SelectMed Metallic Plan Options

SelectMed Metallic Plan Options		SelectMed Bronze	SelectMed Silver
Evidence of insurability		**Guaranteed Acceptance**	**Guaranteed Acceptance**
PPO Network		Multiplan Practitioner and Ancillary network	
Deductible		**In Network Participating Providers (No Out of Network Coverage)**	**In Network Participating Providers (No Out of Network Coverage)**
Individual		$0	$0
Family		$0	$0
Out-of-Pocket Maximum		**In Network Participating Providers (No Out of Network Coverage)**	**In Network Participating Providers (No Out of Network Coverage)**
Individual		$8,150	$5,000
Family		$16,300	$10,000
Medical Services		**In Network Participating Providers (No Out of Network Coverage)**	**In Network Participating Providers (No Out of Network Coverage)**
PHYSICIAN SERVICES			
Primary Care Office Visit	Non-Hospital Based	$25 Copay *(Limited to 8 visits per calendar year)*	$15 Copay *(Limited to 10 visits per calendar year)*
	Hospital Based	Not Covered-100% paid by Member	
Specialist Office Visit	Non-Hospital Based	$50 Copay *(Limited to 8 visits per calendar year)*	$25 Copay *(Limited to 10 visits per calendar year)*
	Hospital Based	Not Covered-100% paid by Member	
Urgent Care		$50 Copay *(Limited to 2 visits per calendar year)*	$35 Copay *(Limited to 3 visits per calendar year)*
Telemedicine Services		$0	$0
PREVENTIVE & WELLNESS SERVICES			
(Non-Hospital Based)		$0 Copay *(Plan pays 100% of covered preventive and wellness services)*	
(Hospital Based)		Not Covered - 100% paid by Member	
HOSPITAL/FACILITY SERVICES (Subject to Referenced Based Pricing)			
Inpatient Hospitalization		$350 Copay per admission *(Limited to 5 days per calendar year)*	$350 Copay per admission *(Limited to 7 days per calendar year)*
Inpatient Visits - Physician		Included in Inpatient Hospitalization Copay *(Limited to visits up to 5 days per calendar year)*	Included in Inpatient Hospitalization Copay *(Limited to visits up to 7 days per calendar year)*
Inpatient Surgery[2]		Included in Inpatient Hospitalization Copay *(Second surgical opinion may be required; Limited to 2 surgeries per calendar year)*	Included in Inpatient Hospitalization Copay *(Second surgical opinion may be required; Limited to 3 surgeries per calendar year)*
Outpatient Hospital or Free Standing Facility Services and Surgery[2]		$350 Copay *(Limited to 1 visit per calendar year)*	$350 Copay *(Limited to 2 visit per calendar year)*
Anesthesia		Included in Inpatient Hospitalization or Outpatient Hospital or Free Standing Facility Services and Surgery Copay *(Limited to 2 inpatient and 1 outpatient anesthetic procedures per calendar year)*	Included in Inpatient Hospitalization or Outpatient Hospital or Free Standing Facility Services and Surgery Copay *(Limited to 3 inpatient and 2 outpatient anesthetic procedures per calendar year)*
Emergency Room Services		$350 Copay *(Limited to 1 visit per calendar year)*	
DIAGNOSTIC SERVICES			
Laboratory Services	Non-Hospital Based	$50 Copay *(Combined limit of 3 visits per calendar year with Radiology)*	
	Hospital Based	Not Covered - 100% paid by Member	
Radiology	Non-Hospital Based	$50 Copay *(Combined limit of 3 visits per calendar year with Laboratory Services)*	
	Hospital Based	Not Covered - 100% paid by Member	
CT/MRI/MRA/PET Scan	Non-Hospital Based[2]	$350 Copay *(Subject to RBP)* *(Limited to 1 per calendar year.)*	$350 Copay *(Subject to RBP)* *(Limited to 2 per calendar year.)*
	Hospital Based	Not Covered - 100% paid by Member	Not Covered - 100% paid by Member

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SelectMed Metallic Plan Options

		SelectMed Bronze	SelectMed Silver
PREGNANCY BENEFITS			
Professional Services		Not Covered - 100% paid by Member	$350 Copay
Childbirth/Delivery (Considered Inpatient Hospital Stay)		Not Covered - 100% paid by Member	$350 Copay per admission *(Subject to RBP)*
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)		$25 Copay	
Home Health Care		$25 Copay *(Limited to 10 visits per calendar year)*	$25 Copay *(Limited to 15 visits per calendar year)*
Treatment for Chemical Abuse & Dependency[2]	In-Patient	$250 Copay per day *(Subject to RBP) (Limited to 5 days per calendar year)*	$250 Copay per day *(Subject to RBP) (Limited to 7 days per calendar year)*
	Out-Patient	$25 Copay per day *(Limited to 5 days per calendar year)*	$25 Copay per day *(Limited to 7 days per calendar year)*
Rehabilitation/Habilitation Services		Not Covered - 100% paid by Member	
Emergency Medical Transportation		$250 Copay *(Subject to RBP) (By land only; Limited to 1 transport per calendar year)*	
PHARMACY BENEFITS		**Participating Pharmacies**	
Preventive Prescriptions - (Subject to Formulary)			
Pharmacy Retail – up to a 30 day supply		Generic - $0 Copay *(Limited to Preventive Generic)*	
Non-Preventive Prescriptions - (Subject to Formulary)			
Prescription Benefit		Brand/Generic, $10 Formulary Generic $50 Formulary Brand; Mail $30 Formulary Generic $150 Formulary Brand, $750 Per Primary $1,500 Per Family Annual Max[1]	
Monthly Rates		**SelectMed Bronze**	**SelectMed Silver**
Individual		$487.89	$589.48
Individual + Spouse		$853.26	$1,016.37
Individual + Child		$880.90	$1,047.49
Family		$1,308.36	$1,588.64

Not available in Alaska, Hawaii, Massachusetts, and New Hampshire.
Reinsurance coverage is provided through Providence Insurance Company II
1. The prescription provided by DataRx is not available in NY, SD, and WA.
For additional information reference the Summary Plan Document for a list of services offered In-Network.
To find a provider through the Multiplan Practitioner and Ancillary network: https://www.multiplan.com/webcenter/portal/ProviderSearch

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SelectMed Metallic Plan Options

Preventive Health Services: Limitations, Intervals, and Requirements[1]

The following table represents the preventive services currently covered under the SelectMed Bronze and SelectMed Silver™ Plans as well as the permitted interval and any requirements of such preventive services.

Benefits are automatically subject to 29 CFR § 2590.715 -2713(a). Amendments to this section through legislative act or regulation are automatically incorporated into this document by reference. Preventive Services covered in this section are explained in more detail through the following official resources:

- Medical services with a rating of "A" or "B" from the current recommendations of the United States Preventive Services Task Force. See https://www.uspreventiveservicestaskforce.org
- Preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Guidelines can be found in https://www.hrsa.gov
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for certain individuals only. See https://www.cdc.gov/vaccines/acip

Preventative and Wellness Services - Covered Benefits

Adults
- Adult Annual Standard Physical
- Alcohol Misuse: Unhealthy Alcohol Use Screening and Counseling
- Aspirin: Preventive Medication
- Blood pressure screening
- Breastfeeding interventions
- Chlamydia screening
- Colorectal Cancer Screening
- Dental cavities prevention: infants and children up to age 5 years
- Depression Screening
- Diabetes Screening
- Fall Prevention: Older Adults
- Healthy Diet and Physical Activity Counseling to Prevent Cardiovascular Disease
- Hemoglobinopathies screening
- Hepatitis B screening
- Hepatitis C virus (HCV) infection screening: born between 1945 and 1965.
- High Blood Pressure Screening
- HIV Preexposure Prophylaxis for the Prevention of HIV Infection
- HIV Screening
- Hypothyroidism screening
- Lung Cancer Screening
- Obesity screening and Counseling
- Sexually Transmitted Infections Counseling
- Skin Cancer Behavioral Counseling
- Statin Preventive Medication
- Tobacco Use Counseling and Interventions
- Syphilis Screening

Men
- Abdominal aortic aneurysm screening

Women
- Aspirin: Preventive Medication
- BRCA risk assessment and genetic counseling/ testing
- Breast Cancer Preventive Medications
- Breast Cancer Screening
- Cervical Cancer Screening: with Cytology (Pap Smear) Lung cancer screening
- Chlamydia Screening
- Contraceptive Methods and Counseling
- Folic Acid Supplementation
- Gonorrhea Screening
- Intimate Partner Violence Screening
- Osteoporosis Screening
- Well-Woman Visits

Pregnant Women
- Bacteriuria Screening
- Breastfeeding Support, Supplies and Counseling
- Depression Screening
- Gestational Diabetes Mellitus Screening
- Hepatitis B Screening
- HIV Screening
- Preeclampsia Screening
- Rh Incompatibility Screening: First Pregnancy Visit
- RH Incompatibility Screening: 24–28 Weeks' Gestation
- Syphilis Screening
- Tobacco Use Counseling and Interventions

Newborns
- Gonorrhea Prophylactic Medication
- Hemoglobinopathies Screening
- Hypothyroidism Screening
- Phenylketonuria Screening

Infants
- Dental Caries Prevention: Infants and Children Up to Age 5

Children
- Dental Caries Prevention: Infants and Children Up to Age 5
- Obesity screening and Counseling
- Skin Cancer Behavioral Counseling
- Tobacco Use Counseling and Interventions
- Vision Screening: Age 3 to 5
- Well-Child Visits

Adolescents
- Depression Screening
- Hepatitis B Screening
- HIV Screening
- Obesity screening and Counseling
- Sexually Transmitted Infections Counseling
- Skin Cancer Behavioral Counseling
- Tobacco Use Counseling and Interventions

Multiple Populations
- Tuberculosis Screening: all populations at risk
- Skin Cancer Behavioral Counseling: young adults, adolescents, children, and parents of young children

***See Schedule of Benefits for Limitations, Intervals and Requirements.**

Vaccines

IMMUNIZATIONS - recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for routine use in children, adolescents, or adults*

Adults 19 Years or Older	Children From 7 Through 18 Years Old	Birth Through 6 Years Old
• IIV • RIV • LAIV • Tdap • MMR • VAR • RZV • ZVL • HPV - Female • HPV- Male • PCV13 • PPSV23	• Flu • Tdap • HPV • MenACWY • MenACWY	• HepB • DTaP • Hib • PCV13 • IPV • Flu • MMR • VAR • HepA • RV

1. None of the Preventive Health Services are covered if they are provided at a hospital.

* Immunization illustrations listed herein are based upon CDC recommendations contained in the following schedules: (i) Recommended Child and Adolescent Immunization Schedule (available at: https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html), and (ii) Recommended Adult Immunization Schedule (available at: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html). Additional immunization scenarios not included in the aforementioned illustrations (such as catch-up immunization recommendations, immunization recommendations for certain high-risk groups, and immunization recommendations subject to individual clinical decision-making) may also be covered under this Plan pursuant to CDC recommendation. Information concerning these additional covered immunization scenarios (including vaccine type, age requirements, and frequency) is available online under the CDC schedule links listed above. Paper copies of these CDC schedules can also be obtained free of charge by written request to the Plan Administrator.

This plan is ACA Compliant. For additional information, visit: https://www.healthcare.gov/coverage/preventive-care-benefits/ as benefits are subject to change. Or reference the Summary Plan Document for a list of Wellness & Preventative services offered In-Network.

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Exclusions

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 Plan
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 this Appendix A or otherwise explicitly provided in this 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
10. Claims which would otherwise be covered by a Worker's Compensation policy for which a participant is entitled to benefit
11. Any claim arising from service received outside of the United States, except for the reasonable cost of claims billed by the Veterans Administration or Department of Defense for benefits covered under this Plan and not incurred during or from service in the Armed Forces of the United States
12. 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
13. 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
14. Charges which are or could be reimbursed by any public health program irrespective of whether such coverage has been elected by a participant
15. Claims due to an act of war, declared or undeclared, not including acts of terrorism
16. Claims for eyeglasses, contacts, hearing aids (or examinations for the fitting thereof) or radial keratotomy
17. 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
18. Travel, unless specifically provided in the schedule of benefits
19. Custodial care for primarily personal, not medical, needs provided by persons with no special medical training or skill
20. Claims from any provider other than a healthcare provider as defined in the Plan Document unless explicitly permitted in the schedule of benefits
21. Investigatory or experimental treatment, services, or supplies unless specifically covered under Approved Clinical Trials
22. Services or supplies which are primarily educational
23. Claims due to attempted suicide or intentionally self-inflicted injury while sane or insane, unless the claim results from a medical condition such as depression
24. 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
25. 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
26. Claims from a medical service provider who is related by blood, marriage, or legal adoption to a participant
27. Any claims for fertility or infertility treatment
28. Claims for weight control, weight reduction, or surgical treatment for obesity or morbid obesity, unless explicitly provided in the schedule of benefits
29. Claims for disability resulting from reversal of sterilization
30. Claims for the completion of forms, or failure to keep scheduled appointments
31. Recreational or diversional therapy
32. 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
33. 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
34. Claims that arise primarily due to medical tourism
35. Supportive devices of the foot
36. Treatments for sexual dysfunction
37. Aquatic or massage therapy
38. Biofeedback training
39. Skilled nursing facilities
40. Durable medical equipment and prosthetics
41. Hospice care, private duty nursing, or long-term care
42. 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
43. Claims for temporomandibular joint syndrome
44. Claims for biotech or specialty prescriptions
45. Any claim which is not explicitly covered in the schedule of benefits
46. Genetic testing unless explicitly covered in the schedule of benefits
47. Organ transplants
48. Claims for cosmetic surgery, not related to mastectomy reconstruction to produce a symmetrical appearance or prosthesis, or physical complications which result from such procedures.
49. Chiropractic care
50. Radiation and chemotherapy
51. Dialysis
52. Acupuncture
53. Alternative medicine/homeopathy
54. Children dental and vision
55. Neonatal intensive care (NICU)
56. Rehabilitative therapies
57. PCP surgery
58. Routine eye care (Adult)
59. Non-emergency care when traveling outside the U.S.
60. Routine well-baby care of newborn infant while inpatient.
61. Pregnancy Benefits, including office visits and childbirth/delivery professional and facility services (Bronze only)

"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."