



**Schedule of Benefits & Plan Design
Medical Services Deductible Information**

Deductible¹	Participating Providers (In Network)	Non-Participating Providers (Out of Network)²
Individual		\$0
Family		\$0

Out of Pocket Information

Out of Pocket Maximum¹	Participating Providers (In Network)	Non-Participating Providers (Out of Network)²
Individual		Not Applicable
Family		Not Applicable

Schedule of Benefits

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

Plan Provisions	Prior Auth Required³	Participating Providers (In Network)	Non-Participating Providers (Out of Network)²
PHYSICIAN SERVICES			
Primary Care Office Visit	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
Specialist Office Visit (Includes Mental and Behavioral Health)	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
Urgent Care	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
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.



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 (Subject to RBP)				
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		YES	Not Covered 100% paid by Member	Not Covered 100% paid by Member
Anesthesia		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	Not Covered 100% paid by Member	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)	No	Not Covered 100% paid by Member	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	Not Covered 100% paid by Member	Not Covered 100% paid by Member
	(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		Not Covered 100% paid by Member	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.