# 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 is a conflict between Materials and the Summary Plan Description ("SPD") or Vendor specific policies, the SPD or Vendor specific policies will control.