

PRECISION HEALTH PLANS: *INDUSTRIAL SERIES*

ENHANCED 250/100



SCHEDULE OF BENEFITS

YOU PAY

Preventive Care Under PPACA	Charges for preventive care as per PPACA on the effective date of the plan provide for certain benefits to be paid absent of cost sharing.	No Deductible, No Copay
Virtual Care / Telemedicine Full Virtual Primary, Urgent and Behavioral Health. See enrollment materials for details.	With Virtual Primary Care (VPC), members and their families receive access to a dedicated physician. Virtual Preventive, Urgent, and Behavioral Health are covered at a \$0 Copay when using a Recuro provider.	No Deductible, No Copay
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Use Disorder	These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical or medical procedures performed by the physician or for diagnostic services billed separately.	\$20 Copay \$40 Copay \$20 Copay
Office Based Diagnostic Tests, Labs & X-Ray	Includes diagnostic tests performed in a physician's office and billed by such physician or a freestanding non-hospital billed facility only.	\$20 Copay
Outpatient Surgical, Diagnostic & Therapeutic Procedures Medical Services Facility Charges	Includes outpatient services, such as miscellaneous medical procedures and supplies, diagnostic and therapeutic procedures and surgery at a physician's office, freestanding surgical center or hospital (when approved).	\$60 Copay \$60 Copay
Vision Annual Exam Only	Any optometrist; member must submit claim for reimbursement. Copay waived for children under 5.	\$30 Copay
Short Term Rehabilitation Services	Physical, chiropractic, speech and occupational therapy. (Includes therapies performed in a provider's office or other non-hospital billed facility only).	\$40 Copay
Emergency Services Hospital Emergency Room Urgent Care/Physician Ambulance	ER copayment waived if admitted; \$250 penalty for non-emergency use of a hospital emergency room. Urgent Care copayments do not include charges for diagnostic, surgical, or medical procedures.	\$200 Copay \$20 Copay \$40 Copay
Allergy Treatment Testing & Injections Serum		\$20 Copay \$150 Copay
Prescription Drug Coverage Tier 1 Tier 2 Tier 3 Tier 4	Up to a 34-day supply may be purchased at retail for the listed copay. Up to a 90-day supply may be purchased at retail or by mail order for 2 copays.	\$0 Copay \$20 Copay \$75 Copay \$150 Copay
EXPENSES ABOVE THIS LINE NOT SUBJECT TO DEDUCTIBLE		
Plan Year Deductible Individual Family	An individual within family coverage will only be required to meet the indicated individual deductible amount before coinsurance benefits begin.	\$250 Deductible \$500 Deductible
Deductible & Coinsurance Maximum Individual Family	Copays do not apply to the deductible and coinsurance maximum. However, copays combined with the deductible and coinsurance maximum do apply to an In Network Out of Pocket maximum of \$7,000 for those with individual coverage and \$14,000 for those with dependents covered.	\$250 per Individual \$500 per Family
Inpatient Hospitalization Medical Services & Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Use Disorder		0% after the Deductible 0% after the Deductible 0% after the Deductible
Home Health Care & Skilled Nursing Facilities		0% after the Deductible
Durable Medical Equipment		0% after the Deductible

PPO Provisions. Benefit Reduction for Non-Network Providers - when receiving care from non-network providers, all benefits are subject to the deductible and an additional 20% coinsurance and an increased out of pocket maximum. Other limits may apply. Out of Network Expense: 20% after the deductible. Maximum Out of Pocket Expense: \$9,000/\$18,000. Please refer to the Summary Plan Description (SPD) for details. The SPD is the final determination of all benefits. Out-of-Network benefits are subject to usual and customary limitations.

PRECISION HEALTH PLANS: *INDUSTRIAL SERIES*

ENHANCED 250/90



SCHEDULE OF BENEFITS

YOU PAY

Preventive Care Under PPACA	Charges for preventive care as per PPACA on the effective date of the plan provide for certain benefits to be paid absent of cost sharing.	No Deductible, No Copay
Virtual Care / Telemedicine Full Virtual Primary, Urgent and Behavioral Health. See enrollment materials for details.	With Virtual Primary Care (VPC), members and their families receive access to a dedicated physician. Virtual Preventive, Urgent, and Behavioral Health are covered at a \$0 Copay when using a Recuro provider.	No Deductible, No Copay
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Use Disorder	These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical or medical procedures performed by the physician or for diagnostic services billed separately.	\$20 Copay \$40 Copay \$20 Copay
Office Based Diagnostic Tests, Labs & X-Ray	Includes diagnostic tests performed in a physician's office and billed by such physician or a freestanding non-hospital billed facility only.	\$20 Copay
Outpatient Surgical, Diagnostic & Therapeutic Procedures Medical Services Facility Charges	Includes outpatient services, such as miscellaneous medical procedures and supplies, diagnostic and therapeutic procedures and surgery at a physician's office, freestanding surgical center or hospital (when approved).	\$60 Copay \$60 Copay
Vision Annual Exam Only	Any optometrist; member must submit claim for reimbursement. Copay waived for children under 5.	\$30 Copay
Short Term Rehabilitation Services	Physical, chiropractic, speech and occupational therapy. (Includes therapies performed in a provider's office or other non-hospital billed facility only).	\$40 Copay
Emergency Services Hospital Emergency Room Urgent Care/Physician Ambulance	ER copayment waived if admitted; \$250 penalty for non-emergency use of a hospital emergency room. Urgent Care copayments do not include charges for diagnostic, surgical, or medical procedures.	\$200 Copay \$20 Copay \$40 Copay
Allergy Treatment Testing & Injections Serum		\$20 Copay \$150 Copay
Prescription Drug Coverage Tier 1 Tier 2 Tier 3 Tier 4	Up to a 34-day supply may be purchased at retail for the listed copay. Up to a 90-day supply may be purchased at retail or by mail order for 2 copays.	\$0 Copay \$20 Copay \$75 Copay \$150 Copay
EXPENSES ABOVE THIS LINE NOT SUBJECT TO DEDUCTIBLE		
Plan Year Deductible Individual Family	An individual within family coverage will only be required to meet the indicated individual deductible amount before coinsurance benefits begin.	\$250 Deductible \$500 Deductible
Deductible & Coinsurance Maximum Individual Family	Copays do not apply to the deductible and coinsurance maximum. However, copays combined with the deductible and coinsurance maximum do apply to an In Network Out of Pocket maximum of \$7,000 for those with individual coverage and \$14,000 for those with dependents covered.	\$1,500 per Individual \$3,000 per Family
Inpatient Hospitalization Medical Services & Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Use Disorder		10% after the Deductible 10% after the Deductible 10% after the Deductible
Home Health Care & Skilled Nursing Facilities		10% after the Deductible
Durable Medical Equipment		10% after the Deductible

PPO Provisions. Benefit Reduction for Non-Network Providers - when receiving care from non-network providers, all benefits are subject to the deductible and an additional 20% coinsurance and an increased out of pocket maximum. Other limits may apply. Out of Network Expense: 30% after the deductible. Maximum Out of Pocket Expense: \$9,000/\$18,000. Please refer to the Summary Plan Description (SPD) for details. The SPD is the final determination of all benefits. Out-of-Network benefits are subject to usual and customary limitations.

PRECISION HEALTH PLANS: *INDUSTRIAL SERIES*

ENHANCED 500/80



SCHEDULE OF BENEFITS

YOU PAY

Preventive Care Under PPACA	Charges for preventive care as per PPACA on the effective date of the plan provide for certain benefits to be paid absent of cost sharing.	No Deductible, No Copay
Virtual Care / Telemedicine Full Virtual Primary, Urgent and Behavioral Health. See enrollment materials for details.	With Virtual Primary Care (VPC), members and their families receive access to a dedicated physician. Virtual Preventive, Urgent, and Behavioral Health are covered at a \$0 Copay when using a Recuro provider.	No Deductible, No Copay
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Use Disorder	These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical or medical procedures performed by the physician or for diagnostic services billed separately.	\$20 Copay \$40 Copay \$20 Copay
Office Based Diagnostic Tests, Labs & X-Ray	Includes diagnostic tests performed in a physician's office and billed by such physician or a freestanding non-hospital billed facility only.	\$20 Copay
Outpatient Surgical, Diagnostic & Therapeutic Procedures Medical Services Facility Charges	Includes outpatient services, such as miscellaneous medical procedures and supplies, diagnostic and therapeutic procedures and surgery at a physician's office, freestanding surgical center or hospital (when approved).	\$60 Copay \$60 Copay
Vision Annual Exam Only	Any optometrist; member must submit claim for reimbursement. Copay waived for children under 5.	\$30 Copay
Short Term Rehabilitation Services	Physical, chiropractic, speech and occupational therapy. (Includes therapies performed in a provider's office or other non-hospital billed facility only).	\$40 Copay
Emergency Services Hospital Emergency Room Urgent Care/Physician Ambulance	ER copayment waived if admitted; \$250 penalty for non-emergency use of a hospital emergency room. Urgent Care copayments do not include charges for diagnostic, surgical, or medical procedures.	\$200 Copay \$20 Copay \$40 Copay
Allergy Treatment Testing & Injections Serum		\$20 Copay \$150 Copay
Prescription Drug Coverage Tier 1 Tier 2 Tier 3 Tier 4	Up to a 34-day supply may be purchased at retail for the listed copay. Up to a 90-day supply may be purchased at retail or by mail order for 2 copays.	\$0 Copay \$20 Copay \$75 Copay \$150 Copay
EXPENSES ABOVE THIS LINE NOT SUBJECT TO DEDUCTIBLE		
Plan Year Deductible Individual Family	An individual within family coverage will only be required to meet the indicated individual deductible amount before coinsurance benefits begin.	\$500 Deductible \$1,000 Deductible
Deductible & Coinsurance Maximum Individual Family	Copays do not apply to the deductible and coinsurance maximum. However, copays combined with the deductible and coinsurance maximum do apply to an In Network Out of Pocket maximum of \$7,000 for those with individual coverage and \$14,000 for those with dependents covered.	\$3,000 per Individual \$6,000 per Family
Inpatient Hospitalization Medical Services & Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Use Disorder		20% after the Deductible 20% after the Deductible 20% after the Deductible
Home Health Care & Skilled Nursing Facilities		20% after the Deductible
Durable Medical Equipment		20% after the Deductible

PPO Provisions. Benefit Reduction for Non-Network Providers - when receiving care from non-network providers, all benefits are subject to the deductible and an additional 20% coinsurance and an increased out of pocket maximum. Other limits may apply. Out of Network Expense: 40% after the deductible. Maximum Out of Pocket Expense: \$9,000/\$18,000. Please refer to the Summary Plan Description (SPD) for details. The SPD is the final determination of all benefits. Out-of-Network benefits are subject to usual and customary limitations.

PRECISION HEALTH PLANS: *INDUSTRIAL SERIES*

ENHANCED 1000/70



SCHEDULE OF BENEFITS

YOU PAY

Preventive Care Under PPACA	Charges for preventive care as per PPACA on the effective date of the plan provide for certain benefits to be paid absent of cost sharing.	No Deductible, No Copay
Virtual Care / Telemedicine Full Virtual Primary, Urgent and Behavioral Health. See enrollment materials for details.	With Virtual Primary Care (VPC), members and their families receive access to a dedicated physician. Virtual Preventive, Urgent, and Behavioral Health are covered at a \$0 Copay when using a Recuro provider.	No Deductible, No Copay
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Use Disorder	These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical or medical procedures performed by the physician or for diagnostic services billed separately.	\$20 Copay \$40 Copay \$20 Copay
Office Based Diagnostic Tests, Labs & X-Ray	Includes diagnostic tests performed in a physician's office and billed by such physician or a freestanding non-hospital billed facility only.	\$20 Copay
Outpatient Surgical, Diagnostic & Therapeutic Procedures Medical Services Facility Charges	Includes outpatient services, such as miscellaneous medical procedures and supplies, diagnostic and therapeutic procedures and surgery at a physician's office, freestanding surgical center or hospital (when approved).	\$60 Copay \$60 Copay
Vision Annual Exam Only	Any optometrist; member must submit claim for reimbursement. Copay waived for children under 5.	\$30 Copay
Short Term Rehabilitation Services	Physical, chiropractic, speech and occupational therapy. (Includes therapies performed in a provider's office or other non-hospital billed facility only).	\$40 Copay
Emergency Services Hospital Emergency Room Urgent Care/Physician Ambulance	ER copayment waived if admitted; \$250 penalty for non-emergency use of a hospital emergency room. Urgent Care copayments do not include charges for diagnostic, surgical, or medical procedures.	\$200 Copay \$20 Copay \$40 Copay
Allergy Treatment Testing & Injections Serum		\$20 Copay \$150 Copay
Prescription Drug Coverage Tier 1 Tier 2 Tier 3 Tier 4	Up to a 34-day supply may be purchased at retail for the listed copay. Up to a 90-day supply may be purchased at retail or by mail order for 2 copays.	\$0 Copay \$20 Copay \$75 Copay \$150 Copay
EXPENSES ABOVE THIS LINE NOT SUBJECT TO DEDUCTIBLE		
Plan Year Deductible Individual Family	An individual within family coverage will only be required to meet the indicated individual deductible amount before coinsurance benefits begin.	\$1,000 Deductible \$2,000 Deductible
Deductible & Coinsurance Maximum Individual Family	Copays do not apply to the deductible and coinsurance maximum. However, copays combined with the deductible and coinsurance maximum do apply to an In Network Out of Pocket maximum of \$7,000 for those with individual coverage and \$14,000 for those with dependents covered.	\$4,500 per Individual \$9,000 per Family
Inpatient Hospitalization Medical Services & Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Use Disorder		30% after the Deductible 30% after the Deductible 30% after the Deductible
Home Health Care & Skilled Nursing Facilities		30% after the Deductible
Durable Medical Equipment		30% after the Deductible

PPO Provisions. Benefit Reduction for Non-Network Providers - when receiving care from non-network providers, all benefits are subject to the deductible and an additional 20% coinsurance and an increased out of pocket maximum. Other limits may apply. Out of Network Expense: 50% after the deductible. Maximum Out of Pocket Expense: \$9,000/\$18,000. Please refer to the Summary Plan Description (SPD) for details. The SPD is the final determination of all benefits. Out-of-Network benefits are subject to usual and customary limitations.

PRECISION HEALTH PLANS: *INDUSTRIAL SERIES*

ENHANCED 2500/70



SCHEDULE OF BENEFITS

YOU PAY

Preventive Care Under PPACA	Charges for preventive care as per PPACA on the effective date of the plan provide for certain benefits to be paid absent of cost sharing.	No Deductible, No Copay
Virtual Care / Telemedicine Full Virtual Primary, Urgent and Behavioral Health. See enrollment materials for details.	With Virtual Primary Care (VPC), members and their families receive access to a dedicated physician. Virtual Preventive, Urgent, and Behavioral Health are covered at a \$0 Copay when using a Recuro provider.	No Deductible, No Copay
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Use Disorder	These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical or medical procedures performed by the physician or for diagnostic services billed separately.	\$20 Copay \$40 Copay \$20 Copay
Office Based Diagnostic Tests, Labs & X-Ray	Includes diagnostic tests performed in a physician's office and billed by such physician or a freestanding non-hospital billed facility only.	\$20 Copay
Outpatient Surgical, Diagnostic & Therapeutic Procedures Medical Services Facility Charges	Includes outpatient services, such as miscellaneous medical procedures and supplies, diagnostic and therapeutic procedures and surgery at a physician's office, freestanding surgical center or hospital (when approved).	\$60 Copay \$60 Copay
Vision Annual Exam Only	Any optometrist; member must submit claim for reimbursement. Copay waived for children under 5.	\$30 Copay
Short Term Rehabilitation Services	Physical, chiropractic, speech and occupational therapy. (Includes therapies performed in a provider's office or other non-hospital billed facility only).	\$40 Copay
Emergency Services Hospital Emergency Room Urgent Care/Physician Ambulance	ER copayment waived if admitted; \$250 penalty for non-emergency use of a hospital emergency room. Urgent Care copayments do not include charges for diagnostic, surgical, or medical procedures.	\$200 Copay \$20 Copay \$40 Copay
Allergy Treatment Testing & Injections Serum		\$20 Copay \$150 Copay
Prescription Drug Coverage Tier 1 Tier 2 Tier 3 Tier 4	Up to a 34-day supply may be purchased at retail for the listed copay. Up to a 90-day supply may be purchased at retail or by mail order for 2 copays.	\$0 Copay \$20 Copay \$75 Copay \$150 Copay
EXPENSES ABOVE THIS LINE NOT SUBJECT TO DEDUCTIBLE		
Plan Year Deductible Individual Family	An individual within family coverage will only be required to meet the indicated individual deductible amount before coinsurance benefits begin.	\$2,500 Deductible \$5,000 Deductible
Deductible & Coinsurance Maximum Individual Family	Copays do not apply to the deductible. However, copays and coinsurance combined with the deductible do apply to an In Network Out of Pocket Maximum of \$7,000 for those with individual coverage and \$14,000 for those with dependents covered.	\$7,000 per Individual \$14,000 per Family
Inpatient Hospitalization Medical Services & Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Use Disorder		30% after the Deductible 30% after the Deductible 30% after the Deductible
Home Health Care & Skilled Nursing Facilities		30% after the Deductible
Durable Medical Equipment		30% after the Deductible

PPO Provisions. Benefit Reduction for Non-Network Providers - when receiving care from non-network providers, all benefits are subject to the deductible and an additional 20% coinsurance and an increased out of pocket maximum. Other limits may apply. Out of Network Expense: 50% after the deductible. Maximum Out of Pocket Expense: \$9,000/\$18,000. Please refer to the Summary Plan Description (SPD) for details. The SPD is the final determination of all benefits. Out-of-Network benefits are subject to usual and customary limitations.

PRECISION HEALTH PLANS: *INDUSTRIAL SERIES*

ENHANCED 3500/70



SCHEDULE OF BENEFITS

YOU PAY

Preventive Care Under PPACA	Charges for preventive care as per PPACA on the effective date of the plan provide for certain benefits to be paid absent of cost sharing.	No Deductible, No Copay
Virtual Care / Telemedicine Full Virtual Primary, Urgent and Behavioral Health. See enrollment materials for details.	With Virtual Primary Care (VPC), members and their families receive access to a dedicated physician. Virtual Preventive, Urgent, and Behavioral Health are covered at a \$0 Copay when using a Recuro provider.	No Deductible, No Copay
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Use Disorder	These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical or medical procedures performed by the physician or for diagnostic services billed separately.	\$20 Copay \$40 Copay \$20 Copay
Office Based Diagnostic Tests, Labs & X-Ray	Includes diagnostic tests performed in a physician's office and billed by such physician or a freestanding non-hospital billed facility only.	\$20 Copay
Outpatient Surgical, Diagnostic & Therapeutic Procedures Medical Services Facility Charges	Includes outpatient services, such as miscellaneous medical procedures and supplies, diagnostic and therapeutic procedures and surgery at a physician's office, freestanding surgical center or hospital (when approved).	\$60 Copay \$60 Copay
Vision Annual Exam Only	Any optometrist; member must submit claim for reimbursement. Copay waived for children under 5.	\$30 Copay
Short Term Rehabilitation Services	Physical, chiropractic, speech and occupational therapy. (Includes therapies performed in a provider's office or other non-hospital billed facility only).	\$40 Copay
Emergency Services Hospital Emergency Room Urgent Care/Physician Ambulance	ER copayment waived if admitted; \$250 penalty for non-emergency use of a hospital emergency room. Urgent Care copayments do not include charges for diagnostic, surgical, or medical procedures.	\$200 Copay \$20 Copay \$40 Copay
Allergy Treatment Testing & Injections Serum		\$20 Copay \$150 Copay
Prescription Drug Coverage Tier 1 Tier 2 Tier 3 Tier 4	Up to a 34-day supply may be purchased at retail for the listed copay. Up to a 90-day supply may be purchased at retail or by mail order for 2 copays.	\$0 Copay \$20 Copay \$75 Copay \$150 Copay
EXPENSES ABOVE THIS LINE NOT SUBJECT TO DEDUCTIBLE		
Plan Year Deductible Individual Family	An individual within family coverage will only be required to meet the indicated individual deductible amount before coinsurance benefits begin.	\$3,500 Deductible \$7,000 Deductible
Deductible & Coinsurance Maximum Individual Family	Copays do not apply to the deductible. However, copays and coinsurance combined with the deductible do apply to an In Network Out of Pocket Maximum of \$8,550 for those with individual coverage and \$17,100 for those with dependents covered.	\$8,550 per Individual \$17,100 per Family
Inpatient Hospitalization Medical Services & Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Use Disorder		30% after the Deductible 30% after the Deductible 30% after the Deductible
Home Health Care & Skilled Nursing Facilities		30% after the Deductible
Durable Medical Equipment		30% after the Deductible

PPO Provisions. Benefit Reduction for Non-Network Providers - when receiving care from non-network providers, all benefits are subject to the deductible and an additional 20% coinsurance and an increased out of pocket maximum. Other limits may apply. Out of Network Expense: 50% after the deductible. Maximum Out of Pocket Expense: \$10,550/\$21,100. Please refer to the Summary Plan Description (SPD) for details. The SPD is the final determination of all benefits. Out-of-Network benefits are subject to usual and customary limitations.

PRECISION HEALTH PLANS: *INDUSTRIAL SERIES*

ENHANCED 2500 EZ



SCHEDULE OF BENEFITS

YOU PAY

Preventive Care Under PPACA	Charges for preventive care as per PPACA on the effective date of the plan provide for certain benefits to be paid absent of cost sharing.	No Deductible, No Copay
Virtual Care / Telemedicine Full Virtual Primary, Urgent and Behavioral Health. See enrollment materials for details.	With Virtual Primary Care (VPC), members and their families receive access to a dedicated physician. Virtual Preventive, Urgent, and Behavioral Health are covered at a \$0 Copay when using a Recuro provider.	No Deductible, No Copay
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Use Disorder	These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical or medical procedures performed by the physician or for diagnostic services billed separately.	\$20 Copay \$40 Copay \$20 Copay
Office Based Diagnostic Tests, Labs & X-Ray	Includes diagnostic tests performed in a physician's office and billed by such physician or a freestanding non-hospital billed facility only.	\$20 Copay
Outpatient Surgical, Diagnostic & Therapeutic Procedures Medical Services Facility Charges	Includes outpatient services, such as miscellaneous medical procedures and supplies, diagnostic and therapeutic procedures and surgery at a physician's office, freestanding surgical center or hospital (when approved).	\$60 Copay \$60 Copay
Vision Annual Exam Only	Any optometrist; member must submit claim for reimbursement. Copay waived for children under 5.	\$30 Copay
Short Term Rehabilitation Services	Physical, chiropractic, speech and occupational therapy. (Includes therapies performed in a provider's office or other non-hospital billed facility only).	\$40 Copay
Emergency Services Hospital Emergency Room Urgent Care/Physician Ambulance	ER copayment waived if admitted; \$250 penalty for non-emergency use of a hospital emergency room. Urgent Care copayments do not include charges for diagnostic, surgical, or medical procedures.	\$200 Copay \$20 Copay \$40 Copay
Allergy Treatment Testing & Injections Serum		\$20 Copay \$150 Copay
Prescription Drug Coverage Tier 1 Tier 2 Tier 3 Tier 4	Up to a 34-day supply may be purchased at retail for the listed copay. Up to a 90-day supply may be purchased at retail or by mail order for 2 copays.	\$0 Copay \$20 Copay \$75 Copay \$150 Copay
EXPENSES ABOVE THIS LINE NOT SUBJECT TO DEDUCTIBLE		
Plan Year Deductible Individual Family	Only one deductible amount applies regardless of dependent status.	\$2,500 Deductible \$2,500 Deductible
Deductible & Coinsurance Maximum Individual Family	Copays do not apply to the deductible and coinsurance maximum. However, copays combined with the deductible and coinsurance maximum do apply to an In Network Out of Pocket maximum of \$7,000 regardless of dependent status.	\$2,500 Deductible \$2,500 Deductible
Inpatient Hospitalization Medical Services & Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Use Disorder		0% after the Deductible 0% after the Deductible 0% after the Deductible
Home Health Care & Skilled Nursing Facilities		0% after the Deductible
Durable Medical Equipment		0% after the Deductible

PPO Provisions. Benefit Reduction for Non-Network Providers - when receiving care from non-network providers, all benefits are subject to the deductible and an additional 20% coinsurance and an increased out of pocket maximum. Other limits may apply. Out of Network Expense: 20% after the deductible. Maximum Out of Pocket Expense: \$9,000. Please refer to the Summary Plan Description (SPD) for details. The SPD is the final determination of all benefits. Out-of-Network benefits are subject to usual and customary limitations.

Centers of Excellence: THIS IS SMARTCARE

Edison is the only TPA in the nation to offer exclusive access to Edison Healthcare as an embedded benefit in every one of our plans. Edison manages the majority of complex care through this proprietary network of 18 of the nations top medical centers. This network was built one center, and one surgical unit at a time for one focused purpose - to find the best surgeons and specialists in each diagnosis vertical, to deliver the most extraordinary outcomes for our members. And it works, every single day of the week!

SELF-FUNDED EMPLOYERS SPEND 80% OF PLAN DOLLARS ON 6% OF ENROLLEES

WHAT WE DO | We address the most flawed aspect of healthcare today, the appropriateness of care. **Misdiagnosis, over-utilization, sub-optimal treatment, and overpricing** plague our healthcare system and lay a substantial financial burden on employers. Through our SmartCare Network, members experience some of the best medical care in the nation: including a proper diagnosis, highly personalized treatment plans, world-class surgery (when necessary), and aggressive custom pricing bundles. Our process leads to vastly superior health outcomes for members and substantial ROI for employers.

OUR MEDICAL NETWORK | Edison Healthcare has contracted with America's top medical centers who are committed to multidisciplinary, team-based approaches for the evaluation and treatment of patients. We vet our centers over 18 months to ensure they meet our standards using our four pillars of accreditation.

STRUCTURE	PHILOSOPHY	OUTCOMES	FINANCIALS
<ul style="list-style-type: none">• Physician Led• Salary Based• Multi-Disciplinary• Setup for Travelers• Integrated Contracting	<ul style="list-style-type: none">• Team Based• Patient Care Focused• Evidence-Based• Accountability• Constant Improvement	<ul style="list-style-type: none">• Top Performance• Risk Adjusted• Continuous Monitoring and Review	<ul style="list-style-type: none">• Global Case Rates• Competitive Pricing• Minimal Or No Outliers

WHAT WE COVER | Edison addresses the 6% - the most complex, costly, and misdiagnosed conditions: **SPINE • ORTHOPEDIC & JOINT • CANCER • HEART & VALVE • TRANSPLANT • BARIATRIC**

RESULTS | One medium sized client. One month. Five spine cases. Each were sent to one of our SmartCare Centers. All five had been misdiagnosed in their local markets, where surgeons recommended unnecessarily risky surgeries that would have led to additional surgeries down the road, months of missed work, high degrees of pain, more pain med usage, and diminished quality of life. After consulting with our surgical teams, 2 needed only injections and PT, and 3 had minor outpatient procedures - for a total employer savings of \$351,000. In one month!

IMPLEMENTING EDISON | Employer responsibilities include:

1. Adopting Edison's SPD language for optimal group & employee utilization of the program
2. Paying all invoices via ACH and prefunding benefit card accounts through our TPA, EHS
3. Providing employee census with email, address, and mobile data for all EH communications
4. Paying for print marketing costs (pass-through), including the Benefit Letter & ID Card Mailer
5. Waiving all out-of-pocket costs for members who utilize Edison's SmartCare Network (for all HMO, PPO, & RBP plans: waiving all co-pays, deductibles, co-insurance, food, travel, and lodging)*