



SCHEDULE OF BENEFITS

YOU PAY

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| 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 |
| Teladoc | The Teladoc program, while not insurance, is a convenient standalone service that provides access by web, phone, or mobile app to qualified doctors who can treat many common medical conditions. | No Deductible, No Copay |
| Plan Year Deductible Individual Family | Only one deductible amount applies regardless of dependent status. | \$3,500 per Individual \$3,500 per Family |
| Out of Pocket Maximum Individual Family | All in network covered cost sharing including copays, deductible and coinsurance combine to meet this OOP maximum. | \$5,000 per Individual \$5,000 per Family |
| 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 after the Deductible \$40 Copay after the Deductible \$20 Copay after the Deductible |
| 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 after the Deductible |
| 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). | 0% after the Deductible 0% after the Deductible |
| Vision | Any optometrist; member must submit claim for reimbursement. Copay waived for children under 5. | \$30 Copay after the Deductible |
| 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 after the Deductible |
| 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 after the Deductible \$20 Copay after the Deductible \$40 Copay after the Deductible |
| Allergy Treatment Testing & Injections Serum | | \$20 Copay after the Deductible \$150 Copay after the Deductible |
| Prescription Drug Coverage Generics Preferred Brand Non-Preferred Brand Expensive Specialty & Injectables | 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 after the Deductible \$20 after the Deductible \$75 after the Deductible \$150 after the 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. 20% after the deductible. Maximum Out of Pocket Expense: \$7,000. 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.