MEC ENHANCED - Minimum Essential Coverage

SERVICES	*PPO PROVIDERS*	*NON-PPO PROVIDERS*
Plan Year Deductible (Embedded)	None	None
Coinsurance	Plan pays 100%	Plan pays 100%
Out-of-Pocket Maximum (Non-PPO providers do not satisfy the PPO provider Out-of-Pocket)	None	None
Preventive Care Provisions	No Deductible, No Copay as Required Under the Law	No Deductible, No Copay As Required Under the Law
Professional Outpatient Office Visits		
Primary Care	$25 Copay per visit	Not Covered
Specialist	$50 Copay per visit	Not Covered
Mental Health	$25 Copay per visit	Not Covered
Substance Abuse	$25 Copay per visit	Not Covered
Diagnostic Testing		
Doctors Office - Lab, X-rays & Imaging (e.g., MRI, MRA, PET, CT)	100% for Tests Required Under the Law; $25 Copay if any other diagnostics during the 3 covered Doctors Office Visits	100% for Tests Required Under the Law
Independent Facility - X-rays & Imaging (e.g., MRI, MRA, PET, CT)	100% for Tests Required Under the Law	100% for Tests Required Under the Law
Inpatient Hospital Services		
Medical Services and Facility	Not Covered	Not Covered
Anesthesiologist & Surgeon Fees (Assistants at 20% of Primary)		
Mental Health & Substance Abuse		
Outpatient Surgical & Diagnostic		

Medical Services	Not Covered	Not Covered
Facility Charges		
Emergency Services		
Hospital Emergency Room	Not Covered	Not Covered
Urgent Care Visits	Not Covered	Not Covered
Ambulance - Ground	Not Covered	Not Covered
Ambulance - Air	Not Covered	Not Covered
Prescription Drugs*	Only if Required Under the Law; ie: Very Limited Coverage *	Not Covered
Supplemental Services		
Home Health	Not Covered	Not Covered
Occupational Therapy	Not Covered	Not Covered
Physical Therapy	Not Covered	Not Covered
Speech Therapy	Not Covered	Not Covered
Private Duty Nursing	Not Covered	Not Covered
Skilled Nursing	Not Covered	Not Covered
Chronic Pain Treatment Program	Not Covered	Not Covered
Manipulative Therapy	Not Covered	Not Covered
Hospice Care	Not Covered	
TMJ	Not Covered	
Allergy Treatment		
Testing and Injections	Not Covered	Not Covered
Serum	Not Covered	Not Covered
Durable Medical Equipment	Not Covered	Not Covered

Please Note: This schedule applies as indicated in the SPD. This schedule must be read in conjunction with the entire Summary Plan Description and has no full meaning by itself.

MEC ENHANCED - Minimum Essential Coverage	
Plan Year Deductible	None
Coinsurance	Plan Pays 100%
Out-of-Pocket Maximum	None
Preventive Care Provisions	Charges for preventive care services coverage are at no cost sharing if Required Under the Law. Cost sharing may apply if a specific service is for non-preventive car (even if billed in conjunction with preventive care services). Although not required under the Law, this plan pays for Prostatic/Testicular exams.
Professional Outpatient Office Visits	These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical, or medical procedures performed by the physician or for diagnostic services billed separately.
Primary Care (In-office Xray/Blood work Incl.)	
Specialist	
Mental Health	Not Covered
Substance Abuse	
Independent Diagnostic Testing Facility	Tests Required Under the Law are Covered.
X-rays & Adv. Imaging (e.g., MRI, MRA, PET, CT)	
Independent Clinical Labs - Blood Work	
Outpatient Surgical & Diagnostic	Tests Required Under the Law are Covered.
Medical Services	
Facility Charges	

Emergency Services	Not Covered
Hospital Emergency Room	
Urgent Care Visits	
Ambulance - Ground	
Ambulance - Air	
*** Prescription Drugs**	Only those prescriptions required by law are covered, e.g., FDA approved contraceptives and Aspirin to prevent CVO.
Short-Term Rehabilitation Services	Not Covered
TMJ	Not Covered