



**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 Office Visit	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

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

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

³If 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.



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 Facility Services 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.



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.