



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

| <i>Deductible</i> | <b>Participating Providers<br/>(In Network)</b> | <b>Non Participating Providers<br/>(Out of Network) <sup>1</sup></b> |
|-------------------|-------------------------------------------------|----------------------------------------------------------------------|
| <b>Individual</b> | \$0                                             | Not Covered                                                          |
| <b>Family</b>     | \$0                                             | Not Covered                                                          |

**Out of Pocket Information**

| <i>Out of Pocket Maximum</i> | <b>Participating Providers<br/>(In Network)</b> | <b>Non Participating Providers<br/>(Out of Network) <sup>1</sup></b> |
|------------------------------|-------------------------------------------------|----------------------------------------------------------------------|
| <b>Individual</b>            | \$0                                             | Not Covered                                                          |
| <b>Family</b>                | \$0                                             | Not Covered                                                          |

**Schedule of Benefits**

The WellMEC™ Plan provides coverage for the preventive health services required by the PHSA § 2713 (a) without any cost sharing requirements. All covered In Network preventive service will be 100% covered by the Plan. Out of Network services will not be covered unless otherwise specified, and the Plan Member will owe 100% of the cost of these services.

| <b>Plan Provisions</b>           | <b>Prior Auth<br/>Required</b> | <b>Participating Providers<br/>(In Network)</b> | <b>Non Participating Providers<br/>(Out of Network)</b> |
|----------------------------------|--------------------------------|-------------------------------------------------|---------------------------------------------------------|
| <b>Member Pays</b>               |                                |                                                 |                                                         |
| <b>PHYSICIAN SERVICES</b>        |                                |                                                 |                                                         |
| <b>Primary Care Office Visit</b> | <b>No</b>                      | Not Covered<br>100% paid by Member              | Not Covered<br>100% paid by Member                      |
| <b>Specialist Office Visit</b>   | <b>No</b>                      | Not Covered<br>100% paid by Member              | Not Covered<br>100% paid by Member                      |
| <b>Urgent Care</b>               | <b>No</b>                      | Not Covered<br>100% paid by Member              | Not Covered<br>100% paid by Member                      |

<sup>1</sup> If the Plan covers Emergency Room and/or Ambulance Services, those services will be covered if they are provided by an Out of Network provider and will be subject to the deductible and Out of Pocket Maximum.

Benefits that are subject to the No Surprises Act will be reimbursed at the Participating Provider level of benefits.



| Plan Provisions                                                        |                                                            | Prior Auth Required | Participating Providers (In Network)                                   | Non Participating Providers (Out of Network) |
|------------------------------------------------------------------------|------------------------------------------------------------|---------------------|------------------------------------------------------------------------|----------------------------------------------|
| Member Pays                                                            |                                                            |                     |                                                                        |                                              |
| <b>PREVENTIVE &amp; WELLNESS SERVICES</b>                              |                                                            |                     |                                                                        |                                              |
| (See Schedule of Preventive Health Services section)                   | (Non-Hospital Based)                                       | No                  | \$0 Copay (Plan pays 100% of covered preventive and wellness services) | Not Covered<br>100% paid by Member           |
|                                                                        | (Hospital Based)                                           | No                  | Not Covered<br>100% paid by Member                                     | Not Covered<br>100% paid by Member           |
| <b>HOSPITAL/FACILITY SERVICES</b>                                      |                                                            |                     |                                                                        |                                              |
| <b>Inpatient Room &amp; Board</b>                                      | (Including Mental & Behavioral Health or Substance Abuse)  | No                  | Not Covered<br>100% paid by Member                                     | Not Covered<br>100% paid by Member           |
| <b>Other Inpatient Services</b>                                        | (e.g., surgery)                                            | No                  | Not Covered<br>100% paid by Member                                     | Not Covered<br>100% paid by Member           |
| <b>Outpatient Services</b><br>(Partial Hospitalization is not covered) | (Limited to Mental & Behavioral Health or Substance Abuse) | No                  | Not Covered<br>100% paid by Member                                     | Not Covered<br>100% paid by Member           |
| <b>Outpatient Surgery: Facility fee</b>                                | (e.g., ambulatory surgery center)                          | No                  | Not Covered<br>100% paid by Member                                     | Not Covered<br>100% paid by Member           |
| <b>Emergency Room Services</b>                                         |                                                            | No                  | Not Covered<br>100% paid by Member                                     | Not Covered<br>100% paid by Member           |
| <b>OUTPATIENT: DIAGNOSTIC SERVICES</b>                                 |                                                            |                     |                                                                        |                                              |
| <b>Laboratory Service</b>                                              | (Non-Hospital Based)                                       | No                  | Not Covered<br>100% paid by Member                                     | Not Covered<br>100% paid by Member           |
|                                                                        | (Hospital Based)                                           | No                  | Not Covered<br>100% paid by Member                                     | Not Covered<br>100% paid by Member           |
| <b>Radiology</b>                                                       | (Non-Hospital Based)                                       | No                  | Not Covered<br>100% paid by Member                                     | Not Covered<br>100% paid by Member           |
|                                                                        | (Hospital Based)                                           | No                  | Not Covered<br>100% paid by Member                                     | Not Covered<br>100% paid by Member           |
| <b>CT/MRI/MRA/PET Scan</b>                                             | (Non-Hospital Based)                                       | No                  | Not Covered<br>100% paid by Member                                     | Not Covered<br>100% paid by Member           |
|                                                                        | (Hospital Based)                                           | No                  | Not Covered<br>100% paid by Member                                     | Not Covered<br>100% paid by Member           |



| Plan Provisions                           | Prior Auth Required | Participating Providers (In Network) | Non Participating Providers (Out of Network) |
|-------------------------------------------|---------------------|--------------------------------------|----------------------------------------------|
| <b>Member Pays</b>                        |                     |                                      |                                              |
| <b>PREGNANCY BENEFITS</b>                 |                     |                                      |                                              |
| Office Visits                             | No                  | Not Covered<br>100% paid by Member   | Not Covered<br>100% paid by Member           |
| Childbirth/Delivery Professional Services | No                  | Not Covered<br>100% paid by Member   | Not Covered<br>100% paid by Member           |
| Childbirth/Delivery Facility Services     | No                  | Not Covered<br>100% paid by Member   | Not Covered<br>100% paid by Member           |
| <b>OTHER SERVICES</b>                     |                     |                                      |                                              |
| Rehabilitation/Habilitation Services      | No                  | Not Covered<br>100% paid by Member   | Not Covered<br>100% paid by Member           |
| Emergency Medical Transportation          | No                  | Not Covered<br>100% paid by Member   | Not Covered<br>100% paid by Member           |

| <b>PHARMACY BENEFITS</b>                                     |  | Participating Pharmacies                               | Non Participating Pharmacies       |
|--------------------------------------------------------------|--|--------------------------------------------------------|------------------------------------|
| <b>Member Pays</b>                                           |  |                                                        |                                    |
| <b>Preventive Prescriptions - (Subject to Formulary)</b>     |  |                                                        |                                    |
| Pharmacy Retail – up to a 30-day supply                      |  | Generic - \$0 Copay<br>(Limited to Preventive Generic) | Not Covered<br>100% paid by Member |
| <b>Non-Preventive Prescriptions - (Subject to Formulary)</b> |  |                                                        |                                    |
| Pharmacy Retail – up to a 30-day supply                      |  | Not Covered<br>100% paid by Member                     | Not Covered<br>100% paid by Member |
| Pharmacy Mail Order – 90-day supply                          |  | Not Covered<br>100% paid by Member                     | Not Covered<br>100% paid by Member |
| Specialty Drugs                                              |  | Not Covered<br>100% paid by Member                     | Not Covered<br>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. Rehabilitative therapies
4. Substance Abuse / Addiction Treatment Facilities
5. Dental procedures
6. Any other medical service, treatment, or procedure not specifically listed in this Schedule of Benefits
7. 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
8. Acupuncture
9. Claims for weight control, weight reduction, or surgical treatment for obesity or morbid obesity, unless explicitly provided in the schedule of benefits
10. Chiropractic care
11. 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
12. Claims for eyeglasses, contacts, hearing aids (or examinations for the fitting thereof) or radial keratotomy
13. Any claims for fertility or infertility treatment
14. Home health care, hospice care, private duty nursing, or long-term care
15. Routine eye care (Adult)
16. 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

"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."