

Schedule of Benefits

In-Network benefits are based on the Exclusive Provider Organization's approved amount. This Policy does not pay benefits for Covered Medical Expenses from an Out-of-Network provider, except for Emergency Services. Benefits are determined after any applicable Deductible and Coinsurance and are subject to General Exclusions and other applicable limitations.

***Deductible**
-Individual
-Family, embedded

"Embedded" = If the policy is covering a family, the amount of Covered Expenses can be satisfied by any combination of family members, but any one individual cannot contribute more than the Individual Deductible amount. An individual family member may be entitled to benefits before the Family Deductible is satisfied if that family member satisfies the Individual Deductible.

****Cost Sharing Maximum**
-Individual
-Family, embedded

Deductible, Coinsurance, and Copays apply to the Cost Sharing Maximum.

"Embedded" = If the policy is covering a family, deductibles, coinsurance and copays will continue to be applied to an individual until either the individual meets the Individual Cost Sharing Maximum or the Family Cost Sharing Maximum is satisfied. Claims paid after the Family Cost Sharing Maximum is met will have no further Cost Sharing applied.

Benefits	In-Network	Out-of-Network
*Individual Deductible	\$0	N/A
*Family Deductible	\$0	N/A
Coinsurance - plan pays	60%	60%
Coinsurance - you pay	40%	40%
**Individual total out-of-pocket max	\$550	N/A
**Family total out-of-pocket max	\$1,100	N/A
Lifetime maximum	Unlimited	Unlimited
Services	You Pay In-Network	You Pay Out-of-Network
Primary care visit to treat an injury or illness	\$25 copay	Not covered
Specialist visit	\$50 copay	Not covered
Other practitioner office visit	\$50 copay	Not covered
Outpatient facility fee (e.g., Ambulatory Surgery Center)	\$550 copay	Not covered

Services	You Pay In-Network	You Pay Out-of-Network
Outpatient surgery physician/surgical services	\$100 copay	Not covered
Hospice services	\$550 copay	Not covered
Routine dental services (adult)	Not covered	Not covered
Infertility treatment	Not covered	Not covered
Long-term/custodial nursing home care	Not covered	Not covered
Private-duty nursing (82 visits per year)	40% coinsurance	Not covered
Routine eye exam (adult)	Not covered	Not covered
Urgent care centers or facilities	\$100 copay	Not covered
Home health care services – 100 visits per Benefit Period	40% coinsurance	Not covered
Emergency room services	\$550 copay	\$550 copay
Emergency transportation/ambulance	\$550 copay	\$550 copay
Inpatient hospital services (e.g., hospital stay)	\$550 copay per day	Not covered
Inpatient physician and surgical services	No charge	Not covered
Bariatric surgery	Not covered	Not covered
Cosmetic surgery	Not covered	Not covered
Skilled nursing facility – 90 Days per Benefit Period	\$550 copay per day	Not covered
Prenatal and postnatal care	\$25 copay	Not covered
Delivery and all inpatient services for maternity care	\$550 copay	Not covered
Mental/behavioral health outpatient services	\$25 copay	Not covered
Mental/behavioral health inpatient services	\$550 copay per day	Not covered
Substance abuse disorder outpatient services	\$25 copay	Not covered
Substance abuse disorder inpatient services	\$550 copay per day	Not covered
Generic drugs	\$25 copay	Not covered

Services	You Pay In-network	You Pay Out-of-Network
Preferred brand drugs	\$50 copay	Not covered
Non-preferred brand drugs	40% coinsurance	Not covered
Specialty drugs	40% coinsurance	Not covered
Outpatient rehabilitation services - 60 visits per benefit period	\$100 copay	Not covered
Habilitation services - 60 visits per benefit period	\$100 copay	Not covered
Chiropractic care – 12 Visits per benefit period	40% coinsurance	Not covered
Durable medical equipment	40% coinsurance	Not covered
Hearing aids	Not covered	Not covered
Imaging (CT/PET scans, MRIs)	\$200 copay	Not covered
Preventive care/screening/immunization	No charge	Not covered
Routine foot care	Not covered	Not covered
Acupuncture	Not covered	Not covered
Routine eye exam for children (Limited to 1 per Plan Year)	\$25 copay	Not covered
Eyeglasses for children (Limited to 1 per Plan Year)	40% coinsurance	Not covered
Dental check-up for children	Not covered	Not covered
Rehabilitative speech therapy - 20 visits per Benefit Period.	\$100 copay	Not covered
Rehabilitative occupational and rehabilitative physical therapy – 40 visits per Benefit Period	\$100 copay	Not covered
Well baby visits and care	No charge	Not covered
Laboratory outpatient and professional services	\$100 copay	Not covered
X-rays and diagnostic imaging	\$200 copay	Not covered
Basic dental care – child	Not covered	Not covered

Services	You Pay In-Network	You Pay Out-of-Network
Orthodontia – child	Not covered	Not covered
Major dental care – child	Not covered	Not covered
Basic dental care – adult	Not covered	Not covered
Orthodontia – adult	Not covered	Not covered
Major dental care – adult	Not covered	Not covered
Abortion for which public funding is prohibited	Not covered	Not covered
Transplant	40% coinsurance	Not covered
Accidental dental - \$3,000 per Episode	40% coinsurance	Not covered
Dialysis	40% coinsurance	Not covered
Allergy testing	\$100 copay	Not covered
Chemotherapy	40% coinsurance	Not covered
Radiation	40% coinsurance	Not covered
Diabetes Education	40% coinsurance	Not covered
Prosthetic devices	40% coinsurance	Not covered
Infusion therapy	40% coinsurance	Not covered
Treatment for temporomandibular joint disorders	40% coinsurance	Not covered
Nutritional counseling	40% coinsurance	Not covered
Reconstructive surgery	40% coinsurance	Not covered
Virtual care - primary care visit	\$10 copay	Not covered
Virtual care - specialist visit	\$25 copay	Not covered
Virtual care - urgent care	\$50 copay	Not covered
Tobacco cessation	No charge	Not covered
Mental health/substance abuse office visits	\$25 copay	Not covered

Services	You Pay In-Network	You Pay Out-of-Network
Gender Affirming Care	Not Covered	Not Covered
Weight Loss Programs	Not Covered	Not Covered