

### 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                           | \$5,800                          | N/A                              |
| *Family Deductible                               | \$11,600                         | N/A                              |
| Coinsurance - plan pays                          | 60% coinsurance after deductible | 60% coinsurance after deductible |
| Coinsurance - you pay                            | 40% coinsurance after deductible | 40% coinsurance after deductible |
| **Individual total out-of-pocket max             | \$8,900                          | N/A                              |
| **Family total out-of-pocket max                 | \$17,800                         | 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 | \$40 copay                       | Not covered                      |
| Specialist visit                                 | \$80 copay                       | Not covered                      |
| Other practitioner office visit                  | \$80 copay                       | Not covered                      |

| Services   | You Pay In-Network               | You Pay Out-of-Network           |
|--|----------------------------------|----------------------------------|
| Outpatient facility fee (e.g., Ambulatory Surgery Center)                      | 40% coinsurance after deductible | Not covered                      |
| Outpatient surgery physician/surgical services                                 | 40% coinsurance after deductible | Not covered                      |
| Hospice services   | 40% coinsurance after deductible | Not covered                      |
| Routine dental services (adult)  | Not covered                      | Not covered                      |
| Infertility treatment  | 40% coinsurance after deductible | Not covered                      |
| Long-term/custodial nursing home care  | Not covered                      | Not covered                      |
| Private-duty nursing   | 40% coinsurance after deductible | Not covered                      |
| Routine eye exam (adult)   | Not covered                      | Not covered                      |
| Urgent care centers or facilities  | \$60 copay                       | Not covered                      |
| Home health care services - 3 visits per year                                  | 40% coinsurance after deductible | Not covered                      |
| Emergency room services  | 40% coinsurance after deductible | 40% coinsurance after deductible |
| Emergency transportation/ambulance - Non-emergent ambulance is not covered OON | 40% coinsurance after deductible | 40% coinsurance after deductible |
| Inpatient hospital services (e.g., hospital stay)                              | 40% coinsurance after deductible | Not covered                      |
| Inpatient physician and surgical services                                      | 40% coinsurance after deductible | Not covered                      |
| Bariatric surgery  | Not covered                      | Not covered                      |
| Cosmetic surgery   | Not covered                      | Not covered                      |
| Skilled nursing facility   | Not covered                      | Not covered                      |
| Delivery and all inpatient services for maternity care                         | 40% coinsurance after deductible | Not covered                      |
| Mental/behavioral health outpatient services                                   | \$40 copay                       | Not covered                      |
| Mental/behavioral health inpatient services                                    | 40% coinsurance after deductible | Not covered                      |
| Substance abuse disorder outpatient services                                   | \$40 copay                       | Not covered                      |
| Substance abuse disorder inpatient services                                    | 40% coinsurance after deductible | Not covered                      |

| Services  | You Pay In-Network               | You Pay Out-of-Network |
|---|----------------------------------|------------------------|
| Generic drugs   | \$20 copay                       | Not covered            |
| Preferred brand drugs   | \$40 copay                       | Not covered            |
| Non-preferred brand drugs   | \$80 copay after deductible      | Not covered            |
| Specialty drugs - subject to prior auth   | \$350 copay after deductible     | Not covered            |
| Outpatient rehabilitation services - Speech Therapy limited to one service per day up to 90 days.   | \$40 copay                       | Not covered            |
| Habilitation services   | \$40 copay                       | Not covered            |
| Chiropractic Care   | 40% coinsurance after deductible | Not covered            |
| Durable medical equipment   | 40% coinsurance after deductible | Not covered            |
| Hearing aids  | Not covered                      | Not covered            |
| Imaging (CT/PET scans, MRIs)  | 40% coinsurance after deductible | Not covered            |
| Preventive care/screening/immunization  | No charge                        | Not covered            |
| Routine foot care   | No charge                        | Not covered            |
| Acupuncture   | Not covered                      | Not covered            |
| Routine eye exam for children   | No charge                        | Not covered            |
| Eyeglasses for children (3 Frames & 3 Lenses per Plan Year)   | No charge                        | Not covered            |
| Dental check-up for children  | Not covered                      | Not covered            |
| Rehabilitative speech therapy - Limited to one service per day up to a maximum benefit of 90 daily services per Insured per Benefit Period. Not applicable to Mental Illness or Substance Use Disorder. | \$40 copay                       | Not covered            |
| Rehabilitative occupational and rehab physical therapy  | \$40 copay                       | Not covered            |
| Well baby visits and care   | No charge                        | Not covered            |

| <b>Services</b>                                 | <b>You Pay In-Network</b>        | <b>You Pay Out-of-Network</b> |
|---|----------------------------------|-------------------------------|
| Laboratory outpatient and professional services | 40% coinsurance after deductible | Not covered                   |
| X-rays and diagnostic imaging                   | 40% coinsurance after deductible | 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                                      | 40% coinsurance after deductible | Not covered                   |
| Accidental dental                               | 40% coinsurance after deductible | Not covered                   |
| Dialysis  | 40% coinsurance after deductible | Not covered                   |
| Allergy Testing                                 | 40% coinsurance after deductible | Not covered                   |
| Chemotherapy                                    | 40% coinsurance after deductible | Not covered                   |
| Radiation                                       | 40% coinsurance after deductible | Not covered                   |
| Prosthetic devices                              | 40% coinsurance after deductible | Not covered                   |
| Infusion therapy                                | 40% coinsurance after deductible | Not covered                   |
| Treatment for temporomandibular joint disorders | 40% coinsurance after deductible | Not covered                   |
| Diabetes Care and Education                     | 40% coinsurance after deductible | Not covered                   |
| Nutritional counseling                          | Not covered                      | Not covered                   |
| Reconstructive surgery                          | 40% coinsurance after deductible | Not covered                   |
| Virtual care - primary care visit               | \$20 copay                       | Not covered                   |
| Virtual care - specialist visit                 | \$40 copay                       | Not covered                   |

| Services                                    | You Pay In-Network | You Pay Out-of-Network |
|---|--------------------|------------------------|
| Virtual care - urgent care                  | \$60 copay         | Not covered            |
| Tobacco cessation                           | No charge          | Not covered            |
| Prenatal and postnatal care                 | \$40 copay         | Not covered            |
| Mental health/substance abuse office visits | \$40 copay         | Not covered            |
| Gender Affirming Care                       | Not Covered        | Not Covered            |
| Weight Loss Programs                        | Not covered        | Not covered            |