WESTBROOK SERVICE CORPORATION HEALTH BENEFIT PLAN
Medical Summary of Benefits **Effective January 1, 2020**

Refer to the Medical Plan Document and Summary Plan Description for details of Coverage.

This Plan is an open access health plan for Hospitals / Facilities that does not restrict member access based on network affiliation. All non-Hospital services should be rendered by a PHCS PPO provider to receive the highest level of Benefits.

MEDICAL BENEFITS	Medical Care Coordinated through AIMM 877-269-6877	Base Medical Benefit
Member Calendar Year Deductible	\$0 per individual \$0 per family	\$3,000 per individual \$6,000 per family (accumulative)
	The Calendar Year deductible does NOT include Medical Plan Co-payments, Prescription Drug Co-payments, pre-certification penalties, non-covered expenses or charges in excess of the Plan Allowable rate.	
Plan Allowable	100% of Plan Allowable	80% of Plan Allowable
	Plan Allowable for Hospital / Facility charge is 140% of the Medicare allowable rate. Plan Allowable for all non-Hospital provider charges is 120% of Medicare allowable rate if provider is not in PHCS PPO Network.	
Member Out-of-Pocket Maximum	\$2,000 per individual \$4,000 per family (accumulative)	\$5,000 per individual \$10,000 per family (accumulative)
	Out-of-Pocket Maximum includes Medical Plan & Prescription Drug Co-payments, Calendar Year deductible and Member Plan Allowable. Pre-certification penalties, non-covered expenses & charges in excess of the Plan Allowable rate do not apply toward the Out-of-Pocket Maximum.	
Lifetime Maximum Benefit	Unlimited.	
Alcohol & Substance Abuse Treatment Inpatient confinement requires Pre-certification	**Inpatient / Partial Hospitalization:** 100% of Plan Allowable following a \$200 Co-payment when care is coordinated through AIMM. **Outpatient Services:** 100% of covered expenses following a \$50 Co-payment.	**Inpatient / Partial Hospitalization:** 80% of Plan Allowable; subject to Calendar Year deductible. **Outpatient Services:** 100% of covered expenses following a \$50 Co-payment.
Allergy Injections & Testing	100% of Plan Allowable.	
Ambulance Services	100% of Plan Allowable.	
Chiropractic Services / Spinal Manipulation	100% of Plan Allowable following a \$50 Co-payment per therapy session. Calendar Year maximum benefit of 26 visits; accumulates toward Outpatient Therapy Services maximum benefit.	
Dermatology Services	100% of Plan Allowable for one (1) annual dermatology office visit to include full body scan for skin cancer. A Specialist Office Visit Co-payment will apply if any additional services or minor surgical procedures are performed during office visit such as biopsies, cutting or freezing procedures.	
Durable Medical Equipment & Supplies	100% of Plan Allowable.	
Emergency Room Services	100% of Plan Allowable following a \$500 Co-payment. Emergency Room Co-payment will be waived if admitted to Hospital.	
Extended Care Facility Requires Pre-certification	100% of Plan Allowable when care is coordinated through AIMM.	80% of Plan Allowable; subject to Calendar Year deductible.
	Calendar Year maximum benefit of 60 days for Skilled Nursing Facility. Calendar Year maximum benefit of 30 days for inpatient Rehabilitation Facility.	
Home Health Care	100% of Plan Allowable.	
Hospice Care Requires Pre-certification	100% of Plan Allowable when care is coordinated through AIMM.	80% of Plan Allowable; subject to Calendar Year deductible.
Inpatient Hospital Services Includes Physician Services	100% of Plan Allowable following a \$200 Co-payment when care is coordinated through AIMM.	80% of Plan Allowable; subject to Calendar Year deductible.
	Inpatient admission requires Pre-certification.	
Maternity Care	**Initial Maternity Office Visit:** 100% of Plan Allowable following a \$25 Co-payment. **Pre-natal, Delivery and Post-natal Care:** 100% of Plan Allowable when care is coordinated through AIMM. **Inpatient Hospital Services:** 100% of Plan Allowable following a \$200 Co-payment when care is coordinated through AIMM.	**Initial Maternity Office Visit:** 100% of Plan Allowable following a \$25 Co-payment. **Pre-natal, Delivery, Post-natal Care and Inpatient Hospital Services:** 80% of Plan Allowable; subject to Calendar Year deductible.
Mental Health Services Inpatient admission requires Pre-certification	**Inpatient / Partial Hospitalization:** 100% of Plan Allowable following a \$200 Co-payment when care is coordinated through AIMM. **Outpatient Services:** 100% of covered expenses following a \$50 Co-payment.	**Inpatient / Partial Hospitalization:** 80% of Plan Allowable; subject to Calendar Year deductible. **Outpatient Services:** 100% of covered expenses following a \$50 Co-payment.

MEDICAL BENEFITS	Medical Care Coordinated through AIMM 877-269-6877	Base Medical Benefit
Outpatient Imaging Services Complex Imaging Services	100% of Plan Allowable when care is coordinated through AIMM.	80% of Plan Allowable; subject to Calendar Year deductible.
	Includes but is not limited to CT scans, MRI's, MRA's, PET scans and nuclear cardiology in any location, including the Physician's office.	
Outpatient Laboratory & X-Ray Services	100% of Plan Allowable.	
Outpatient Physician Office Visit Services Includes office visit charges, standard x-ray, minor surgical procedures, laboratory and diagnostic services performed in the Physician's office during the office visit.	▪ **Teladoc Visit:** 100% of covered expenses; Co-payment waived. ▪ **Convenience Care Clinic:** 100% of Plan Allowable following a $25 Co-payment. ▪ **Primary Care Office Visit:** 100% of Plan Allowable following a $25 Co-payment. ▪ **Specialist Office Visit:** 100% of Plan Allowable following a $50 Co-payment. ▪ **Urgent Care Provider:** 100% of Plan Allowable following a $50 Co-payment.	
	Refer to Outpatient Imaging Services benefit for complex imaging including CT scans, MRI's, MRA's and PET scans in any location, including the Physician's office.	
Outpatient Surgery	100% of Plan Allowable following a $100 Co-payment when care is coordinated through AIMM.	80% of Plan Allowable; subject to Calendar Year deductible.
Outpatient Therapy Services	100% of Plan Allowable. Referral from Physician not needed for first three (3) visits. Combined Calendar Year maximum of 35 visits for all therapy services including Physical Therapy, Speech Therapy, Occupational Therapy, Chiropractic Treatment and Cardiac Rehabilitation.	
Pre-Certification for Inpatient Hospital Admissions	Pre-admission certification is mandatory for inpatient Hospital Admissions. Emergency hospital admissions must be approved within 48 hours. Failure to comply will result in a $500 reduction of benefits due to pre-certification non-compliance.	
Prescription Drug Benefits ▪ Retail Prescriptions (90 day supply maximum; Co-pay listed applies to each 30 day supply filled) ▪ Mail Order Prescriptions (90 day supply maximum)	**Retail Network Pharmacy Co-payments:** ▪ Tier 1 - Low Cost Generics: $0 ▪ Tier 2 - Generics & Lower Cost Brand: $25 ▪ Tier 3 - Generics & High Cost Brand: $50 **Mail Order Prescription Co-payments:** ▪ Tier 1 - Low Cost Generics: $0 ▪ Tier 2 - Generics & Lower Cost Brand: $62.50 ▪ Tier 3 - Generics & High Cost Brand: $125.00	**Specialty / Injectible Prescription Co-pay:** $90 Co-payment per Prescription. Some Specialty Rx's may be available with a $0 Co-pay through US RxCare / Script Sourcing. Contact US RxCare to see if your Rx qualifies. Prescription medications purchased from Non-Participating Pharmacies are not eligible for reimbursement by the Plan.
Prosthetic Appliances	100% of Plan Allowable.	
Routine Colonoscopy (Age 50+)	100% of Plan Allowable.	
Routine Mammogram (Age 40+)	100% of Plan Allowable.	
Routine Well Adult Care (Age 18 and above)	100% of Plan Allowable. This routine benefit includes, but is not limited to, physician charges for an annual routine examination, routine x-rays and laboratory, immunizations and the routine services listed below: ▪ Immunizations. ▪ Fasting lipoprotein profile (cholesterol screening). ▪ Annual Prostate Specific Antigen (PSA) screening. ▪ Fasting blood sugar screening (for diabetes mellitus). ▪ Annual colorectal screening. ▪ Blood pressure screening. ▪ Obesity screening and counseling. ▪ Tobacco use screening and cessation interventions. ▪ Statin preventive medication ▪ Bone Mineral Density (BMD) screening (once every 24 months). ▪ Women's Health Services to include pelvic exam and Pap test; screening for gestational diabetes; DNA Testing; HPV (Human Papillomavirus); counseling for sexually transmitted infections; counseling and screening for human immunodeficiency virus; screening and counseling for interpersonal and domestic violence; breastfeeding support, supplies and counseling; sterilization; and contraceptive methods and counseling. Limitations may apply. **A complete list of covered ACA mandated routine services for women / adults is available at: https://www.healthcare.gov/coverage/preventive-care-benefits/**	
Routine Well Child Care (Birth through age 17)	100% of Plan Allowable. Includes Office Visit charges, immunizations, laboratory blood tests, developmental screening, behavioral assessments, routine vision screening & hearing screening for newborns. **A complete list of covered ACA mandated routine services for children is available at: https://www.healthcare.gov/coverage/preventive-care-benefits/**	
Transplant Benefit	100% of Plan Allowable.	80% of Plan Allowable; subject to Calendar Year deductible.
All Other Covered Medical Expenses	100% of Plan Allowable.	80% of Plan Allowable; subject to Calendar Year deductible.

Questions regarding Coverage / Benefits should be directed to:

Preferred Benefit Administrators
PO Box 916188
Longwood, FL 32791-6188
407-786-2777 or 888-524-2777
www.PreferredTPA.com

For Medical Care coordinated through AIMM call:

AIMM
877-269-6877