ULTRA ADVANTAGE	ULTRA MEC	ULTRA MVP	
PPO Provider Search	PHCS	Cigna.	Cigna.
SBC	SBC Medical Benefit Schedule Click Here	SBC	SBC
RX - FORMULARY	US-Rx Care	Maxor NATIONAL PHARMACY SERVICES	Maxor NATIONAL PHARMACY SERVICES
Plan Availability	All 50 States	All 50 States	All 50 States
Enrollment Deadline	20th of month Prior to Effective date	20th of month Prior to Effective date	20th of month Prior to Effective date
Deductible	$0/$0	$0/$0	$0/$0
Max out of pocket	$7,350/ $14,700	$7,350/ $14,700	$5,000/ $10,000
Coinsurance			
Primary	$20	$25 Not covered if provided at a hospital. Limited to 6 visits per plan year.	$15 Not covered if provided at a hospital. Limited to 12 visits per plan year.
Specialist	$40	$50 Not covered if provided at a hospital. Limited to 6 visits per plan year.	$25 Not covered if provided at a hospital. Limited to 12 visits per plan year.
Urgent Care	$60	$50 copay/visit Not covered if provided at a hospital. Limited to 2 visits per plan year.	$35 copay/visit Not covered if provided at a hospital. Limited to 3 visits per plan year.
Preventive Care	Covered 100%	0% coinsurance Not covered if provided at a hospital. You may have to pay for services that	0% coinsurance Not covered if provided at a hospital. You may have to pay

		aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Limited to 1 visit per year. Subject to plan allowable.	for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Limited to 1 visit per year. Subject to plan allowable.
Diagnostic Test (1)	Deductible then 20%	Independent Lab and X-Ray: $50 copay/visit Independent lab, does not include services provided in physician s office or hospital. Limited to 3 visits per year.	Independent Lab and X-Ray: $50 copay/visit Independent lab, does not include services provided in physician s office or hospital. Limited to 4 visits per year.
CT, PET, MRI's up to plan allowance	$150 copay 2 per year (Subject to Maximum Plan Allowable)	$350 copay (Subject to Maximum Plan Allowable) Not covered if services are provided at a hospital. Limited to 1 per plan year. Preauthorization is required.	$350 copay (Subject to Maximum Plan Allowable) Not covered if services are provided at a hospital. Limited to 3 per plan year. Preauthorization is required.
Hospitalization	$150 copay per day up to $750 per stay (Subject to Maximum Plan Allowable)	$350 copay (Subject to Maximum Plan Allowable) Limited to 3 days per plan year. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician s office) will be subject to reference based pricing reimbursements based on the Medicare reimbursement rate. Preauthorization is required.	$350 copay (Subject to Maximum Plan Allowable) Limited to 10 days per plan year. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician s office) will be subject to reference based pricing reimbursements based on the Medicare reimbursement rate. Preauthorization is required.
Emergency Room	$350 copay (Subject to Maximum Plan Allowable)	$350 copay (Subject to Maximum Plan Allowable) Limited to 1 visit per plan year. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician s office) will be subject to reference based pricing reimbursements based on the Medicare reimbursement rate.	$350 copay (Subject to Maximum Plan Allowable) Limited to 2 visits per plan year. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician s office) will be subject to reference based pricing reimbursements based on the Medicare reimbursement rate.

Emergency Medical Transport	$500 copay (Subject to Maximum Plan Allowable)	$250 copay (Subject to Maximum Plan Allowable) By land only. Limited to 1 transport per plan year	$250 copay (Subject to Maximum Plan Allowable)
Mental health outpatient	Coverage through SwiftMD	$25 copay/visit Not covered if provided at a hospital. Limited to 6 visits per plan year.	$25 copay/visit Not covered if provided at a hospital. Limited to 12 specialists visits and 10 non-specialist visits per plan year. Preventive services are covered for mental, behavioral health or substance abuse. Cost sharing does not apply for preventive services.
Mental health inpatient	$60 copay 4 days per year (Subject to Maximum Plan Allowable)	$350 copay (Subject to Maximum Plan Allowable) Limited to 3 days per plan year. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician s office) will be subject to reference based pricing reimbursements based on the Medicare reimbursement rate. Preauthorization is required.	$250 copay (Subject to Maximum Plan Allowable) Limited to 10 days per plan year. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician s office) will be subject to reference based pricing reimbursements based on the Medicare reimbursement rate. Preauthorization is required.
Maternity	Not covered	Not covered	$350 copay per admission (Subject to Maximum Plan Allowable) Professional Services only, including standard office visits.
Home Health Care	Not covered	$25 copay Limited to 5 visits per plan year. Preauthorization is required.	$25 copay Limited to 20 visits per plan year. Preauthorization is required.
Rehab/ Habilitative Service	Not covered	$50 copay Combined limit of 6 visits per plan year with physical, speech, and occupational therapies.	$50 copay Combined limit of 12 visits per plan year with physical, speech, and occupational therapies.
Skilled Nursing	Not covered	Not covered	Not covered

Durable medical equipment	Not covered	Not covered	Not covered
Hospice Services	Not covered	Not covered	Not covered
OUT OF NETWORK			
Deductible			
MOOP			
Coinsurance			
Reimbursement			
RX			
RX	**Generic** $0 copay/prescription for retail **Not Covered** Preferred Non-Preferred Specialty	**Generic** $10 copay/prescription for retail **Not Covered** Preferred Non-Preferred Specialty	**Generic** 20% copay /prescription for retail **Not Covered** Preferred Non-Preferred Specialty

Monthly Premium: There is an added $50 a month to the premiums amount below when you are checking out. This is for the FIG Health Telehealth plans. Please see separate attachment for details.

PW ULTRA MVP

$682.00 + $50.00 (FIG Health Telehealth Bundle) =$732.00 (Member Only)
$1,161.00 + $50.00 =$1,211.00 (Member+ Spouse)
$992 + $50.00 = $1,042 (Member+Child(ren)
$1,448.00+ $50.00= $1,498.00 (Family)

PW ULTRA MEC

$527.00+$50.00=$577.00 (Member Only)
$850.00+$50.00=$900.00 (Member+Spouse)
$765+ $50.00=$815.00 (Member+Child(ren)
$1,027.00+ $50.00=$1,077.00 (Family)

PW Ultra Advantage MEC PHCS

$481.00+$50.00=$531.00 (Member Only)
$780.00+$50.00=$830.00 (Member+Spouse)
$686+ $50.00=$736.00 (Member+Child(ren)
$1,032+$50.00=$1,082.00 (Family)