Schedule of Benefits & Plan Design

Medical Services Deductible Information

Deductible	Participating Providers (In Network)	Non-Participating Providers (Out of Network)
Individual	$0	**Not Covered** 100% paid by Member
Family	$0	**Not Covered** 100% paid by Member

Out of Pocket Information

Out of Pocket Maximum	Participating Providers (In Network)	Non-Participating Providers (Out of Network)
Individual	$5,000	**Not Covered** 100% paid by Member
Family	$10,000	**Not Covered** 100% paid by Member

Schedule of Benefits

The following table represents the medical services currently covered under the VALUE MVP™, 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[1]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)
		Member Pays	
PHYSICIAN SERVICES			
Primary Care OfficeVisit (Limited to 10 visits per plan year)	No	$15 Copay	**Not Covered** 100% paid by Member
Specialist Office Visit (Includes Mental and Behavioral Health. Limited to 10 visits per plan year)	No	$25 Copay	**Not Covered** 100% paid by Member
Other Physicians Services performed in the office (Limited to Primary Care/Specialists visits per plan year)	Yes	$50 Copay per service billed	**Not Covered** 100% paid by Member
Urgent Care (Limited to 3 visits per plan year)	No	$35 Copay	**Not Covered** 100% paid by Member
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 Required[1]	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	**Not Covered** 100% paid by Member
	(Hospital Based)	No	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member
HOSPITAL/FACILITY SERVICES				
Inpatient Hospitalization (Limited to 7 days per plan year)		YES	$350 Copay per admission	**Not Covered** 100% paid by Member
Inpatient Visits - Physician (Limited to visits up to 7 days per plan year)		YES	Included in Inpatient Hospitalization Copay	**Not Covered** 100% paid by Member
Inpatient Surgery - Physician Charges (Limited to 3 surgeries per plan year)		YES	Included in Inpatient Hospitalization Copay	**Not Covered** 100% paid by Member
Outpatient Hospital or Free-Standing Facility Services and Surgery (Limited to 2 visit per plan year)		YES	$350 Copay	**Not Covered** 100% paid by Member
Anesthesia (Limited to 3 inpatient and 2 outpatient anesthetic procedures per plan year)		YES	Included in Inpatient Hospitalization or Outpatient Hospital or Free Standing Facility Services and Surgery Copay	**Not Covered** 100% paid by Member
Emergency Room Services (Limited to 1 visit per plan year)		YES	$350 Copay	**Not Covered** 100% paid by Member
OUTPATIENT DIAGNOSTIC SERVICES				
Laboratory Service	**(Non-Hospital Based)** (Combined limit of 3 visits per plan year with Radiology)	No	$50 Copay	**Not Covered** 100% paid by Member
	(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)** (Combined limit of 3 visits per plan year with Laboratory Services)	No	$50 Copay	**Not Covered** 100% paid by Member
	(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	$350 Copay	**Not Covered** 100% paid by Member
	(Hospital Based)	YES	**Not Covered** 100% paid by Member	**Not Covered** 100% paid by Member

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Plan Provisions		Prior Auth Required[1]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)
			Member Pays	
PREGNANCY BENEFITS - 12 MONTH WAITING PERIOD				
Professional Services		No	$350 Copay	**Not Covered** 100% paid by Member
Maternity/Childbirth/Delivery (Considered Inpatient Hospital Stay)		Yes	$350 Copay per admission	**Not Covered** 100% paid by Member
OTHER SERVICES				
Allergy Services (Included in Primary Care Office Visit or Specialist Office Visit limits. The copay applies to the administration of the allergy service and is separate from the copay for the office visit)		No	$25 Copay	**Not Covered** 100% paid by Member
Chiropractic Services (Limited to 10 visits per plan year)		No	$25 Copay	**Not Covered** 100% paid by Member
Second Surgical Opinion		No	$0 Copay	**Not Covered** 100% paid by Member
Home Health Care (Limited to 15 visits per plan year)		Yes	$25 Copay	**Not Covered** 100% paid by Member
Treatment for Chemical Abuse & Dependency	**(In-Patient)** (Limited to 7 days per plan year)	Yes	$250 Copay per day	**Not Covered** 100% paid by Member
Treatment for Chemical Abuse & Dependency	**(Out-Patient)** (Limited to 10 visits perplan year)	Yes	$25 Copay per day	**Not Covered** 100% paid by Member
Emergency Medical Transportation (By land only; Limited to 1 transport per plan year)		No	$250 Copay	**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

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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 (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
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

Exclusions

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. Radiation and chemotherapy
47. Dialysis
48. Rehabilitative therapies
49. Acupuncture
50. Alternative medicine/homeopathy
51. Children dental and vision
52. Neonatal intensive care (NICU)
53. Routine eye care (Adult)
54. Inpatient facility claims for surgery after the inpatient hospital day limit per plan year has been exhausted
55. 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
56. Diagnosis and treatment for sleep apnea
57. 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
58. Use of Emergency Room Services for non-emergency care
59. This coverage does not include benefits for grandchildren (unless they are under your legal guardianship).
60. Gene therapy
61. Private room unless medically necessary or if a semi-private room is not available.
62. 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.