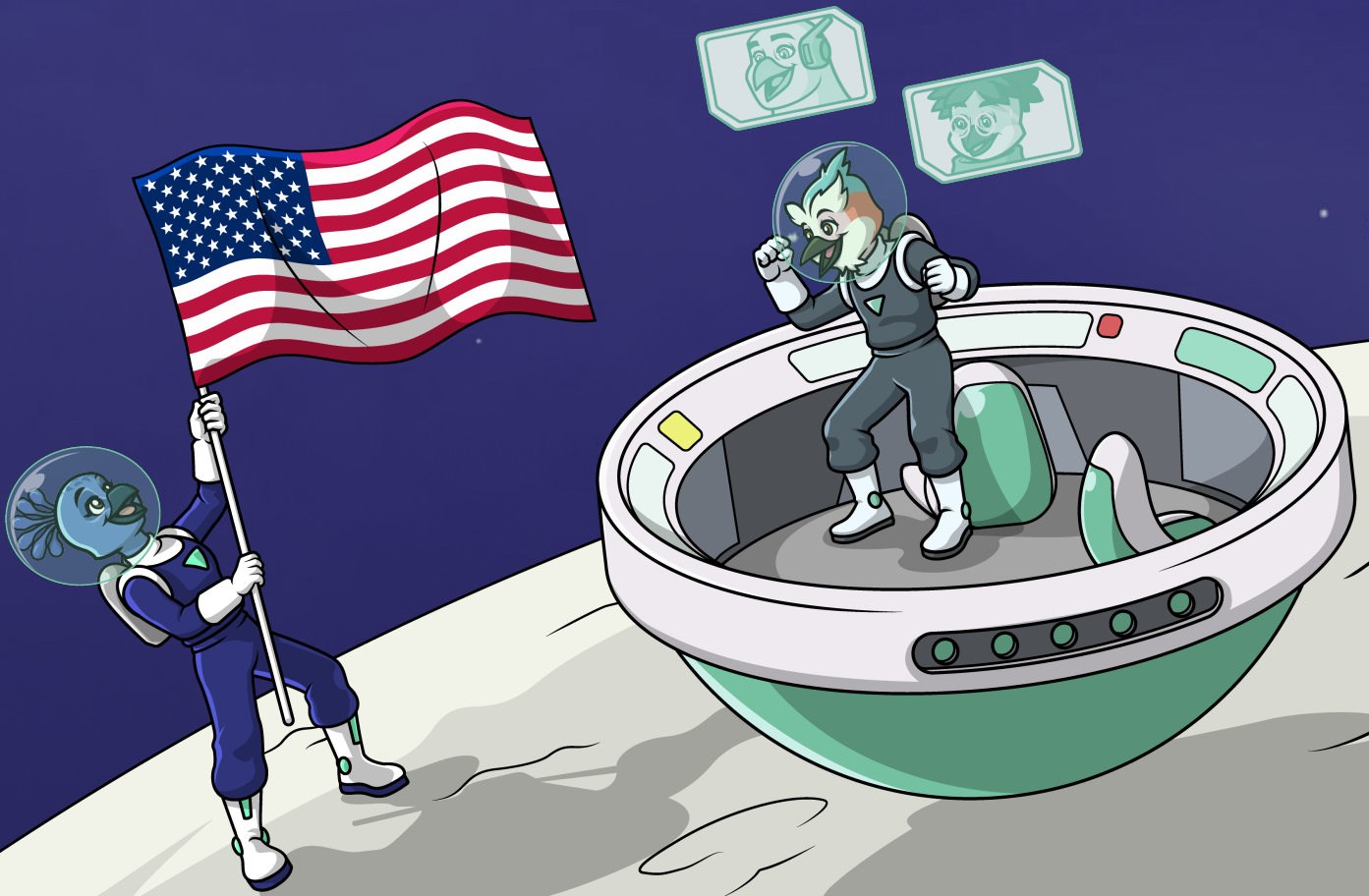




Remote Health
by SafetyWing

USA

Benefits overview



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Plan basics

This guide is a detailed, readable summary of what your plan covers, what's excluded, and what may need pre-authorization.

	In network	Out of network
Lifetime coverage limit	Unlimited	Unlimited

Annual coverage limit	Unlimited	Unlimited
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Annual deductible	Individual	\$0	\$1,000
	Family	\$0	\$3,500

- No person can be required to pay more than their individual deductible amount. Each family member contributes toward the family deductible until it's met.
- Deductible amounts for in-network and out-of-network care are tracked separately and don't count toward each other.
- Your medical and pharmacy expenses both count towards the same deductible.

Out-of-pocket limit	Single	\$1,000	\$2,000
	Family	\$3,000	\$7,000

- Your out-of-pocket limit includes everything you pay: deductibles, coinsurance, and copays (for both medical and pharmacy). Your plan pays a set percentage of covered costs until you reach your out-of-pocket limit. After that, it pays 100% of covered costs for the rest of the year.
 - For this plan, the only expenses that contribute to your in-network out-of-pocket limit are prescription co-pays or a non-emergency ambulance.
 - In-network and out-of-network out-of-pocket limits are tracked separately.
 - Some charges never count toward your limit and are never covered at 100%:
 - Out-of-network charges above what the plan agrees to pay
 - Services not covered (including pre-authorization penalties)

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In case of emergency

	In network	Out of network
Emergency services		
For emergency medical condition	100%	100%
	Pre-authorization required (see pre-authorization section for details)	
For non-emergency medical condition	100%	70% after deductible
	Pre-authorization required	
Emergency ambulance	100%	100%
	Up to \$25,000 for each air/water ambulance ride, pre-authorization required	
Non-emergency ambulance	Not covered	Not covered
Water, air, ground	Except as covered under emergency ambulance	
Urgent care facility	100%	70% after deductible
	Pre-authorization required	

Hospital charges

	In network	Out of network
Semi-private room when hospitalized	100%	70% after deductible
A private room is covered only if it's medically necessary. If the hospital only has private rooms, coverage is limited to the lowest private room rate.	Pre-authorization required	
Physician's services	100%	70% after deductible

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	In network	Out of network
Intensive care unit This plan pays the ICU rate	100% Pre-authorization required	70% after deductible
Surgery	100% Pre-authorization required	70% after deductible
Oncology services (e.g., chemotherapy, radiation therapy, cancer-related surgery)	100% Pre-authorization required	70% after deductible
Injections	100% Pre-authorization required for pain programs	70% after deductible
Day surgery	100% Pre-authorization required	70% after deductible
Oral surgery	100% Pre-authorization required	70% after deductible
Extraction of impacted wisdom teeth	100% Pre-authorization required	70% after deductible
Endoscopic tests (non-routine)	100% Pre-authorization required	70% after deductible
Second surgical opinion	100%	70% after deductible
All other services & supplies	100%	70% after deductible

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Doctors and specialists

	In network	Out of network
Primary care doctor (PCP) visit	100%	70% after deductible
Specialist doctor visit	100%	70% after deductible
Walk-in clinic	100%	70% after deductible
Private duty nursing (outpatient) <small>60 visits a year</small>	100% <small>Pre-authorization required</small>	70% after deductible
Diagnostic testing (X-ray, MRI, CT, PET scans, labs)	100% <small>Pre-authorization required</small>	70% after deductible
Genetic testing (e.g., BRACA, BART)	100% <small>Pre-authorization required</small>	70% after deductible
Allergy testing <small>1 testing (based on provider type)</small>	100%	70% after deductible
Hearing examination <small>1 exam</small>	100%	70% after deductible
Routine eye exam <small>1 exam</small>	100%	70% after deductible

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Preventive care

	In network	Out of network
Routine care (birth through adulthood)	100%	70% after deductible
Immunizations	100%	70% after deductible
Screenings	100%	70% after deductible

Specialty support

	In network	Out of network
Mental and substance use disorders <small>While hospitalized, office or virtual visit</small>	100% Pre-authorization required	70% after deductible
Physical, speech and occupational therapies <small>Including virtual visits</small>	100%	70% after deductible
Home health care <small>Pre-authorization required</small>	100%	70% after deductible
Skilled nursing facility and rehabilitation <small>120 days per 12 month period</small>	100% Pre-authorization required	70% after deductible
Hospice care <small>Lifetime maximum benefit of 180 days</small>	100% Pre-authorization required	70% after deductible
Dialysis <small>Pre-authorization required</small>	100%	70% after deductible
Cardiac rehab visits <small>Single 12-week period, max 36 sessions</small>	100%	70% after deductible

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	In network	Out of network
<p>Pulmonary therapy (outpatient)</p> <p>Inpatient pulmonary therapy covered under hospital charges</p>	100%	70% after deductible
	Covered for a single 6-week period, up to 36 visits	
<p>Temporomandibular joint dysfunction</p>	100%	70% after deductible
	Up to \$2,000	
<p>Transplants</p> <p>Cornea transplants performed by any provider are covered under the plan as a separate benefit and paid the same as any other illness</p>	100%	70% after deductible
	Pre-authorization required	
<p>Hyperbaric oxygen treatments</p>	100%	70% after deductible
	Pre-authorization required	
<p>Infusion services</p>	100%	70% after deductible
	Pre-authorization required	

Supplies and equipment

	In network	Out of network
<p>Durable medical equipment</p>	100%	70% after deductible
	Pre-authorization required	
<p>Hearing aids and related supplies</p> <p>One hearing aid per ear every 48 months</p>	100%	70% after deductible
	Up to \$4,000	
<p>Prosthetics</p>	100%	70% after deductible
	Pre-authorization required	
<p>Diabetic education and supplies</p> <p>Includes preventive and non-preventive education and supplies</p>	100%	70% after deductible
	Pre-authorization required for insulin pumps	

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Reproductive health

	In network	Out of network
Testing, diagnosis and treatment of underlying cause	100%	70% after deductible
Infertility treatment and procedures	Not covered	Not covered
Contraceptive management <small>Deductible waived for preventive (per law). OTC contraceptives not covered</small>	100%	70% after deductible

Maternity care

	In network	Out of network
Preventive prenatal and breastfeeding support	100%	70% after deductible
Lactation consultations	100%	70% after deductible
All other prenatal and postnatal care	100%	70% after deductible
Delivery	100%	70% after deductible

Wellness therapies

	In network	Out of network
Acupuncture <small>20 visits</small>	100%	70% after deductible
Chiropractic care/spinal manipulation <small>20 visits</small>	100%	70% after deductible

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All other eligible medical expenses

In network	Out of network
100%	70% after deductible

Drug type

Retail pharmacy: 30-day supply

	Copay	Notes
Generic drug	\$10	No deductible
Brand name drug (preferred)	\$30	No deductible
Brand name drug (non-preferred)	\$50	No deductible
Preventive drug	No charge	As classified by HHS

Mail order pharmacy: 90-day supply

Generic drug	\$10	No deductible
Brand name drug	\$30	No deductible
Non-preferred drug	\$50	No deductible

Specialty drugs: 30-day supply

\$50	No deductible
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In most cases, your in-network provider will request pre-authorization on your behalf, especially for hospital stays or surgeries. Some providers may refer to this process as "pre-certification."

It is your responsibility to confirm a treatment has been pre-authorized. If it isn't obtained for whatever reason, you may have to pay 10% of the cost, up to \$500.

To avoid this penalty, be sure to double-check that pre-authorization has been requested before care begins.

Instructions:

- Check that your provider has obtained or is obtaining pre-authorization for you. If not, ensure that they start the process as soon as possible. Get in touch with our customer service for any assistance.
- If you have an emergency admission for any of the services below, call 1 (800) 337-0792 (toll free) within 24 hours of the admission. On the weekend or a holiday, call within 72 hours by the following Monday.
- If pre-authorization isn't done, the plan reduces covered charges by 10% (up to \$500). This penalty does not count toward your deductible or out-of-pocket maximum.

Services requiring pre-authorization:

- A. Inpatient admissions (hospital, rehab, skilled nursing, extended care, mental health/substance use disorder)
- B. Transplants
- C. Hospital stays over 48 hours
- D. Dialysis
- E. Chemotherapy, radiation therapy
- F. Reconstructive or spinal surgery
- G. Hyperbaric oxygen treatments
- H. Durable medical equipment (over 30-day rental or purchase) and insulin pumps
- I. Substance use disorder programs (outpatient)
- J. Outpatient surgery, procedures, or private duty nursing
- K. Diagnostic testing (MRI/PET/CT)
- L. Infusion services
- M. Home health care
- N. Genetic testing (e.g., BRACA, BART)
- O. Air/water ambulance
- P. Hospice care
- Q. Prosthetics
- R. Injection therapy for pain programs
- S. Treatment/surgery for morbid obesity
- T. Gender dysphoria surgical treatment

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Like all major U.S. employer health plans, this one is designed to cover care that is medically necessary for illness, injury, and prevention. It follows the same federal standards (ACA / ERISA) that most corporate plans use.

That means everyday doctor visits, emergencies, hospital care, prescriptions, and approved therapies are covered but cosmetic procedures, experimental treatments, lifestyle services (like massage or fitness programs), or items for comfort or convenience usually are not.

If you're unsure whether something qualifies, just ask. We're here to help before you book care.

Note: the exclusions are only briefly listed here and do not include full details. For the complete list of non-covered services and specific limitations, please refer to your Summary Plan Description (SPD).

Abortion

Only abortions for spontaneous miscarriage complications, to prevent the woman's death, or from reported rape or incest are covered.

Allergy services

Non-standard allergy tests, home-based treatments, or non-prescription allergy drugs aren't covered.

Administrative services

Fees for claim forms, shipping, or handling aren't covered.

Adoption

Adoption-related costs aren't covered.

After coverage ends

Care received after your coverage terminates isn't covered.

Alternative therapies

Non-medical treatments like aromatherapy, hair analysis, or hyperbaric therapy (unless for decompression or wound healing) aren't covered.

Biofeedback

Biofeedback or bioenergetic treatments aren't covered.

Cardiac rehab (Phase III)

Maintenance-level (Phase III) cardiac rehab or exercise programs after recovery aren't covered.

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Chelation therapy	Covered only for heavy metal poisoning.
Complications	Issues resulting from non-covered treatments aren't covered.
Convenience items	Comfort or personal items (like TVs, internet, or cleaning services) aren't covered.
Cosmetic procedures	Cosmetic surgeries like facelifts, implants, or tattoo removal aren't covered
Custodial care	Daily living or non-medical care isn't covered except under hospice or home health benefits.
Dental care	Dental work isn't covered unless related to a covered medical procedure.
Developmental delays	Therapy for developmental delays isn't covered unless part of a diagnosed mental health condition or preventive care.
Exercise programs	Fitness or training programs aren't covered.
Excess charges	You may be billed the difference directly if you visit an out-of-network provider and they charge more than what the plan covers.
Experimental care	Experimental or unproven treatments, devices, or drugs aren't covered.
Foot care	Routine foot care isn't covered except for diabetes or vascular conditions.
Foot orthotics	Orthopedic shoes or arch supports aren't covered unless part of a leg brace or to treat/prevent diabetes complications.
Gender dysphoria	Cosmetic or non-medically necessary transition procedures aren't covered.
Government services	Care provided free by a government program isn't covered.
Growth/height	Treatments or drugs used solely to change height aren't covered.

[Benefits summary](#)[Pre-authorization requirements](#)[General plan exclusions](#)[Add-ons](#)**Hair loss**

Hair restoration or transplants aren't covered.

Hazardous activities

Injuries from risky recreational activities aren't covered unless due to medical conditions or domestic violence.

Home and mobility

Modifications to your home, vehicle, or workplace (like ramps or air purifiers) aren't covered.

Home births

Births at home or unlicensed locations aren't covered unless approved as lower cost.

Homeopathic treatments

Naturopathic or homeopathic care isn't covered unless approved as lower cost.

Hypnotherapy

Only covered if used as anesthesia when standard anesthesia can't be used in a covered surgery.

Illegal acts

Injuries from illegal acts aren't covered, except for victims of domestic violence or medical conditions.

Infertility

Treatments like IVF, donor eggs, or surrogacy aren't covered unless specifically listed.

Immunizations

Vaccines for work or travel aren't covered (preventive vaccines are).

Maintenance therapy

Ongoing therapy after the maximum level of improvement is reached isn't covered.

Mandible treatment

Jaw surgeries for bite or shape correction aren't covered.

Massage therapy

Massage or rolfing isn't covered.

Medical error

Care required due to preventable medical mistakes isn't covered.

Medically necessary

Services not medically necessary aren't covered.

Missed appointments

Fees for missed appointments aren't covered.

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Services you don't have to pay for aren't covered.

Not specified as covered

Any service not listed as covered in the plan isn't eligible.

Not performed under the direction of a physician

Services not ordered or supervised by a physician aren't covered.

Not recommended by a physician

Hospital stays not recommended by a doctor aren't covered.

Nutritional supplements

Nutritional or infant supplements aren't covered unless specified as eligible medical expenses.

Government facilities

Care at government hospitals isn't covered unless you're required to pay.

Outside the U.S.

Medical travel abroad isn't covered unless preapproved as lower cost.

Over-the-counter medication and supplies

OTC drugs and disposable supplies (like bandages or syringes) aren't covered.

Plan maximums

Costs above plan limits aren't covered.

Pregnancy (dependent)

A dependent child's newborn isn't covered unless the baby qualifies as an eligible dependent.

Prior to effective date

Care received before your coverage begins isn't covered.

Radioactive contamination

Injuries from nuclear materials aren't covered.

Recreational or educational therapy

Non-medical therapies like music or pool therapy aren't covered unless for mental health.

Refractive errors

Vision correction surgeries (like LASIK) aren't covered.

Required by law

Costs that should be covered by legally required insurance (like auto insurance) aren't covered.

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Riot or revolt

Injuries from riots aren't covered unless due to domestic violence or medical conditions.

Stand-by physician

Fees for on-call or stand-by doctors aren't covered.

Sterilization

Elective sterilization or reversal isn't covered unless preventive.

Strength and performance

Treatments to enhance strength or athletic ability aren't covered.

Surrogacy

Pregnancy costs for surrogates aren't covered unless preventive.

Travel and lodging

Travel or lodging for medical care isn't covered unless preapproved.

Vision care

Vision exams, glasses, and contacts aren't covered except after eye surgery.

Wage or profit

Injuries or illnesses that arise out of employment or self-employment are not covered.

War

Injuries or illness from war or terrorism aren't covered.

Weekend admissions

Non-emergency weekend admissions aren't covered unless surgery is within 24 hours.

Worker's compensation

Injuries covered by workers' compensation or similar laws aren't covered.

Still have questions?

We're here to help. Get in touch with us via 24/7 live chat on safetywing.com or email support@safetywing.com.

This document reflects the coverage in the official Summary Plan Document (SPD) in a friendlier format. [See an example SPD.](#)



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The add-ons listed below are only available if your employer allowed you to select them during open enrollment. Add-on coverage may vary between you and your family members.

Dental benefits overview

	In network	Out of network
Annual limit Combined for both; after \$5,000, no further benefits for Out of network	\$5,000	\$5,000
Deductible	\$0	\$0
Annual limit for orthodontics Only for dependent children under age 20 when treatment begins, paid in installments	\$2,500	\$2,500
Deductible for orthodontics Applies after deductible is met	\$0	\$0
Dental emergency (per incident) Included as part of overall maximum	Up to \$5,000	Up to \$5,000

Covered services

Preventive and diagnostic

Oral exams & cleanings	1 every 6 months
Bitewing x-rays	1 per year
Full-mouth x-ray	1 every 36 months
Fluoride treatment	1 per year (under age 19)
Space maintainers	Covered for children under 16
Sealants	1 per tooth every 3 years (under age 19)
Emergency treatment for pain	Covered

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Basic restorative

Fillings (amalgam, composite)	Covered
Simple & surgical extractions	Covered
Periodontics (surgical & non-surgical)	Covered
Periodontal maintenance	2 per year after treatment
Root canals, pulpal therapy	Covered
Oral surgery (except TMJ)	Covered
Stainless steel crowns	Covered (under 16)
Repair/re-cementing crowns, bridges, inlays	Covered
Anesthetics (if medically necessary)	Covered
Antibiotic injections	Covered

Major restorative

Crowns, inlays, onlays, veneers	Covered if tooth cannot be restored otherwise
Gold restorations	Only if medically necessary, otherwise covered at amalgam/composite rate
Dentures (partial, full, removable)	Covered, incl. adjustments within 6 months
Repairs, clasp additions, re-cementing	Covered
Rebasing/relines of dentures	Covered
Prostodontics (bridges, dentures, fixed bridgework)	Covered
Replacement of dentures/bridges	Covered after 5 years (exceptions apply)
Periodontal splinting	Covered
Implants (endosteal)	Covered

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Orthodontic services

Preliminary study (x-rays, casts, treatment plan)	Covered
Active treatment	Covered
Retention appliances	Covered
Payment	Benefits paid in installments (¼ upfront, balance monthly)
Service fees	Only one orthodontist per treatment course
Eligibility	Dependent children under age 20 when treatment begins

Dental exclusions (not covered)

Administrative/non-medical	Claim form/report fees, dental records, missed appointments, services not ordered by a dentist
Cosmetic	Cosmetic dentistry, bleaching/whitening, bonding, personalization of dentures
Coverage timing	Services before coverage starts or after it ends, claims filed after 12 months
Frequency/limits	More than one filling per surface, replacement of bridge/crown/denture within 5 years (unless exceptions apply)
Implants	Including any appliances and/or crowns and the surgical insertion or removal of implants unless listed as covered
Dental appliances	Replacement of lost/stolen appliances, crowns/fillings/appliances used for splinting or bite alteration
Preventive/hygiene	Oral hygiene, plaque control, dietary instruction

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Work, war, injury

Services for work-related injuries, war-related injuries (declared or undeclared), self-inflicted injury

Cost sharing

Services with no charge to patient, services not on the covered list

Medical overlap

Services payable under medical expense benefits of the plan

Oral/jaw surgery

Surgery to correct jaw malposition

Hygienist

Only scaling, cleaning, fluoride by licensed hygienist under dentist supervision



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Vision benefits overview

Annual limit	\$500 (per person, per year)
Vision exam copay	\$0
Vision hardware copay	\$0

Covered services

Eye exam (refraction & dilation)	1 per calendar year
Retinal imaging	Covered
Contact lens exam/fitting (refraction & dilation)	1 per calendar year
Frames	1 per calendar year
Prescription lenses	In lieu of contact lenses
Contact lenses	Allowance must be used at once

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Medically necessary contacts

Covered if prescribed due to one of the following

1. Anisometropia of 3D in meridian powers
2. High ametropia exceeding -10D or +10D
3. Keratoconus not correctable to 20/30 with glasses
4. Vision improves at least 2 lines on visual acuity chart vs. glasses
(Not covered for other conditions even if provider deems necessary.)

Vision exclusions (not covered)

Not covered

Both eyeglasses and contacts at the same time

Replacement of lost, stolen, or broken glasses/contacts

Safety eyewear

Laser vision correction

Non-prescription glasses/sunglasses

Services/supplies covered under medical insurance (treatment, drugs)

Cosmetic lenses or processes

Experimental corrective vision treatments

Accessories for eyeglasses

Vision care solutions

Orthoptics (eye muscle exercises)

Vision training or subnormal vision aids

Services excluded under General Exclusions & Limitations