WELLPREMIUM™

Schedule of Benefits & Plan Design

Medical Services Deductible Information

Deductible	Participating Providers (In Network)	Non Participating Providers (Out of Network) [1]
Individual	$0	Not Covered
Family	$0	Not Covered

Out of Pocket Information

Out of Pocket Maximum	Participating Providers (In Network)	Non Participating Providers (Out of Network) [1]
Individual	$9,100	Not Covered
Family	$18,200	Not Covered

Schedule of Benefits

The WellPREMIUM™ 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.

Plan Provisions	Prior Auth Required	Participating Providers (In Network)	Non Participating Providers (Out of Network)
		Member Pays	
PHYSICIAN SERVICES			
Primary Care OfficeVisit	No	$35 Copay Existing Doctor $70 Copay New Doctor	Not Covered 100% paid by Member
Specialist Office Visit	No	$75 Copay Existing Doctor $150 Copay New Doctor	Not Covered 100% paid by Member
Urgent Care	No	$75 Copay	Not Covered 100% paid by Member

[1] 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.

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Plan Provisions		Prior Auth Required	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 (Plan pays 100% of covered preventive and wellness services)	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 Room & Board	(Including Mental & Behavioral Health or Substance Abuse)	**No**	Not Covered 100% paid by Member	Not Covered 100% paid by Member
Other Inpatient Services	(e.g., surgery)	**No**	Not Covered 100% paid by Member	Not Covered 100% paid by Member
Outpatient Services (Partial Hospitalization is not covered; Considered a Specialist Visit)	(Limited to Mental & Behavioral Health or Substance Abuse)	**No**	$75 Copay Existing Doctor $150 Copay New Doctor	Not Covered 100% paid by Member
Outpatient Surgery: Facility fee	(e.g., ambulatory surgery center)	**No**	Not Covered 100% paid by Member	Not Covered 100% paid by Member
Emergency Room Services		**No**	Not Covered 100% paid by Member	Not Covered 100% paid by Member
OUTPATIENT: DIAGNOSTIC SERVICES				
Laboratory Service	**(Non-Hospital Based)**	**No**	$50 Copay per panel tested	Not Covered 100% paid by Member
	(Hospital Based)	**No**	Not Covered 100% paid by Member	Not Covered 100% paid by Member
Radiology	**(Non-Hospital Based)**	**No**	$50 Copay per image billed	Not Covered 100% paid by Member
	(Hospital Based)	**No**	Not Covered 100% paid by Member	Not Covered 100% paid by Member
CT/MRI/MRA/PET Scan	**(Non-Hospital Based)**	**Yes**	$500 Copay per image billed	Not Covered 100% paid by Member
	(Hospital Based)	**Not Applicable**	Not Covered 100% paid by Member	Not Covered 100% paid by Member

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Plan Provisions	Prior Auth Required	Participating Providers (In Network)	Non Participating Providers (Out of Network)
		Member Pays	
PREGNANCY BENEFITS			
Office Visits (Considered a Specialist Visit)	No	$75 Copay Existing Doctor $150 Copay New Doctor	Not Covered 100% paid by Member
Childbirth/Delivery Professional Services	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
Childbirth/Delivery Facility Services	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
OTHER SERVICES			
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 Prescriptions - (Subject to Formulary)			
Pharmacy Retail – up to a 30-day supply		Not Covered 100% paid by Member	Not Covered 100% paid by Member
Pharmacy Mail Order – 90-day supply		Not Covered 100% paid by Member	Not Covered 100% paid by Member
Specialty Drugs		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. 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 themedical 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 withing 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.”