Allco, Inc.

Script Care, Ltd.

Pharmacy Help Desk 1-800-880-9988
BIN # 021585 www.scriptcare.com

Rx Group No	**BAS6000**
Member ID	**SUBMIT CARDHOLDER SS**
Member Name	**#Type!**

REVERSE SIDE CONTAINS MEDICAL INFORMATION

Group Name: Allco, Inc.
Group Number: 6000
RMEC Plan

Benefit Administration Services, Ltd.

Providers: All claims or eligibility questions, visit: www.baslimited.com
Members: Call: 800-748-8696. Email: clientservice@baslimited.com

This card is for identification only, NOT FOR CERTIFICATION OF ELIGIBILITY. Please call Benefit Administration Services to check eligibility before any services are rendered.

Send all claims to:
Benefit Administration Services, Ltd
P.O. Box 21515
Eagan, MN 55121

PHCS

Network: PHCS/Multiplan
For a list of providers in your network, please call 888-263-7543 or visit www.multiplan.com

MEDICAL BENEFITS SCHEDULE-ALLCO, LLC.

PPO: PHCS 1-800-922-4362 **This group requires no pre-certification.**		
	NETWORK PROVIDERS	**NON-NETWORK PROVIDERS**
MAXIMUM CALENDAR YEAR BENEFIT AMOUNT	UNLIMITED	N/A
COPAYMENTS		
Physician visits – Limited to 4 Physician visits in a Calendar Year for each covered person.	$15	N/A
COVERED CHARGES ***Note: Benefits are payable as shown below. However, to the extent that a service is specifically described in the Summary of Benefits and Coverage and it is not specifically addressed below, benefits will be payable at the levels shown in the Summary of Benefits and Coverage.***		
Diagnostic Testing (Testing & Lab) Limited to one test per Calendar Year for each covered person for the following tests: • **Complete blood count** • **Comprehensive metabolic panel** • **Urinalysis** • **Basic metabollic panel (calcium total)** • **Creatine kinase**	100%	N/A
Preventive Care		
Routine Well Care	100%	N/A
Includes: 63 preventive services covered at 100% under the required Affordable Care Act (ACA) list of Preventive and Wellness Benefits when services are rendered by a network provider. See the "COVERED CHARGES" section of this document for a complete list of the required preventive services.		

PRESCRIPTION DRUG BENEFIT SCHEDULE

Pharmacy Option *(30 day supply)*

Copayment, per Prescription:

Generic Only……. $10

Generic prescriptions are limited to 24 prescriptions per covered person per calendar year.

All generic prescriptions are subject to a maximum cost of $100 per prescription. If a generic prescription drug cost exceeds the $100 maximum benefit, then the generic prescription drug will not be covered by the Plan.

The Affordable Care Act provides certain prescriptions at no cost to a Covered Person. Please contact the prescription drug company as indicated on your insurance identification card for more details.

Note: Specialty Drugs are not covered under the Plan.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

COVERED CHARGES

Covered Charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Physician Visit.** The charge associated with the consultation between a physician and a covered person to get health advice or treatment for a symptom or condition. Each covered person is limited to four physician office visits per Calendar Year. Tests, x-rays, injections, or other services rendered by a physician are **NOT COVERED** by the plan unless specifically listed in the plan document.

(2) **Laboratory studies.** Covered Charges for diagnostic lab testing and services for the following:

- Complete blood count
- Comprehensive metabolic panel
- Urinalysis
- Basic metabolic panel (calcium total)
- Creatine kinase

A covered person is eligible for each of the diagnostic lab testing and services listed above once per Calendar Year.

Charges for preventive lab testing and services will be covered as required by the Affordable Care Act.

(3) **Preventive Care.** Covered Charges under Medical Benefits are payable for Preventive Care as described in the Schedule of Benefits. Standard Preventive Care shall be provided as required by the Affordable Care Act if provided by a Network Provider.

(a) Covered Preventive Services for Adults (ages 18 and older):

- Abdominal Aortic Aneurysm one time screening for ages 65-75
- Alcohol Misuse screening and counseling
- Aspirin use for men ages 45-79 and women ages 55-79 to prevent cardiovascular disease when prescribed by a physician
- Blood pressure screening
- Cholesterol screening for adults
- Colorectal Cancer screening for adults starting at age 50 limited to one every 5 years
- Depression screening
- Type 2 Diabetes screening
- Diet counseling
- Human Immunodeficiency Virus (HIV) screening
- Immunizations and vaccines (Hepatitis A & B, Herpes Zoster, Human Papillomavirus, Influenza (flu shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diptheria, Pertussis, Varicella)
- Obesity screening and counseling
- Sexually Transmitted Infection (STI) prevention counseling

- Tobacco Use screening and cessation interventions
- Syphilis screening

(b) Covered Preventive Services for Women, Including Pregnant Women

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling and genetic testing for women at high risk
- Breast Cancer Mammography screenings every year for women age 40 and over
- Breast Cancer Chemo Prevention counseling for women
- Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
- Cervical Cancer screening
- Chlamydia Infection screening
- Contraception: Food and Drug Administration – approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
- Domestic and interpersonal violence screening and counseling for all women
- Folic Acid supplements for women who may become pregnant when prescribed by a physician
- Gestational diabetes screening
- Gonorrhea screening
- Hepatitis B screening for pregnant women
- Human Immunodeficiency Virus (HIV) screening and counseling
- Human Papillomavirus (HPV) DNA Test: HPV DNA testing every three years for women with normal cytology results who are 30 or older
- Osteoporosis screening over age 60
- Routine prenatal visits for pregnant women
- Rh Incompatibility screening for all pregnant women and follow-up testing
- Tobacco Use screening and interventions and expanded counseling for pregnant tobacco users
- Sexually Transmitted Infections(STI) counseling
- Syphilis screening
- Well-women visits to obtain recommended preventive services

(c) Covered Services for Children

- Alcohol and Drug Use assessments
- Autism screening for children limited to two screenings up to 24 months
- Behavioral assessments for children limited to 5 assessments up to age 17
- Blood Pressure screening
- Cervical Dysplasia screening
- Congenital Hypothyroidism screening for newborns
- Depression screening for adolescents age 12 and older
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children
- Fluoride Chemo Prevention supplements for children without fluoride in their water source when prescribed by a physician
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, Weight and Body Maxx Index measurements for children
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- Human Immunodeficiency Virus (HIV) screening for adolescents
- Immunization vaccines for children from birth to age 18; doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis, Hepatitis A & B, Human

Papillomavirus, Inactivated Poliovirus, Influenza (Flu shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus, Varicella, Haemophilus influenza type b

- Iron supplements for children up to 12 months when prescribed by a physician
- Lead screening for children
- Medical History for all children throughout development ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Obesity screening and counseling
- Oral Health risk assessment for young children up to age 10
- Phenylketonuria (PKU) screening in newborns
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents
- Tuberculin testing for children
- Vision screening for all children under the age of 5

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/recs/acip/
- www.uspreventiveservicestaskforce.org

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Abortion.** Services, supplies, care or treatment in connection with an abortion.

(2) **Acupuncture.**

(3) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for alcohol related preventive services, as specified in this Plan.

(4) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.

(5) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(6) **Educational or vocational testing.** Services for educational or vocational testing or training.

(7) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(8) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

(9) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary. For Plan Years beginning on or after January 1, 2014, this exclusion shall not apply to the extent that the charge is for a Qualified Individual who is a participant in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. The Plan shall not deny, limit or impose additional conditions on routine patient costs for items and services furnished in connection with participation in the clinical trial. However, this provision does not require the Plan to pay charges for services or supplies that are not otherwise Covered Charges (including, without limitation, charges which the Qualified Individual would not be required to pay in the absence of this coverage) or prohibit the Plan from imposing all applicable cost sharing and reasonable cost management provisions. For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Network Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

(10) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to services that may be covered under the covered services for children section of this Plan.

(11) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(12) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(13) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

(14) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

(15) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the covered services for children section of this Plan.

(16) **Home Health Care Services and Supplies.**

(17) **Hospice Care Services and Supplies.**

(18) **Hospital Care.**

(19) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(20) **Hypnosis.**

(21) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required.

(22) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician.

(23) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence.

(24) **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization.

(25) **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.

(26) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(27) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

(28) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday.

(29) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(30) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(31) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(32) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals.

(33) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

(34) **Other Medical Services and Supplies.** These services and supplies are not covered:

(a) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions.

(c) **Cardiac rehabilitation.**

(d) Radiation or **chemotherapy** and treatment with radioactive substances.

(e) Initial **contact lenses** or glasses required following cataract surgery.

(f) Rental of **durable medical or surgical equipment.**

(g) Care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome (TMJ)**.

(h) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services except as may be covered under the Covered Charges section of this Plan.

(i) Treatment of **Mental Disorders and Substance Abuse**, except as may be covered under the Covered Charges Section of this Plan.

(j) Injury to or care of **mouth, teeth and gums**.

(k) **Occupational therapy.**

(l) **Organ transplants.**

(m) **Orthotic appliances** such as braces, splints or other appliances.

(n) **Physical therapy.**

(o) **Prosthetic devices.**

(p) **Reconstructive Surgery.**

(q) **Speech therapy.**

(r) **Spinal Manipulation services.**

(s) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(t) Charges associated with the initial purchase of a **wig after chemotherapy**.

(u) Diagnostic **X-rays**.

(35) **Personal comfort items.**

(36) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(37) **Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy, except as may be covered under the Covered Charges section of this Plan.

(38) **Private Duty Nursing Care.**

(39) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(40) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs.

(41) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.

(42) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury.

(43) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(44) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(45) **Skilled Nursing Facility Care.**

(46) **Sleep disorders.** Care and treatment for sleep disorders.

(47) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent products, except as may be covered under the Covered Charges Section of this Plan.

(48) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(49) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician.

(50) **War.** Any loss that is due to a declared or undeclared act of war.