • Autism screening for children at 18 and 24 months • Behavioral assessments for children • Cervical Dysplasia screening for sexually active females • Congenital Hypothyroidism screening for newborns • Developmental screening for children under age 3, and surveillance throughout childhood • Dyslipidemia screening for children at higher risk for lipid disorders • Fluoride Chemoprevention supplements for children without fluoride in their water source • Gonorrhea preventive medication for the eyes of newborns • Hearing screening for newborns • Height, Weight and Body Mass Index measurements • Hematocrit or Hemoglobin screening for children • Hemoglobinopathis or sickle cell screening for newborns • HIV screening for adolescents at higher risk • Immunization vaccines: (Doses, ages, and recommended populations vary) Diphtheria, Tetanus, Pertussis Haemophilus influenzae type b Hepatitis A Hepatitis B Human Papillomavirus Inactivated Poliovirus Influenza Measles, Mumps, Rubella Meningococcal Pneumococcal Rotavirus Varicella • Iron supplements for children ages 6 to 12 months at risk for anemia • Lead screening for children at risk of exposure • Medical History for all children throughout development • Obesity screening and counseling • Oral Health risk assessment for young children • Phenylketonuria (PKU) screening for this genetic disorder in newborns • Sexually Transmitted Infection (STI) prevention counseling for adolescents at higher risk • Tuberculin testing for children at higher risk of tuberculosis • Vision screening for all children	
Organ Transplants	Not covered
Implantable Devices	100%, as part of the applicable Surgery benefit

Prenatal/Postnatal Care	100%, subject to plan allowable
Inpatient Facility Maternity Services (Room and Board charges limited to semi-private room rate)	100% after $150 copayment per day up to $750 per stay, subject to plan allowable
	(Dependent daughter pregnancy is not covered) Limited to 5 days per benefit period per Member
Inpatient Physician Maternity Services	100% after $500 copayment per visit, subject to plan allowable
Chemotherapy/Radiation	Not covered
Jaw Joint / TMJ	Not covered
Orthopedic Shoes	Not covered
Hearing Aids	Not covered
Routine Vision Exams	100%, subject to plan allowable
	Limited to dependent children Limited to 1 exam per benefit period per Member
Prescription Frames/Lenses	100%, subject to plan allowable
	Limited to dependent children Contact Lenses are not covered. Frame maximum of $150.00 ever 2 years. Standard single vision, bifocal and trifocal Lens coverage only. Lens enhancements are not covered (I.E., transitional lenses or scratch-resistant coatings).
Dental Exam	100%, subject to plan allowable
	Limited to dependent children Limited to 1 exam per benefit period per Member
All Other Eligible Charges	Not covered – only the services listed in this schedule are covered charges under this plan

PRESCRIPTION DRUG BENEFIT SCHEDULE

Pharmacy Option (30 day Supply)

Generic Drugs
Copayment $0.00

Brand Name
Copayment ..... Not covered

Non-Preferred Brand
Copayment ..... Not covered

Specialty
Copayment ..... Not covered

*There is no coverage available for specialty drugs through the plan

90-Day Pharmacy and Mail Order Options

Generic Drugs
Copayment $30.00

Brand Name
Copayment ..... Not covered

Non-Preferred Brand
Copayment ..... Not covered

Specialty
Copayment ..... Not covered

*There is no coverage available for specialty drugs through the plan

**Non-Participating Pharmacies are not covered.

Refer to the Prescription Drug Section for details on the Prescription Drug benefit.

Prescription coverage is through Precision Rx through APS
(800) 378-4025
www.myprecisionrxpharmacy.com