American Traveler Staffing Professionals Plus Benefit Plan

Effective December 1, 2020
Medical Schedule of Benefits
In-Network Benefits Only

This Preventive Plus Plan DOES NOT include coverage for services rendered by Non-PPO Network Providers. **This Plan is NOT a comprehensive major medical plan; however, it does provide Minimum Essential Coverage.** Covered services are limited to benefits listed below. Refer to the Plan Document and Summary Plan Description for details of Coverage.

Preventive Plan Benefits	First Health Limited Benefit PPO Network Providers (www.FirstHealthLBP.com)	
Calendar Year Deductible	This Plan does not contain a Calendar Year deductible.	
Out-of-Pocket Maximum	This Plan does not have an Out-of-Pocket Maximum. Members will be responsible for all charges incurred after applicable PPO discounts and benefits payable by this Plan are applied.	
Calendar Year Maximum Benefit	Unlimited.	
Lifetime Maximum Benefit	Unlimited.	
Emergency Room Benefit	100% coverage up to $100; maximum benefit of 1 (one) visit per Calendar Year.	
Inpatient Hospital Services	**Day 1:** 100% coverage up to $1,500 per day for Inpatient Hospital Services. **Day 2-5:** 100% coverage up to $1,000 per day for Inpatient Hospital Services.	
Outpatient Laboratory & X-Ray Benefit	100% coverage up to the maximum benefit specified below for each type of service provided: **Laboratory:** Up to $30; maximum of 2 (two) times per Calendar Year. **Radiology:** Up to $50; maximum of 2 (two) times per Calendar Year. **CT/PET:** Up to $100; maximum of 1 (one) time per Calendar Year. **MRI:** Up to $250; maximum of 1 (one) time per Calendar Year.	
Outpatient Physician Office Visit Services	**Telemedicine Visit:** 100% of covered expenses; Co-payment waived. **Primary Care Physician Office Visit / Walk-in Clinic:** 100% coverage up to $70 per visit following $10 Co-payment. ***** **Specialist Office Visit:** 100% coverage up to $70 per visit following $10 Co-payment. ***** ***** Combined Primary Care Physician Office Visit / Walk-in Clinic / Specialist Calendar Year maximum benefit of 3 (three) visits**.** **Urgent Care Provider:** 100% coverage up to $150 per visit following $10 Co-payment; Calendar Year maximum benefit payment of 3 (three) visits. The above Co-payment(s) include laboratory services performed in the Physician's office during the office visit. Co-payments DO NOT include x-ray/imaging or surgical procedures performed during the office visit. Refer to Outpatient Laboratory & X-Ray Benefit or Outpatient Surgical Procedures to determine if additional Co-payment(s) may apply.	
Prescription Drug Benefit	**Pharmacy Prescriptions** **Generic Drugs:** $10 Co-payment **Formulary Brand:** $30 Co-payment **Non-Formulary Brand:** $30 Co-payment	**Mail Order Prescriptions** **Generic Drugs:** $30 Co-payment **Formulary Brand:** $90 Co-payment **Non-Formulary Brand:** $90 Co-payment
	Monthly maximum prescription benefit of $100 for Generic drugs. Monthly maximum prescription benefit of $200 for Brand drugs.	
Preventive Care Services	The Plan will pay 100% of all ACA required Preventive Services. A complete list of covered ACA mandated routine services for women / adults is available at: **https://www.healthcare.gov/coverage/preventive-care-benefits/**	
Surgical Procedures	**Outpatient:** 100% coverage up to $1,000; Calendar Year maximum of 1 (one) surgery. **Inpatient:** 100% coverage up to $1,500; Calendar Year maximum of 1 (one) surgery.	

Questions regarding Coverage / Benefits should be directed to:

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Preferred BENEFIT ADMINISTRATORS INCORPORATED

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