Medical Benefit Schedule - Click Here

Performance Advantage Plan

Plan	PAP Plan
Network	PHCS / Multiplan
Deductible *(Indv/Fam)*	$0 / $0
Maximum Out of Pocket *(Indv/Fam)*	$7,350 / $14,700
Preventive, Physician & Diagnostic Services	
Preventive & Wellness *(Non-Hospital Based)*	Included
Primary Care Office Visit *(Non-Hospital Based)*	$20 Copay *(6 visits per plan year)*
Specialist Office Visit *(Non-Hospital Based) (Includes Mental and Behavioral Health)*	$40 Copay *(6 visits per plan year)*
Urgent Care	$60 Copay *(3 visits per plan year)*
Telemedicine	$0 Copay *(Unlimited) SwiftMD*
Laboratory Services & Radiology *(Non-Hospital Based)*	$60 Copay *(6 visits per plan year)*
CT / MRI / MRA / PET Scan *(Non-Hospital Based) (Prior Auth. Required)*	$150 Copay[1] *(2 per plan year)*
Allergy Services	Not Covered
Hospital & Facility Services (Subject to Referenced Based Pricing)	
Inpatient Hospitalization *(Prior Auth. Required)*	$150 Copay per day up to $750 per stay *(6 days per plan year)*
Inpatient Visits - Physician	Included in IP Hospitalization Copay
Inpatient Surgery *(Prior Auth. Required)*	$500 Copay per stay *(2 surgeries per plan year)*
Outpatient Hospital or Free-Standing Facility Services and Surgery *(Prior Auth. Required)*	$500 Copay[1] *(1 visit per plan year)*
Anesthesia	Included in IP Hospitalization or OP Hospital or FSF Services and Surgery Copay *(2 IP and 1 OP per plan year)*
Emergency Room	$350 Copay[1] *(2 visit per plan year)*

Ambulance Service *(Ground Services Only)*	$500 Copay[1] *(2 per plan year)*
Second Surgical Opinion	$0 Copay
Pregnancy Benefits	
Professional Services	Not Covered
Maternity / Childbirth / Delivery *(Considered Inpatient Hospital Stay) (Prior Auth. Required)*	Not Covered
Other Services	
Home Health Care *(Prior Auth. Required)*	Not Covered
Hospice *(Prior Auth. Required)*	Not Covered
Treatment for Chemical Abuse & Dependency – Inpatient *(Prior Auth. Required)*	$60 Copay per Day[1] *(4 days per plan year)*
Treatment for Chemical Abuse & Dependency – Outpatient *(Prior Auth. Required)*	Coverage through SwiftMD
Chemotherapy / Radiation Therapy *(Prior Auth. Required) (Chemotherapy only includes infusion, not oral)*	Not Covered
Dialysis *(Prior Auth. Required)*	Not Covered
Rehabilitation / Habilitation Services *(Physical, Speech, and Occupational) (Prior Auth. Required)*	Not Covered
Transplant – Facility *(Prior Auth. Required)*	Not Covered
Transplant – Physician & Anesthesiologist Charges during IP Hosp. *(Prior Auth. Required)*	Not Covered
Pharmacy Benefits (Subject to Formulary)	
Preventive *(Generic Only)*	$0 Copay
Non-Preventive *(Retail)*	
Non-Preventive *(Mail Order)*	

[1] After Copay, benefit subject to Reference Based Pricing

1) These plans are **not traditional major medical insurance**. These are limited day benefit plans. These plans have exclusions and limitations not associated with major medical plans. Please review the Summary of Benefits for each plan for a description of coverage and a list of exclusions.
2) The benefit summaries in this material and any subsequent material ("Materials") are intended to be brief descriptions of the benefits. In the event there