

COPAY 3500 MAJOR MEDICAL

Schedule of Benefits & Plan Design Medical Services Deductible Information

<i>Deductible</i>	Participating Providers (In Network)	Non-Participating Providers (Out of Network)
Individual	\$3,500	\$7,500
Family	\$7,000	\$15,000

Out of Pocket Information

<i>Out of Pocket Maximum</i>	Participating Providers (In Network)	Non-Participating Providers (Out of Network)
Individual	\$7,350	\$14,700
Family	\$17,000	\$35,000

Coinsurance Information

<i>Coinsurance</i>	Participating Providers (In Network)	Non-Participating Providers (Out of Network)
After Deductible	20%	50%

UNLIMITED ANNUAL MAXIMUM BENEFIT

Schedule of Benefits

The following table represents the medical services currently covered under the COPAY 3500 MAJOR MEDICAL plan as well as the permitted interval and any requirements of such medical services.

Plan Provisions	Prior Auth Required¹	Participating Providers (In Network)	Non-Participating Providers (Out of Network)
Member Pays			
PHYSICIAN SERVICES			
Primary Care Office Visit	No	\$40 Copay	Deductible & Coinsurance
Specialist Office Visit (Includes Mental and Behavioral Health, Second Surgical / Medical Opinion)	No	\$75 Copay	Deductible & Coinsurance
Other Physicians Services performed in the office	Yes	20% Coinsurance	Deductible & Coinsurance
Urgent Care	No	\$90 Copay	Deductible & Coinsurance
Telemedicine Services	No	\$0 Copay	Not Applicable

¹ 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. Prior authorization is required for any service or procedure over \$1,000.

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Plan Provisions		Prior Auth Required¹	Participating Providers (In Network)	Non-Participating Providers\ (Out of Network)
Member Pays				
PREVENTIVE & WELLNESS SERVICES				
(See Schedule of Preventive Health Services section)	(Non-Hospital Based)	No	\$0 Copay	Deductible & Coinsurance
	(Hospital Based)	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
HOSPITAL/FACILITY SERVICES				
Inpatient Hospitalization		Yes	Deductible & Coinsurance	
Inpatient Physician & Ancillary Services		Yes	Deductible & Coinsurance	
Inpatient Surgery – Physician Charges		Yes	Deductible & Coinsurance	
Outpatient Hospital or Free-Standing Facility Services and Surgery		Yes	Deductible & Coinsurance	
Anesthesia		Yes	Deductible & Coinsurance	
Emergency Room Facilities and Covered Services		No	Deductible & Coinsurance	
Diagnostic Services				
Laboratory Services		No	\$500 First dollar coverage combined for Outpatient Laboratory, Radiology, & Scans, then Deductible & Coinsurance	Deductible & Coinsurance
Radiology		No		Deductible & Coinsurance
CT/MRI/MRA/PET Scan		Yes		Deductible & Coinsurance
Mental Health Services				
Inpatient Care Mental Health Facility	(Non-Hospital Based)	Yes	Deductible & Coinsurance	
Outpatient Mental Health and Substance Abuse Care	(Hospital Based)	Yes		

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Plan Provisions	Prior Auth Required ¹	Participating Providers (In Network)	Non-Participating Providers (Out of Network)
Member Pays			
PREGNANCY BENEFITS			
Professional Services	No	Deductible & Coinsurance	
Maternity/Childbirth/Delivery (Considered Inpatient Hospital Stay)	Yes	Deductible & Coinsurance	
OTHER SERVICES			
Allergy Services (The copay applies to the administration of the allergy service and is separate from the copay for the office visit)	No	Deductible & Coinsurance	
Chemotherapy/Radiation Therapy (Chemotherapy only includes infusion, not oral)	Yes	Deductible & Coinsurance	
Chiropractic Services (Limited to 30 visits per plan year)	No	Deductible & Coinsurance	
Colonoscopy (Diagnostic Purposes)	Yes	Deductible & Coinsurance	
Dialysis	Yes	Deductible & Coinsurance	
Durable Medical Equipment (Subject to limitations)	Yes	Deductible & Coinsurance	
Emergency Medical Transportation (Ground Service Only)	No	Deductible & Coinsurance	
Home Health Care (Limited to 200 visits per plan year)	Yes	Deductible & Coinsurance	
Hospice Care (Limited to 210 visits per plan year)	Yes	Deductible & Coinsurance	
Rehabilitation/Habilitation Services (Combined limit of 30 visits per plan year with physical, speech, and occupational therapies. Prior authorization is required after 6 visits.)	Yes	Deductible & Coinsurance	
Inpatient Care Substance Abuse Detoxification Facility (7 Day Maximum)	Yes	Deductible & Coinsurance	
Transplant - Facility	Yes	Deductible & Coinsurance	
Transplant - Physician and Anesthesiologist Charges during Inpatient Hospitalization	Yes	Deductible & Coinsurance	

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Plan Provisions		Prior Auth Required ¹	Participating Providers (In Network)	Non-Participating Providers (Out of Network)
Treatment for Chemical Abuse & Dependency 30 Day Maximum	(In-Patient)	Yes	Deductible & Coinsurance	
Treatment for Chemical Abuse & Dependency	(Out-Patient)	Yes	Deductible & Coinsurance	

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 - \$20 Copay	Not Covered 100% paid by Member
Preferred Brand, Non-Preferred Brand, & Specialty Prescriptions (Subject to Formulary)			
Pharmacy Retail – up to a 30-day supply		Preferred Brand- \$65 Copay Non-Preferred Brand - \$95 Copay Specialty - \$200 Copay	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. Elective, voluntary abortions, except in the case of rape, incest, or congenital deformities of the fetus as determined through pre-natal testing, or when the life of the mother would be threatened if the fetus were carried to term
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 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. Private duty nursing, or long-term care
39. 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
40. Claims for temporomandibular joint syndrome
41. Claims for biotech or specialty prescriptions
42. Claims for biotech or specialty drugs, including biologics and hemophiliac drugs
43. Claims for cosmetic surgery, not related to mastectomy reconstruction to produce a symmetrical appearance or prosthesis, or physical complications which result from such procedures.
44. Acupuncture
45. Alternative medicine/homeopathy
46. Children dental and vision
47. Routine eye care (Adult)
48. 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
49. 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.
50. Use of Emergency Room Services for non-emergency care
51. Diagnosis and treatment for sleep apnea
52. This coverage does not include benefits for grandchildren (unless they are under your legal guardianship).
53. Gene therapy
54. 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.