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	75% coinsurance	75% coinsurance
Coinsurance - you pay	25% coinsurance	25% coinsurance
**Individual total out-of-pocket max	$1,700	N/A
**Family total out-of-pocket max	$3,400	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	No charge	Not covered
Specialist visit	$10 copay	Not covered
Other practitioner office visit	$10 copay	Not covered
Outpatient facility fee (e.g., Ambulatory Surgery Center)	25% coinsurance	Not covered

Services	You Pay In-Network	You Pay Out-of-Network
Outpatient surgery physician/surgical services	25% coinsurance	Not covered
Hospice services	25% coinsurance	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)	25% coinsurance	Not covered
Routine eye exam (adult)	Not covered	Not covered
Urgent care centers or facilities	$5 copay	Not covered
Home health care services – 100 visits per Benefit Period	25% coinsurance	Not covered
Emergency room services	25% coinsurance	25% coinsurance
Emergency transportation/ambulance	25% coinsurance	25% coinsurance
Inpatient hospital services (e.g., hospital stay)	25% coinsurance	Not covered
Inpatient physician and surgical services	25% coinsurance	Not covered
Bariatric surgery	Not covered	Not covered
Cosmetic surgery	Not covered	Not covered
Skilled nursing facility – 90 Days per Benefit Period	25% coinsurance	Not covered
Prenatal and postnatal care	No charge	Not covered
Delivery and all inpatient services for maternity care	25% coinsurance	Not covered
Mental/behavioral health outpatient services	No charge	Not covered
Mental/behavioral health inpatient services	25% coinsurance	Not covered
Substance abuse disorder outpatient services	No charge	Not covered
Substance abuse disorder inpatient services	25% coinsurance	Not covered

Services	You Pay In-network	You Pay Out-of-Network
Generic drugs	$0 copay	Not covered
Preferred brand drugs	$15 copay	Not covered
Non-preferred brand drugs	$50 copay	Not covered
Specialty drugs	$150 copay	Not covered
Outpatient rehabilitation services - 60 visits per benefit period	No charge	Not covered
Habilitation services - 60 visits per benefit period	No charge	Not covered
Chiropractic care – 12 Visits per benefit period	25% coinsurance	Not covered
Durable medical equipment	25% coinsurance	Not covered
Hearing aids	Not covered	Not covered
Imaging (CT/PET scans, MRIs)	25% coinsurance	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)	No charge	Not covered
Eyeglasses for children (Limited to 1 per Plan Year)	25% coinsurance	Not covered
Dental check-up for children	Not covered	Not covered
Rehabilitative speech therapy - 20 visits per Benefit Period.	No charge	Not covered
Rehabilitative occupational and rehabilitative physical therapy – 40 visits per Benefit Period	No charge	Not covered
Well baby visits and care	No charge	Not covered
Laboratory outpatient and professional services	25% coinsurance	Not covered

Services	You Pay In-Network	You Pay Out-of-Network
X-rays and diagnostic imaging	25% coinsurance	Not covered
Basic dental care – child	Not covered	Not covered
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	25% coinsurance	Not covered
Accidental dental - $3,000 per Episode	25% coinsurance	Not covered
Dialysis	25% coinsurance	Not covered
Allergy testing	25% coinsurance	Not covered
Chemotherapy	25% coinsurance	Not covered
Radiation	25% coinsurance	Not covered
Diabetes Education	25% coinsurance	Not covered
Prosthetic devices	25% coinsurance	Not covered
Infusion therapy	25% coinsurance	Not covered
Treatment for temporomandibular joint disorders	25% coinsurance	Not covered
Nutritional counseling	25% coinsurance	Not covered
Reconstructive surgery	25% coinsurance	Not covered
Virtual care - primary care visit	No charge	Not covered
Virtual care - specialist visit	$5 copay	Not covered
Virtual care - urgent care	$5 copay	Not covered
Tobacco cessation	No charge	Not covered

Services	You Pay In-Network	You Pay Out-of-Network
Mental health/substance abuse office visits	No charge	Not covered
Gender Affirming Care	Not Covered	Not Covered
Weight Loss Programs	Not Covered	Not Covered