Schedule of Benefits & Plan Design

Medical Services Deductible Information

Deductible [1]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)[2]
Individual	$0	
Family	$0	

Out of Pocket Information

Out of Pocket Maximum [1]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)[2]
Individual	$8,700	
Family	$17,400	

Schedule of Benefits

The following table represents the medical services currently covered under the CHOICE MEC™ Plan, as well as the permitted interval and any requirements of such medical services. If the service is not listed on this Schedule of Benefits, it is not covered.

Plan Provisions	Prior Auth Required[3]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)[2]
		Member Pays	
PHYSICIAN SERVICES			
Primary Care OfficeVisit	No	$35 Copay	$35 Copay
Specialist Office Visit	No	$75 Copay	$75 Copay
Urgent Care	No	$85 Copay	$85 Copay
Telemedicine Services	No	$0 Copay	Not Applicable

[1] The Deductible and Out of Pocket amounts are combined across In Network and Out of Network Providers.

[2] Out of Network services are covered at 85% of usual and customary charges.

[3] If prior authorization is not obtained for services requiring a prior authorization, the benefits payable by the Plan for such services will be reduced to 50% of the allowed charges after the copay.

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Plan Provisions		Prior Auth Required[3]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)[2]
			Member Pays	
PREVENTIVE & WELLNESS SERVICES				
(See Schedule of Preventive Health Services section)	**(Non-Hospital Based)**	No	$0 Copay	$0 Copay
	(Hospital Based)	No	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member
HOSPITAL/FACILITY SERVICES				
Inpatient Hospitalization		YES	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member
Inpatient Visits - Physician		YES	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member
Inpatient Surgery - Physician Charges		YES	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member
Outpatient Hospital or Free-Standing FacilityServices and Surgery (Limited to 1 visit per plan year)		YES	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member
Anesthesia (Limited to 1 outpatient anesthetic procedures per plan year)		YES	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member
Emergency Room Services		YES	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member
OUTPATIENT DIAGNOSTIC SERVICES				
Laboratory Service	**(Non-Hospital Based)**	No	$50 Copay	$50 Copay
	(Hospital Based)	YES	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member
Diagnostic Services - Minor **(ultrasounds, bone density, echography, etc)**	**(Non-Hospital Based)**	No	$50 Copay	$50 Copay
	(Hospital Based)	YES	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member
Diagnostic Services - Major **(MRI, CT, PET, Nuclear Medicine,etc.)**	**(Non-Hospital Based)**	YES	$500 Copay (3 per year)	
	(Hospital Based)	YES	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member

Plan Provisions		Prior Auth Required[3]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)[2]
			Member Pays	
PREGNANCY BENEFITS				
Professional Services		No	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member
Maternity/Childbirth/Delivery		Yes	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member
OTHER SERVICES				
Allergy Services		No	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member
Second Surgical Opinion		No	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member
Home Health Care		No	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member
Treatment for Chemical Abuse & Dependency	**Inpatient**	No	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member
Treatment for Chemical Abuse & Dependency	**Outpatient**	No	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member
Rehabilitation/Habilitation Services		No	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member
Emergency Medical Transportation		No	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member

PHARMACY BENEFITS		Participating Pharmacies	Non Participating Pharmacies
		Member Pays	
Preventive Prescriptions - (Subject to Formulary)			
Pharmacy Retail – up to a 30-day supply		Generic - $0 Copay (Limited to Preventive Generic)	**Not Covered** 100% paid by Member
Non-Preventive GENERIC Prescriptions - (Subject to Formulary)			
Pharmacy Retail – up to a 30-day supply		Generic - $5 Copay	**Not Covered** 100% paid by Member
Preferred Brand, Non-Preferred Brand, & Specialty Prescriptions - (NOT COVERED)			
Pharmacy Retail – up to a 30-day supply		**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member

Exclusions

The following exclusions apply to the benefits offered under this Plan:

1. Office visits, physical examinations, immunizations, and tests when required solely for the following:

- a. Sports,
- b. Camp,
- c. Employment,
- d. Travel,
- e. Insurance,
- f. Marriage,
- g. Legal proceedings

2. Routine foot care for treatment of the following:

- a. Flat feet,
- b. Corns,
- c. Bunions,
- d. Calluses,
- e. Toenails,
- f. Fallen arches,
- g. Weak feet,
- h. Chronic foot strain

3. Dental procedures

4. Any other medical service, treatment, or procedure not covered under this Schedule of Benefits

5. Any other expense, bill, charge, or monetary obligation not covered under this Plan, including but not limited to all non-medical service expenses, bills, charges, and monetary obligations. Unless the medical service is explicitly provided by any appendix or otherwise explicitly provided in the Plan Document, this Plan does not cover the medical service or any related expense, bill, charge, or monetary obligation to the medical service

6. Claims unrelated to treatment of medical care or treatment

7. Cosmetic surgery unless authorized as medically necessary. Such authorization is based on the following causes for cosmetic surgery: accidental injury, correction of congenital deformity within six (6) years of birth, or as a treatment of a diseased condition

8. Any treatment with respect to treatment of teeth or periodontium, any treatment of periodontal or periapical disease involving teeth surrounding tissue, or structure. Exceptions to this exclusion include only malignant tumors or benefits specifically noted in the schedule of benefits to the Plan Document

9. Any claim related to an injury arising out of, or in the course of, any employment for wage or profit that would be covered by other coverage for which the member is eligible

10. Claims for which a participant is not legally required to pay or claims which would not have been made if this Plan had not existed

11. Claims for services which are not medically necessary as determined by this Plan or the excess of any claim above reasonable and customary rates when a PPO network has not been contracted

12. Charges which are or could be reimbursed by any public health program irrespective of whether such coverage has been elected by a participant

13. Claims due to an act of war, declared or undeclared, not including acts of terrorism

14. Claims for eyeglasses, contacts, hearing aids (or examinations for the fitting thereof) or radial keratotomy

15. Abortion Services

16. Travel, unless specifically provided in the schedule of benefits

17. Custodial care for primarily personal, not medical, needs provided by persons with no special medical training or skill

18. Claims from any provider other than a healthcare provider as defined in the Plan Document unless explicitly permitted in the schedule of benefits

19. Investigatory or experimental treatment, services, or supplies unless specifically covered under Approved Clinical Trials

20. Services or supplies which are primarily educational

21. Claims due to attempted suicide or intentionally self-inflicted injury (Including intoxication/impairment) while sane or insane, unless the claim results from a medical condition such as depression

22. Claims resulting from, or which arise due to the attempt or commission of, an illegal act. Claims by victims of domestic violence will not be subject to this exclusion

23. Claims with respect to any treatment or procedure to change one's physical anatomy to those of the opposite sex and any other treatment or study related to sex change.

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Exclusions

24. Claims from a medical service provider who is related by blood, marriage, or legal adoption to a participant

25. Any claims for fertility or infertility treatment

26. Claims for weight control, weight reduction, or surgical treatment for obesity or morbid obesity, unless explicitly provided in the schedule of benefits

27. Claims for disability resulting from reversal of sterilization

28. Claims for the completion of forms, or failure to keep scheduled appointments

29. Recreational or diversional therapy

30. Personal hygiene or convenience items, including but not limited to air conditioning, humidifiers, hot tubs, whirlpools, or exercise equipment, irrespective of the recommendations or prescriptions of a medical service provider

31. Claims due to participation in a dangerous activity, including but not limited to sky-diving, motorcycle or automobile racing, bungee jumping, rock climbing, rappelling, or hang gliding

32. Claims that arise primarily due to medical tourism

33. Supportive devices of the foot

34. Treatments for sexual dysfunction

35. Aquatic or massage therapy

36. Biofeedback training

37. Skilled nursing facilities

38. Durable medical equipment and prosthetics

39. Hospice care, private duty nursing, or long-term care

40. Residential facility – for charges from a residential halfway house or home, or any facility which is not a health care institution licensed for the primary purpose of treatment of an illness or injury

41. Claims for temporomandibular joint syndrome

42. Claims for biotech or specialty drugs, including biologics and hemophiliac drugs

43. Genetic testing unless explicitly covered in the schedule of benefits

44. Human Cell, Tissue and Organ transplantation

45. Claims for cosmetic surgery, not related to mastectomy reconstruction to produce a symmetrical appearance or prosthesis, or physical complications which result from such procedures.

46. Chiropractic care

47. Radiation and chemotherapy

48. Dialysis

49. Acupuncture

50. Alternative medicine/homeopathy

51. Children dental and vision

52. Neonatal intensive care (NICU)

53. Rehabilitative therapies

54. PCP surgery

55. Routine eye care (Adult)

56. Pregnancy Benefits, including office visits and childbirth/delivery professional and facility services.

57. All maternity coverage for dependent children, including adult children up to age 26, and all coverage for the resultant newborn child. However, ACA mandated Preventive Health Services are not excluded

58. Diagnosis and treatment for sleep apnea

59. Any claim arising from service received outside of the United States and its territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands

60. Use of Emergency Room Services for non-emergency care

61. This coverage does not include benefits for grandchildren (unless they are under your legal guardianship).

62. Gene therapy

63. Emerging gene and cell therapies

The purpose of this list of exclusions is solely to provide additional clarity regarding treatments, procedures, products, services, or any other items which are not covered under this plan. Accordingly, no exclusion shall be interpreted by negative implication, or otherwise, as evidence of the existence of coverage under this plan.