

## 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                          | \$5,700                          | N/A                              |
| *Family deductible                              | \$11,400                         | 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            | \$7,200                          | N/A                              |
| **Family total out-of-pocket max                | \$14,400                         | 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  | 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  | \$40.00                          | Not covered                      |
| Habilitation Services  | \$40.00                          | Not covered                      |
| Hearing Aids   | Not covered                      | Not covered                      |
| Home Health Care Services ( <b>3 visits per year on educational visits</b> ) | 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  | 40% coinsurance after deductible | 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                      |
| 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                      |

| Services  | You Pay In-Network               | You Pay Out-of-Network |
|---|----------------------------------|------------------------|
| Mental/Behavioral Health Outpatient Services  | \$40.00                          | Not covered            |
| Nutritional Counseling  | Not covered                      | 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 ( <b>Speech Therapy is limited to one service per day, up to 90 days</b> )                                       | \$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  | 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 Occupational and Rehabilitative Physical Therapy   | \$40.00                          | Not covered            |
| Rehabilitative Speech Therapy ( <b>Limited to one service per day up to a maximum benefit of 90 daily services per insured per benefit period</b> ) | \$40.00                          | Not covered            |
| Routine Foot Care   | No charge                        | Not covered            |

| Services  | You Pay In-Network               | You Pay Out-of-Network |
|---|----------------------------------|------------------------|
| Skilled Nursing Facility ( <b>Covered Skilled Nursing Facility Expenses include: Semi-private room and board, other services and supplies ordered by a Physician and furnished by the Skilled Nursing Facility for Inpatient medical care, or services provided in the course of Treatment of the Insured by an anesthesiologist, pathologist, physical therapist, occupational therapist, speech therapist, or radiologist. Refer to Policy for coverage details</b> ) | Not covered                      | 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   | \$15.00                          | Not covered            |
| Virtual Care - Specialist Visit   | \$30.00                          | Not covered            |
| Virtual Care - Urgent Care  | \$45.00                          | 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            |

| Services  | You Pay In-Network               | You Pay Out-of-Network |
|---|----------------------------------|------------------------|
| Accidental Dental   | 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            |
| 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 ( <b>3 frames and 3 lenses per year</b> ) | No charge                        | Not covered            |
| Routine Eye Exam (Adult)  | Not covered                      | Not covered            |
| Routine Eye Exam for Children                                     | No charge                        | Not covered            |