LINDSEY WILSON COLLEGE – PLAN YEAR 2024

MEDICAL SCHEDULE OF BENEFITS – CORE PLAN

	NETWORK	NON-NETWORK
Lifetime Maximum Benefit	Unlimited	Unlimited
Annual Deductible (Single/Family)[1] The Family Amount Can Be Any Combination Of Family Members But An Individual Would Never Satisfy More Than Their Own Individual Amount. Deductibles Apply to Out-of-Pocket Maximum	$2,500/$5,000	$5,000/$10,000
Maximum Out-Of-Pocket (Single/Family)[2] The Family Amount Can Be Any Combination Of Family Members But An Individual Would Never Satisfy More Than Their Own Individual Amount. Maximum Excludes: • Cost Containment Penalties • Exclusions and Limitations • Charges in Excess of Maximum Allowed Amount • Non-Network Transplant Services	$4,000/$8,000	$8,000/$16,000
COVERED BENEFITS		
PHYSICIAN SERVICES		
Physician Office Services (PCP/Specialist)	$30/$60 Copayment	40% After Deductible
• Allergy Serum[3]	20% After Deductible	40% After Deductible
• Allergy Injection[4]	$5 Copayment	40% After Deductible
• Allergy Testing	20% After Deductible	40% After Deductible
• Imaging Services (MRI, MRA, PETS, C-SCAN)	20% After Deductible	40% After Deductible
• Diagnostic Test (Lab and X-Ray) -Billed with OV	$30/$60 Copayment	40% After Deductible
• Routine Vision Exam (Limited to one per year)	$30/$60 Copayment	40% After Deductible
Contracted Providers with T.J. Samson • Primary Care Services	No Cost Share	N/A
Preventive Care Services Office Visit Copayment Services include, but are not limited to: • Routine Exams (PCP/Specialist) • Colonoscopy • Contraceptives • Mammogram • PAP/PSA Testing • Immunizations • Annual Diabetic Eye Exam • Diabetic Education • PCP Vision/Hearing Screening • Breast Pumps – 1 Pump/Pregnancy[5]	No Cost Share	40% After Deductible
Live Health Online	$10 Copayment	40% After Deductible
Telehealth Services (PCP/SPC)	$30/$60 Copayment	40% After Deductible

COVERED BENEFITS		
FACILITY SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Behavioral Health & Substance Use Disorders Covered As Outlined In The Medical Benefits Section • Inpatient Facility Services • Inpatient Professional Services • Other Outpatient Services	 20% After Deductible 20% After Deductible 20% After Deductible	 40% After Deductible 40% After Deductible 40% After Deductible
Emergency Room Covered As Outlined In The Medical Benefits Section • Emergency Room Services • Emergency Room Physician • Non-Emergent Emergency Room Services	 $200 Copayment No Cost Share Not A Covered Benefit	 Covered as In-Network Covered as In-Network Not A Covered Benefit
NOTE: Copayment Waived If Admitted To Hospital.		
Hospice Care Covered As Outlined In The Medical Benefits Section	No Cost Share	No Cost Share
Hospital Inpatient Services **Precertification Required** Covered As Outlined In The Medical Benefits Section • Room & Board (Semiprivate or ICU/CCU) • Hospital Services & Supplies **Inpatient Hospital Professional Services** • Assistant Surgeon • Anesthesiologist • Radiologist • Pathologist	 20% After Deductible 20% After Deductible 20% After Deductible	 40% After Deductible 40% After Deductible 40% After Deductible
NOTE: The In-Network Benefit Applies To Non-Network Providers In The Following Situations: • Professional Services (Radiologist, Pathologist or Anesthesiologist) When Services Are Rendered At An In-Network Facility • Services Are Not Available At An In-Network Facility/Provider • Covered Individuals Traveling Outside The United States • Medical Emergency Treatment • Diagnostic Procedures Performed In An In-Network Physician's Office & Sent To An Outside Diagnostic Facility For Evaluation		
Inpatient Facility Services (Other Than Hospital) Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
NOTE: Skilled Nursing Facility Has A 90 Day Calendar Year Maximum Benefit Combined In-Network & Non-Network. Inpatient Physical Medicine & Rehabilitation Has A 60 Day Calendar Year Maximum Benefit Combined In-Network & Non-Network.		
Outpatient Surgery/Alternative Care Facility Covered As Outlined In The Medical Benefits Section Services Include, But Not Limited To: • Surgery • Administration of General Anesthesia	20% After Deductible	40% After Deductible
NOTE: The In-Network Benefit Applies To Non-Network Providers In The Following Situations: • Professional Services (Radiologist, Pathologist or Anesthesiologist) When Services Are Rendered At An In-Network Facility • Services Are Not Available At An In-Network Facility/Provider • Covered Individuals Traveling Outside The United States • Medical Emergency Treatment • Diagnostic Procedures Performed In An In-Network Physician's Office & Sent To An Outside Diagnostic Facility For Evaluation		
Urgent Treatment Center • Urgent Treatment Center Services[6]	$50 Copayment	Covered as In-Network

COVERED BENEFITS		
SPECIALIZED SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Abortion (Medically Necessary) Covered As Outlined In The Medical Benefits Section		
• Physician Office Visit Copayment (PCP/SPC)	$30/$60 Copayment	40% After Deductible
• Other Place Of Service	20% After Deductible	40% After Deductible
Accidental Dental Injury Covered As Outlined In The Medical Benefits Section		
• Physician Office Visit Copayment (PCP/SPC)	$30/$60 Copayment then 20% After Deductible	40% After Deductible
• Other Place Of Service	20% After Deductible	40% After Deductible
Ambulance Services (Land / Air) Covered As Outlined In The Medical Benefits Section	20% After Deductible	Covered as In-Network
Attention Deficit Disorder (ADD) **Attention Deficit Hyperactivity Disorder (ADHD)** Covered As Outlined In The Medical Benefits Section		
• Physician Office Visit Copayment (PCP/SPC)	$30/$60 Copayment then 20% After Deductible	40% After Deductible
• Other Place Of Service	20% After Deductible	40% After Deductible
Autism (ages 1-21) Covered As Outlined In The Medical Benefits Section		
• Physician Office Visit Copayment (PCP/SPC)	$30/$60 Copayment, then 20% After Deductible	40% After Deductible
• Other Place Of Service	20% After Deductible	40% After Deductible
Bariatric Surgery/Morbid Obesity	Not A Covered Benefit	Not A Covered Benefit
Behavioral Health & Substance Use Disorders Covered As Outlined In The Medical Benefits Section		
• Physician Office Visit Copayment (PCP/SPC)	$30 Copayment	40% After Deductible
• Other Place Of Service	20% After Deductible	40% After Deductible
Cardiac Rehabilitation Therapy Covered As Outlined In The Medical Benefits Section		
• Physician Office Visit Copayment (PCP/SPC)	$30/$60 Copayment	40% After Deductible
• Other Place Of Service	20% After Deductible	40% After Deductible
NOTE: Cardiac Rehab Has A 36 Visit Calendar Year Maximum Benefit Combined In-Network & Non-Network.		
Chemotherapy/Infusion Therapy Covered As Outlined In The Medical Benefits Section		
• Physician Office Visit Copayment (PCP/SPC)	$30/$60 Copayment, then 20% After Deductible	40% After Deductible
• Other Place Of Service	20% After Deductible	40% After Deductible
Chiropractic/Spinal Manipulation Covered As Outlined In The Medical Benefits Section	$30 Copayment	40% After Deductible
NOTE: Chiropractic/Spinal Manipulation Has A 12 Visit Calendar Year Maximum Benefit Combined In-Network & Non-Network.		

COVERED BENEFITS		
SPECIALIZED SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Hearing Exams (Non-Routine) Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30/$60 Copayment 20% After Deductible	 40% After Deductible 40% After Deductible
Hearing Aid Services/Cochlear Implants Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
NOTE: Hearing Aids Are Limited To One Hearing Aid Per Hearing Impaired Ear Every 36 Months For Dependents To Age 18.		
Home Health Care Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
NOTE: Home Health Care Has A 90 Visit Calendar Year Maximum Benefit Combined In-Network & Non-Network.		
Infertility Services/Treatment	Not A Covered Benefit	Not A Covered Benefit
Inpatient & Outpatient Professional Services Covered As Outlined In The Medical Benefits Section Services Include, But Not Limited To: • Medical Care Visit (One Per Day) • Intensive Medical Care • Concurrent Care • Surgery • Anesthesia Administration • Newborn Exams	20% After Deductible	40% After Deductible
NOTE: The In-Network Benefit Applies To Non-Network Providers In The Following Situations: • Professional Services (Radiologist, Pathologist or Anesthesiologist) When Services Are Rendered At An In-Network Facility • Services Are Not Available At An In-Network Facility/Provider • Covered Individuals Traveling Outside The United States • Medical Emergency Treatment • Diagnostic Procedures Performed In An In-Network Physician's Office & Sent To An Outside Diagnostic Facility For Evaluation		
Maternity/Pregnancy Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30/$60 Copayment 20% After Deductible	 40% After Deductible 40% After Deductible
NOTE: Dependent Daughters Are Covered.		
Medical Supplies and Equipment Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
Nutritional Counseling (Non-Diabetic) Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30/$60 Copayment 20% After Deductible	 40% After Deductible 40% After Deductible

COVERED BENEFITS		
SPECIALIZED SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Occupational Therapy Covered As Outlined In The Medical Benefits Section		
• Physician Office Visit Copayment (PCP/SPC)	$30 Copayment	40% After Deductible
• Other Place of Service	$30 Copayment	40% After Deductible
NOTE: Occupational Therapy Has A 20 Visit Calendar Year Maximum Benefit Combined In-Network & Non-Network. Not Combined With Any Other Therapies.		
Oral Surgery Covered As Outlined In The Medical Benefits Section		
• Physician Office Visit Copayment (PCP/SPC)	$30/$60 Copayment	40% After Deductible
• Other Place Of Service	20% After Deductible	40% After Deductible
Organ Transplant Services [7] Covered As Outlined In The Transplant Benefit Section	No Cost Share	50% After Deductible
Orthotic/Prosthetic Devices Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
Physical Therapy Covered As Outlined In The Medical Benefits Section		
• Physician Office Visit Copayment (PCP/SPC)	$30 Copayment	40% After Deductible
• Other Place Of Service	$30 Copayment	40% After Deductible
NOTE: Physical Therapy Has A 20 Visit Calendar Year Maximum Benefit Combined In-Network & Non-Network. Not Combined With Any Other Therapies.		
Private Duty Nursing Covered Only With Home Health Care Benefit	20% After Deductible	40% After Deductible
NOTE: Private Duty Nursing Has A 90 Visit Calendar Year Maximum Benefit Combined In-Network & Non-Network.		
Respiratory Therapy Covered As Outlined In The Medical Benefits Section		
• Physician Office Visit Copayment (PCP/SPC)	$30/$60 Copayment, then 20% After Deductible	40% After Deductible
• Other Place Of Service	20% After Deductible	40% After Deductible
NOTE: Respiratory Therapy Has A 20 Visit Calendar Year Maximum Benefit Combined In-Network & Non-Network.		
Sleep Disorder Therapy Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
Speech Therapy Covered As Outlined In The Medical Benefits Section		
• Physician Office Visit Copayment (PCP/SPC)	$30 Copayment	40% After Deductible
• Other Place Of Service	$30 Copayment	40% After Deductible
NOTE: Speech Therapy Has A 20 Visit Calendar Year Maximum Benefit Combined In-Network & Non-Network. Not Combined With Any Other Therapies. Developmental Delays Are Not Covered.		

COVERED BENEFITS		
SPECIALIZED SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Sterilization (Reversal Excluded) Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30/$60 Copayment 20% After Deductible	 40% After Deductible 40% After Deductible
NOTE: Female Participants Covered At 100% Per ACA Guidelines.		
Temporomandibular Joint Dysfunction (TMJ) Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
Tobacco Cessation Programs Covered As A Standard Preventive Care Benefit Through A Network Provider	No Cost Share	Not A Covered Benefit
Vision Exams (Non-Routine) Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30/$60 Copayment 20% After Deductible	 40% After Deductible 40% After Deductible

COVERED BENEFITS		
PRESCRIPTION DRUGS	**YOUR COST SHARE RESPONSIBILITY**	
Retail Pharmacy (30-Day Supply) Generic Formulary Brand Name Non-Formulary Brand Name	 $10 Copayment $30 Copayment $60 Copayment	 50% Coinsurance, Minimum $60 Copayment
Direct Mail Service (90-Day Supply) Generic Formulary Brand Name Non-Formulary Brand Name	 $20 Copayment $75 Copayment $150 Copayment	 Not A Covered Benefit
Specialty Drugs (Retail & Mail) **Separate Max Out-of-Pocket $1,500**	Covered At 100% If Prudent Rx Is Used; 30% Coinsurance If Prudent Rx Is Not Used	Not A Covered Benefit
NOTE: The Covered Individual's Prescription Drug Copayments Will Apply To The Plan's Out-Of-Pocket Maximum. Covered Prescriptions Will Be Reimbursed At 100% Once The Out-Of-Pocket Maximum Is Met. Please Refer To The Plan Document For Full Disclosure On The Prudent Rx Program.		

COVERED BENEFITS		
HUMAN ORGAN TRANSPLANTS (BLUE DISTINCTION CENTER)		
Transplant Services – Human Organ & Tissue Transplant Covered As Outlined In The Transplant Benefits Section Any Medically Necessary Human Organ & Stem Cell/Bone Marrow Transplant And Transfusion As Determined By The Claims Administrator, Including Necessary Acquisition Procedures, Harvest And Storage, Including Medically Necessary Preparatory Myeloablative Therapy. A Blue Distinction Center Requirement Does Not Apply To Cornea Or Kidney Transplants, Or For Any Covered Charges Related To A Covered Transplant Procedure Prior To Or After The Transplant Benefit Period.		
NOTE: Even If A Hospital Is A Network Provider For Other Services, It May Not Be A Network Transplant Provider For These Services. Prior To Seeking Care Please Contact Aspirant Care Coordination At (855) 984-2583 To Determine Which Hospitals Are Network Transplant Providers.		
TRANSPLANT BENEFIT	**IN-NETWORK**	**NON-NETWORK**
	YOUR COST SHARE RESPONSIBILITY	
Transplant Benefit	No Cost Share	50% After Deductible
Transplant Benefit – Blue Distinction Center Facility	No Cost Share	Not A Covered Benefit
Transportation & Lodging Covered As Outlined In The Transplant Benefits Section	No Cost Share	50% After Deductible
NOTE: **$10,000 Maximum Benefit Per Transplant.** The Plan Will Provide Assistance With Reasonable And Necessary Travel Expenses As Determined By The Plan When You Obtain Prior Approval And Are Required To Travel More Than 75 Miles From Your Residence To Reach The Facility Where The Covered Transplant Procedure Will Be Performed. Assistance With Travel Expenses Includes Transportation To And From The Facility And Lodging For The Transplant Recipient And One Adult Companion For An Adult Transplant Recipient Or Two Adult Companions For A Child Transplant Recipient Under Age 18. The Member Must Submit Itemized Receipts For Transportation And Lodging Expenses In A Form Acceptable To The Plan. Internal Revenue Service (IRS) Guidelines Will Be Applied In Determining Which Expenses May Be Paid By The Plan.		
Donor Searches Donor Benefits Are Limited To Benefits Not Available To The Donor From Any Other Source.	No Cost Share	50% After Deductible
NOTE: **$30,000 Maximum Benefit Per Transplant.** Medically Necessary Charges For Procurement Of An Organ From A Live Donor Are Covered To The Maximum Allowable Amount Including Complications From The Donor Procedure For Up To Six Weeks From The Date Of Procurement. Kidney And Cornea Transplants Are Covered The Same As Any Other Illness And Not Covered Under The Transplant Benefits.		
All Other Transplant Services Covered As Outlined In The Transplant Benefits Section	No Cost Share	50% After Deductible

Benefit Schedule Notes:

All Copayments Are Included in The Out-Of-Pocket Limits.

Cost Containment Penalties and Non-Network Transplant Services are excluded for the Out-Of-Pocket Limits.

Deductibles apply only to Covered Medical Services listed with a Coinsurance Percentage and do not apply where a fixed dollar copayment is required unless otherwise denoted.

Network and Non-Network Deductibles, Coinsurance and Out-of-Pocket Maximums are separate and accumulate separately.

Dependent Coverage to the end of the birthdate month in which Child attains age 26.

No Deductible/Coinsurance means No Cost Share up to the Maximum Allowable Amount.

PCP Is a Network Provider who is a Practitioner that specializes in Family Practice, General Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology, Geriatrics or Any Other Network Provider as allowed by The Plan.

SCP Is a Network Provider, other than a Primary Care Physician (PCP), who provides services within a designated Specialty Area of Practice.

All Specialty Medications must be obtained via the Specialty Pharmacy network in order to receive network level benefits.

Benefit Period is on a Calendar Benefit Year Basis beginning January 1st and ending December 31st.

[1] Charges in excess of the Maximum Allowed Amount do not contribute to the deductible. Deductible Amounts accumulate separately for In-Network and Out-of-Network.

[2] Out-of-Pocket amounts accumulate separately for In-Network and Out-of-Network Charges.

[3] Allergy Serum is subject to deductible and coinsurance when billed alone. When billed in conjunction with an In-Network Physician Office Visit then only the Office Visit copayment applies.

[4] Allergy Injections are subject to the allergy injection copayment when billed alone. When billed in conjunction with an In-Network Physician Office Visit then only the Office Visit copayment applies.

[5] Manual and electric pumps are covered. Must be provided by a DME (Durable Medical Equipment) Provider. Member will not be reimbursed for a breast pump purchased from a retail/online store.

[6] Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs received in an Urgent Care Center and billed alone are subject to the Other Outpatient Services Copayment / Coinsurance.

[7] In-Network Transplants are covered at 100%, except Kidney and Cornea transplants are treated the same as any other illness and subject to medical benefits, during the Transplant Benefit Period. The Transplant Benefit Period starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (the number of days will vary depending on the type of transplant received and Network Transplant Provider agreement.) For specific Transplant questions, contact Aspirant and ask to speak with someone regarding Transplants. Prior to and after the Transplant Benefit Period, Covered Service will be paid as Inpatient Services, Outpatient Services or Physician Visits/Office Services depending on where the service is performed.