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	80% after deductible	80% after deductible
Coinsurance - you pay	20% after deductible	20% after deductible
**Individual total out-of-pocket max	$1,200	N/A
**Family total out-of-pocket max	$2,400	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)	20% coinsurance	Not covered

Services	You Pay In-Network	You Pay Out-of-Network
Outpatient surgery physician/surgical services	20% coinsurance	Not covered
Hospice services	20% coinsurance	Not covered
Routine dental services (adult)	Not covered	Not covered
Infertility treatment	20% coinsurance	Not covered
Long-term/custodial nursing home care	Not covered	Not covered
Private-duty nursing	Not covered	Not covered
Routine eye exam (adult)	Not covered	Not covered
Urgent care centers or facilities	20% coinsurance	Not covered
Home health care services	20% coinsurance	Not covered
Emergency room services	20% coinsurance	20% coinsurance
Emergency transportation/ambulance	20% coinsurance	20% coinsurance
Inpatient hospital services (e.g., hospital stay)	20% coinsurance	Not covered
Inpatient physician and surgical services	20% coinsurance	Not covered
Bariatric surgery (1 Procedure per Lifetime)	20% coinsurance	Not covered
Cosmetic surgery	Not covered	Not covered
Skilled nursing facility (45 Days per Year)	20% coinsurance	Not covered
Prenatal and postnatal care	No charge	Not covered
Delivery and all inpatient services for maternity care	20% coinsurance	Not covered
Mental/behavioral health outpatient services	No charge	Not covered
Mental/behavioral health inpatient services	20% coinsurance	Not covered
Substance abuse disorder outpatient services	No charge	Not covered
Substance abuse disorder inpatient services	20% coinsurance	Not covered
Generic drugs	$10 copay	Not covered

Services	You Pay In-Network	You Pay Out-of-Network
Preferred brand drugs	$20 copay	Not covered
Non-preferred brand drugs	50% coinsurance	Not covered
Specialty drugs	50% coinsurance	Not covered
Outpatient rehabilitation services - Speech Therapy limited to 30 Visits per Year PT/OT/Chiropractic combined limit of 30 Visits per Year	20% coinsurance	Not covered
Habilitation services - Speech Therapy limited to 30 Visits per Year PT/OT/Chiropractic combined limit of 30 Visits per Year	20% coinsurance	Not covered
Chiropractic care - PT/OT/Chiropractic combined limit of 30 Visits per Year	20% coinsurance	Not covered
Durable medical equipment	20% coinsurance	Not covered
Hearing aids	Not covered	Not covered
Imaging (CT/PET scans, MRIs)	20% 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 (1 Exam per year)	No charge	Not covered
Eyeglasses for children (1 Item per year)	20% coinsurance	Not covered
Dental check-up for children	Not covered	Not covered
Rehabilitative speech therapy - 30 visits per year	20% coinsurance	Not covered
Rehabilitative occupational and rehabilitative physical therapy (30 Visits per year, combined with Chiropractic)	20% coinsurance	Not covered
Well baby visits and care (Includes annual routine visitation and hearing exams as part of a physical to determine vision or hearing loss. For newborns, screening test for hearing impairment and necessary diagnostic follow-up care through age two (2).)	No charge	Not covered

Services	You Pay In-Network	You Pay Out-of-Network
Laboratory outpatient and professional services	20% coinsurance	Not covered
X-rays and diagnostic imaging	20% 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	20% coinsurance	Not covered
Accidental dental	Not covered	Not covered
Dialysis	20% coinsurance	Not covered
Allergy testing	20% coinsurance	Not covered
Chemotherapy	20% coinsurance	Not covered
Radiation	20% coinsurance	Not covered
Diabetes Care and Education (Including Medically Necessary foot orthotics which are not subject to a Plan Year maximum. Also including Nutritional and Diet counseling through a diabetes management plan and for adults at higher risk of chronic disease)	20% coinsurance	Not covered
Prosthetic devices	20% coinsurance	Not covered
Infusion therapy	20% coinsurance	Not covered
Treatment for temporomandibular joint disorders	20% coinsurance	Not covered
Nutritional counseling (6 visits per Year)	20% coinsurance	Not covered
Reconstructive surgery	20% coinsurance	Not covered

Services	You Pay In-Network	You Pay Out-of-Network
Virtual care - primary care visit	No charge	Not covered
Virtual care - specialist visit	$5 copay	Not covered
Virtual care - urgent care	$10 copay	Not covered
Tobacco cessation	No charge	Not covered
Mental health/substance abuse office visits	No charge	Not covered