American Plan ADMINISTRATORS

Employee Benefit Summary

Tender Touch Rehab – Base Plan

Covered Benefits	In-network	Out-of-network
FINANCIAL		
Maximum Annual Benefits	Unlimited	Unlimited
Annual Deductible	$2,000 per Individual $4,000 per Family	$10,000 per Individual $20,000 per Family
Coinsurance	We pay 70% and you Pay 30%	We pay 50% and you Pay 50% Allowed amounts are based on 100% of the Medicare Fee Schedule
Maximum Out-Of- Pocket (100% after limit)	$6,000 per Individual $12,000 per Family	$20,000 per Individual (including deductible) $40,000 per Family (including deductible)
INPATIENT SERVICES		
***Semi-private room and Board** **All drugs and medications** **Anesthesia** ***Intensive Care & Coronary Units**	Subject to Deductible & Coinsurance *Base coverage 90 days Single Hospital confinement*	Subject to Deductible & Coinsurance *Base coverage 90 days Single Hospital confinement*
***Maternity**	Subject to Deductible & Coinsurance *Base coverage 90 days Single Hospital confinement*	Subject to Deductible & Coinsurance *Base coverage 90 days Single Hospital confinement*
***Routine Nursery Care**	Subject to Deductible & Coinsurance *Base coverage 90 days Single Hospital confinement*	Subject to Deductible & Coinsurance *Base coverage 90 days Single Hospital confinement*
***Skilled Nursing Facility Care**	Subject to Deductible & Coinsurance *Maximum of 60 days per Calendar year*	Subject to Deductible & Coinsurance *Maximum of 60 days per Calendar year*
***Hospice Care (in-patient/in-home)**	Subject to Deductible & Coinsurance *Maximum of 30 days per Calendar year*	Subject to Deductible & Coinsurance *Maximum of 30 days per Calendar year*
***Inpatient Admission for Medical Rehabilitation (i.e., Physical Therapy, Physical Medicine and Rehabilitation)**	Subject to Deductible & Coinsurance *Maximum of 30 days per Calendar year*	Subject to Deductible & Coinsurance *Maximum of 30 days per Calendar year*
*** Organ Transplants**	Subject to Deductible & Coinsurance *Base coverage 90 days Single Hospital confinement*	Covered only at our approved facility
OUTPATIENT SERVICES		
Pre-Admission Testing	Subject to Deductible & Coinsurance	Subject to Deductible & Coinsurance
***Ambulatory Surgery**	Subject to Deductible & Coinsurance	Subject to Deductible & Coinsurance
***Outpatient Dialysis**	Subject to Deductible & Coinsurance *Maximum of 156 visits per calendar year*	Subject to Deductible & Coinsurance *Maximum of 156 visits per calendar year*
***Home Health Care Services**	*Subject to Deductible & Coinsurance* *Maximum of 40 visits per calendar year*	Subject to Deductible & Coinsurance *Maximum of 40 visits per calendar year*
MEDICAL		
Home, Office and I/P hospital physician visits	$20 Copay (deductible does not apply)	Subject to Deductible & Coinsurance
Prenatal and post-natal care	$20 Copay (deductible does not apply)	Subject to Deductible & Coinsurance
Routine Adult Physical (one per year)	No Charge	Subject to Deductible & Coinsurance
Preventive Mammography and Pap Smear Screening	No Charge	Subject to Deductible & Coinsurance
Preventive Prostate Screening	No Charge	Subject to Deductible & Coinsurance
Well Baby and Well Child Care up to age 19 Includes: Routine physical examinations, laboratory tests, vision & hearing Screening and routine immunizations	No Charge	Subject to Deductible & Coinsurance

Specialist office visits	$20 Copay (deductible does not apply)		Subject to Deductible & Coinsurance
Allergy Care	$40 Copay (deductible does not apply) *Maximum of 36 visits per calendar year*		Subject to Deductible & Coinsurance *Maximum of 36 visits per calendar year*
Chiropractic Care	$40 Copay (deductible does not apply) *Maximum of 30 visits per calendar year*		Subject to Deductible & Coinsurance *Maximum of 30 visits per calendar year*
Physical Therapy, Osteopathic Manipulation, Occupational Therapy Benefits are covered only at a freestanding P/T Center. P/T performed at an Outpatient hospital is not covered.	$40 Copay (deductible does not apply) *Maximum of 30 combined visits per calendar year*		Subject to Deductible & Coinsurance *Maximum of 30 combined visits per calendar year*
Speech Therapy	$40 Copay (deductible does not apply) *Maximum of 15 visits per calendar year*		Subject to Deductible & Coinsurance *Maximum of 15 visits per calendar year*
LAB & RADIOLOGY			
Diagnostic Lab Tests	No Charge/office based $150 copay/hospital		Subject to Deductible & Coinsurance
***High Tech Radiology (e.g., CT Scan, MRI)** **X-rays**	$100 Copay (deductible does not apply)/office based $500 Copay (deductible does not apply)/hospital No charge/office based $300 Copay (deductible does not apply)/hospital		Subject to Deductible & Coinsurance
EMERGENCY COVERAGE			
Emergency Care	$300 Copay (deductible does not apply)		$300 Copay (deductible does not apply) Coverage is based on the in-network allowance
Freestanding Urgent Care Facility	$50 Copay (deductible does not apply)		Subject to Deductible & Coinsurance
Non-Urgent Emergency Room Visits	Not Covered		Not Covered
Ambulance (Emergency ground transportation only)	Subject to Deductible & Coinsurance		Subject to Deductible & Coinsurance
ER professional charges	No Charge		No Charge Coverage is based on the in-network allowance
OTHER SERVICES			
Prosthetic Devices and Durable Medical Equipment	Subject to Deductible & Coinsurance		Subject to Deductible & Coinsurance
*** Home Infusion Therapy**	Subject to Deductible & Coinsurance		Subject to Deductible & Coinsurance
Routine Eye Exam	No charge One exam per 24 months		Subject to Deductible & Coinsurance One exam per 24 months
Vision Eyewear - One pair in 24 month period **Benefit is limited to the member and spouse only**	No charge – up to $100		No charge – up to $100
MENTAL HEALTH & CHEMICAL DEPENDENCY			
***Inpatient Mental Health**	Subject to Deductible & Coinsurance *Base coverage 90 days Single Hospital confinement*		Subject to Deductible & Coinsurance *Base coverage 90 days Single Hospital confinement*
***Outpatient Mental Health**	$40 Copay (deductible does not apply)		Subject to Deductible & Coinsurance
*** Inpatient Chemical Dependency treatment**			
Detoxification	Subject to Deductible & Coinsurance *Maximum of 7 days per Calendar year*		Subject to Deductible & Coinsurance *Base coverage 7 days Single Hospital confinement*
Rehabilitation	Subject to Deductible & Coinsurance *Maximum of 30 days per Calendar year*		Subject to Deductible & Coinsurance *Maximum of 30 days per Calendar year*
***Outpatient Chemical Dependency treatment**	$40 Copay (deductible does not apply)		Subject to Deductible & Coinsurance
PRESCRIPTION DRUGS			
	Retail – 30 day supply	**Mail Order – 90 day supply** *Required for maintenance drugs after filling three times at a retail pharmacy * $100 surcharge applies for employee that continues to fill scripts that are covered by CanRx.	
Generic	$20 copay	$40 Copay	Not Covered
Preferred Brand	$40 Copay	$80 Copay	Not Covered
Non-preferred Brand	$60 Copay	$120 Copay	Not Covered
Specialty Drugs	30% Coinsurance	30% Coinsurance	Not Covered

*** These services require precertification.**

The maximums listed above are the total for Network & Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year Maximum is 60 days total, which may be split between Network & Non-Network providers.

Dependent children are covered to age 26.

General Exclusions
You are not covered for physical exams for employment, insurance, school, premarital requirement or summer camp (unless substituted for a normal well visit/physical exam); prescription drugs prescribed for a non-covered service; dental services; hearing aid appliances; routine foot care; some transplant procedures; cosmetic or reconstructive surgery, unless medically necessary; custodial services; Fertility treatment; weight-reduction programs and Bariatric surgery for any reason; marriage counseling