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, 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.

Benefits	In-Network	Out-of-Network
*Individual Deductible	$5,900	N/A
*Family deductible	$11,800	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	$9,100	N/A
**Family total out-of-pocket max	$18,200	N/A
Lifetime maximum	Unlimited	Unlimited
Services	**You Pay In-Network**	**You Pay Out-of-Network**
Abortion for Which Public Funding is Prohibited	Not covered	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	40% coinsurance after deductible	Not covered
Bariatric Surgery	Not covered	Not covered

Services	You Pay In-Network	You Pay Out-of-Network
Chemotherapy	40% coinsurance after deductible	Not covered
Chiropractic Care **(12 visits per benefit period)**	40% coinsurance after deductible	Not covered
Cosmetic Surgery	Not covered	Not covered
Delivery and All Inpatient Services for Maternity Care	40% coinsurance after deductible	Not covered
Diabetes Education	40% coinsurance after deductible	Not covered
Dialysis	40% coinsurance after deductible	Not covered
Durable Medical Equipment	40% coinsurance after deductible	Not covered
Emergency Room Services	40% coinsurance after deductible	40% coinsurance after deductible
Emergency Transportation/Ambulance	40% coinsurance after deductible	40% coinsurance after deductible
Gender Affirming Care	Not covered	Not covered
Habilitation Services **(Speech Therapy limited to 20 visits per benefit period, Occupational Therapy limited to 20 visits per benefit period, Physical Therapy limited to 20 visits per benefit period)**	$40.00	Not covered
Hearing Aids	Not covered	Not covered
Home Health Care Services **(100 visits per benefit period)**	40% coinsurance after deductible	Not covered
Hospice Services	40% coinsurance after deductible	Not covered
Imaging (CT/PET Scans, MRIs)	40% coinsurance after deductible	Not covered
Infertility Treatment	Not covered	Not covered
Infusion Therapy	40% coinsurance after deductible	Not covered
Inpatient Hospital Services (e.g., Hospital Stay)	40% coinsurance after deductible	Not covered
Inpatient Physician and Surgical Services	40% coinsurance after deductible	Not covered

Services	You Pay In-Network	You Pay Out-of-Network
Laboratory Outpatient and Professional Services	40% coinsurance after deductible	Not covered
Long-Term/Custodial Nursing Home Care	Not covered	Not covered
Mental Health/Substance Abuse Care Visits	$40.00	Not covered
Mental/Behavioral Health Inpatient Services	40% coinsurance after deductible	Not covered
Mental/Behavioral Health Outpatient Services	$40.00	Not covered
Nutritional Counseling	40% coinsurance after deductible	Not covered
Other Practitioner Office Visit (Nurse, Physician Assistant)	$80.00	Not covered
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	40% coinsurance after deductible	Not covered
Outpatient Rehabilitation Services **(Speech Therapy limited to 20 visits per benefit period, Occupational Therapy limited to 20 visits per benefit period, Physical Therapy limited to 20 visits per benefit period)**	$40.00	Not covered
Outpatient Surgery Physician/Surgical Services	40% coinsurance after deductible	Not covered
Prenatal and Postnatal Care	$40.00	Not covered
Preventive Care/Screening/Immunization	No charge	Not covered
Primary Care Visit to Treat an Injury or Illness	$40.00	Not covered
Private Duty Nursing **(82 visits per year)**	40% coinsurance after deductible	Not covered
Prosthetic Devices	40% coinsurance after deductible	Not covered
Radiation	40% coinsurance after deductible	Not covered
Reconstructive Surgery	40% coinsurance after deductible	Not covered
Rehabilitative Services **(Speech Therapy limited to 20 visits per benefit period, Occupational Therapy limited to 20 visits per benefit period, Physical Therapy limited to 20 visits per benefit period)**	$40.00	Not covered

Services	You Pay In-Network	You Pay Out-of-Network
Routine Foot Care	Not covered	Not covered
Skilled Nursing Facility **(90 days per benefit period)**	40% coinsurance after deductible	Not covered
Specialist Visit	$80.00	Not covered
Substance Abuse Disorder Inpatient Services	40% coinsurance after deductible	Not covered
Substance Abuse Disorder Outpatient Services	$40.00	Not covered
Tobacco Cessation	No charge	Not covered
Transplant	40% coinsurance after deductible	Not covered
Treatment for Temporomandibular Joint Disorders	40% coinsurance after deductible	Not covered
Urgent Care Centers or Facilities	$60.00	Not covered
Virtual Care - Primary Care Visit	$20.00	Not covered
Virtual Care - Specialist Visit	$40.00	Not covered
Virtual Care - Urgent Care	$60.00	Not covered
Weight Loss Programs	Not covered	Not covered
Well Baby Visits and Care	No charge	Not covered
X-rays and Diagnostic Imaging	40% coinsurance after deductible	Not covered
Generic Drugs	$20.00	Not covered
Preferred Brand Drugs	$40.00	Not covered
Non-Preferred Brand Drugs	$80.00 copay after deductible	Not covered
Specialty Drugs	$350.00 copay after deductible	Not covered
Accidental Dental **($3,000 per episode)**	40% coinsurance after deductible	Not covered
Dental Check-Up for Children	Not covered	Not covered
Basic Dental Care - Child	Not covered	Not covered
Major Dental Care - Child	Not covered	Not covered

Services	You Pay In-Network	You Pay Out-of-Network
Orthodontia - Child	Not covered	Not covered
Routine Dental Services (Adult)	Not covered	Not covered
Basic Dental Care - Adult	Not covered	Not covered
Major Dental Care - Adult	Not covered	Not covered
Orthodontia - Adult	Not covered	Not covered
Eyeglasses for Children **(1 item per Plan year)**	40% coinsurance after deductible	Not covered
Routine Eye Exam (Adult)	Not covered	Not covered
Routine Eye Exam for Children (**1 exam per Plan year)**	$40.00	Not covered