# 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 | 100% | 100% |
| Coinsurance - you pay | 0% | 0% |
| **Individual total out-of-pocket max | N/A | N/A |
| **Family total out-of-pocket max | N/A | 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 | No Charge | Not Covered |
| Other practitioner office visit | No Charge | Not Covered |
| Outpatient facility fee (e.g., Ambulatory Surgery Center) | No Charge | Not Covered |

| Services | You Pay In-Network | You Pay Out-of-Network |
|---|---|---|
| Outpatient surgery physician/surgical services | No Charge | Not Covered |
| Hospice services | No Charge | 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) | Not Covered | Not Covered |
| Routine eye exam (adult) | Not Covered | Not Covered |
| Urgent care centers or facilities | No Charge | Not Covered |
| Home health care services – 100 visits per Benefit Period | No Charge | Not Covered |
| Emergency room services | No Charge | No Charge |
| Emergency transportation/ambulance | No Charge | No Charge |
| Inpatient hospital services (e.g., hospital stay) | No Charge | 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 | No Charge | Not Covered |
| Prenatal and postnatal care | No Charge | Not Covered |
| Delivery and all inpatient services for maternity care | No Charge | Not Covered |
| Mental/behavioral health outpatient services | No Charge | Not Covered |
| Mental/behavioral health inpatient services | No Charge | Not Covered |
| Substance abuse disorder outpatient services | No Charge | Not Covered |
| Substance abuse disorder inpatient services | No Charge | Not Covered |

| Services | You Pay In-Network | You Pay Out-of-Network |
|---|---|---|
| Generic drugs | No Charge | Not Covered |
| Preferred brand drugs | No Charge | Not Covered |
| Non-preferred brand drugs | No Charge | Not Covered |
| Specialty drugs | No Charge | 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 | No Charge | Not Covered |
| Durable medical equipment | No Charge | Not Covered |
| Hearing aids | No Charge | Not Covered |
| Imaging (CT/PET scans, MRIs) | No Charge | 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) | No Charge | 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 | No Charge | Not Covered |
| X-rays and diagnostic imaging | No Charge | Not Covered |

| Services | You Pay In-Network | You Pay Out-of-Network |
|---|---|---|
| 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 | No Charge | Not Covered |
| Accidental dental - $3,000 per Episode | No Charge | Not Covered |
| Dialysis | No Charge | Not Covered |
| Allergy testing | No Charge | Not Covered |
| Chemotherapy | No Charge | Not Covered |
| Radiation | No Charge | Not Covered |
| Diabetes Education | No Charge | Not Covered |
| Prosthetic devices | No Charge | Not Covered |
| Infusion therapy | No Charge | Not Covered |
| Treatment for temporomandibular joint disorders | No Charge | Not Covered |
| Nutritional counseling | No Charge | Not Covered |
| Reconstructive surgery | No Charge | Not Covered |
| Virtual care - primary care visit | No Charge | Not Covered |
| Virtual care - specialist visit | No Charge | Not Covered |
| Virtual care - urgent care | No Charge | Not Covered |
| Tobacco cessation | No Charge | Not Covered |
| Mental health/substance abuse office visits | No Charge | 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 |