



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 | \$9,450 | N/A |
| *Family deductible | \$18,900 | N/A |
| Coinsurance - plan pays | 100% after deductible | 100% after deductible |
| Coinsurance - you pay | 0% after deductible | 0% after deductible |
| **Individual total out-of-pocket max | \$9,450 | N/A |
| **Family total out-of-pocket max | \$18,900 | N/A |
| Lifetime maximum | Unlimited | Unlimited |
| Services | <u>You Pay</u> In-Network | <u>You Pay</u> Out-of-Network |
| Abortion for Which Public Funding is Prohibited | Not covered | Not covered |
| Acupuncture | Not covered | Not covered |
| Allergy Testing | No charge after deductible | Not covered |
| Bariatric Surgery | Not covered | Not covered |

| Services | You Pay In-Network | You Pay Out-of-Network |
|---|----------------------------|----------------------------|
| Chemotherapy | No charge after deductible | Not covered |
| Chiropractic Care (20 visits per year) | No charge after deductible | Not covered |
| Cosmetic Surgery | Not covered | Not covered |
| Delivery and All Inpatient Services for Maternity Care | No charge after deductible | Not covered |
| Diabetes Education | No charge after deductible | Not covered |
| Dialysis | No charge after deductible | Not covered |
| Durable Medical Equipment | No charge after deductible | Not covered |
| Emergency Room Services | No charge after deductible | No charge after deductible |
| Emergency Transportation/Ambulance | No charge after deductible | No charge after deductible |
| Gender Affirming Care | Not covered | Not covered |
| Habilitation Services (20 visits per year) | No charge after deductible | Not covered |
| Hearing Aids (1 item per 3 years) | No charge after deductible | Not covered |
| Home Health Care Services (60 visits per year) | No charge after deductible | Not covered |
| Hospice Services | No charge after deductible | Not covered |
| Imaging (CT/PET Scans, MRIs) | No charge after deductible | Not covered |
| Infertility Treatment | Not covered | Not covered |
| Infusion Therapy | No charge after deductible | Not covered |
| Inpatient Hospital Services (e.g., Hospital Stay) | No charge after deductible | Not covered |
| Inpatient Physician and Surgical Services | No charge after deductible | Not covered |
| Laboratory Outpatient and Professional Services | No charge after deductible | Not covered |
| Long-Term/Custodial Nursing Home Care | Not covered | Not covered |
| Mental Health/Substance Abuse Care Visits | \$25.00 | Not covered |
| Mental/Behavioral Health Inpatient Services | No charge after deductible | Not covered |

| Services | You Pay In-Network | You Pay Out-of-Network |
|---|----------------------------|------------------------|
| Mental/Behavioral Health Outpatient Services | \$25.00 | Not covered |
| Nutritional Counseling | No charge after deductible | Not covered |
| Other Practitioner Office Visit (Nurse, Physician Assistant) | No charge after deductible | Not covered |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center) | No charge after deductible | Not covered |
| Outpatient Rehabilitation Services (20 visits per year) | No charge after deductible | Not covered |
| Outpatient Surgery Physician/Surgical Services | No charge after deductible | Not covered |
| Prenatal and Postnatal Care | \$25.00 | Not covered |
| Preventive Care/Screening/Immunization | No charge | Not covered |
| Primary Care Visit to Treat an Injury or Illness | \$25.00 | Not covered |
| Private Duty Nursing | Not covered | Not covered |
| Prosthetic Devices | No charge after deductible | Not covered |
| Radiation | No charge after deductible | Not covered |
| Reconstructive Surgery | No charge after deductible | Not covered |
| Rehabilitative Occupational and Rehabilitative Physical Therapy (20 visits per year) | No charge after deductible | Not covered |
| Rehabilitative Speech Therapy (20 visits per year) | No charge after deductible | Not covered |
| Routine Foot Care | Not covered | Not covered |
| Skilled Nursing Facility (60 days per year) | No charge after deductible | Not covered |
| Specialist Visit | No charge after deductible | Not covered |
| Substance Abuse Disorder Inpatient Services | No charge after deductible | Not covered |
| Substance Abuse Disorder Outpatient Services | \$25.00 | Not covered |
| Tobacco Cessation | No charge | Not covered |
| Transplant | No charge after deductible | Not covered |
| Treatment for Temporomandibular Joint Disorders | No charge after deductible | Not covered |
| Urgent Care Centers or Facilities | No charge after deductible | Not covered |

| Services | You Pay In-Network | You Pay Out-of-Network |
|---|----------------------------|------------------------|
| Virtual Care - Primary Care Visit | \$10.00 | Not covered |
| Virtual Care - Specialist Visit | \$20.00 | Not covered |
| Virtual Care - Urgent Care | \$30.00 | Not covered |
| Weight Loss Programs | Not covered | Not covered |
| Well Baby Visits and Care | No charge | Not covered |
| X-rays and Diagnostic Imaging | No charge after deductible | Not covered |
| Generic Drugs | \$20.00 | Not covered |
| Preferred Brand Drugs | No charge after deductible | Not covered |
| Non-Preferred Brand Drugs | No charge after deductible | Not covered |
| Specialty Drugs | No charge after deductible | Not covered |
| Accidental Dental | No charge 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 (1 item per Plan year) | No charge after deductible | Not covered |
| Routine Eye Exam (Adult) | Not covered | Not covered |
| Routine Eye Exam for Children (1 exam per Plan year) | \$25.00 | Not covered |