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	$0	N/A
*Family deductible	$0	N/A
Coinsurance - plan pays	80% coinsurance after deductible	80% coinsurance after deductible
Coinsurance - you pay	20% coinsurance after deductible	20% coinsurance 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**
Abortion for Which Public Funding is Prohibited	Not covered	Not covered
Acupuncture	Not covered	Not covered
Allergy Testing	20%	Not covered

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

Services	You Pay In-Network	You Pay Out-of-Network
Mental/Behavioral Health Outpatient Services	No charge	Not covered
Nutritional Counseling	20%	Not covered
Other Practitioner Office Visit (Nurse, Physician Assistant)	$10.00	Not covered
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20%	Not covered
Outpatient Rehabilitation Services **(20 visits per year)**	20%	Not covered
Outpatient Surgery Physician/Surgical Services	20%	Not covered
Prenatal and Postnatal Care	No charge	Not covered
Preventive Care/Screening/Immunization	No charge	Not covered
Primary Care Visit to Treat an Injury or Illness	No charge	Not covered
Private Duty Nursing	Not covered	Not covered
Prosthetic Devices	20%	Not covered
Radiation	20%	Not covered
Reconstructive Surgery	20%	Not covered
Rehabilitative Occupational and Rehabilitative Physical Therapy **(20 visits per year)**	20%	Not covered
Rehabilitative Speech Therapy **(20 visits per year)**	20%	Not covered
Routine Foot Care	Not covered	Not covered
Skilled Nursing Facility **(60 days per year)**	20%	Not covered
Specialist Visit	$10.00	Not covered
Substance Abuse Disorder Inpatient Services	20%	Not covered
Substance Abuse Disorder Outpatient Services	No charge	Not covered
Tobacco Cessation	No charge	Not covered
Transplant	20%	Not covered
Treatment for Temporomandibular Joint Disorders	20%	Not covered
Urgent Care Centers or Facilities	50%	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	$5.00	Not covered
Virtual Care - Urgent Care	$10.00	Not covered
Weight Loss Programs	Not covered	Not covered
Well Baby Visits and Care	No charge	Not covered
X-rays and Diagnostic Imaging	20%	Not covered
Generic Drugs	$10.00	Not covered
Preferred Brand Drugs	$20.00	Not covered
Non-Preferred Brand Drugs	50%	Not covered
Specialty Drugs	50%	Not covered
Accidental Dental	20%	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)**	20%	Not covered
Routine Eye Exam (Adult)	Not covered	Not covered
Routine Eye Exam for Children (**1 exam per Plan year)**	No charge	Not covered