DISCLAIMER: *Once this benefit grid is approved, any subsequent changes to the benefits will not be applied retroactively to the effective date, unless written edits are communicated within 48 hours of final grid approval. If written edits are received more than 48 hours after final grid approval, requested benefit changes will take effect on the first of the month following written notification. Any edits requested after final grid approval and after the policy effective date will result in* ***claims being held*** *until: (1) the revised benefit grid is approved in writing by an authorized group representative and (2) the plan build has been updated in the system.*

SCHEDULE OF BENEFITS – GROUP #79417/EPO $1,000 PLAN

Deductibles, out-of-pocket maximums, and benefit limits are on a Calendar Year basis.

ALL ESSENTIAL HEALTH BENEFITS	Unlimited

Deductible and Out-of-Pocket Maximum	Network	Non-Network	Limits, Exceptions & Important Information
DEDUCTIBLE			
Individual	$1,000	N/A	
Family	$3,000	N/A	

This Plan has an embedded deductible. If there are other family members on the Plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

OUT-OF-POCKET MAXIMUM			
Individual	$4,000	N/A	
Family	$12,000	N/A	

This Plan's Network and Non-Network deductible and out-of-pocket maximum amounts are combined, meaning both Network and Non-Network covered expenses apply to both the Network and Non-Network deductible and out-of-pocket maximum amounts. Once the deductible and out-of-pocket maximum amounts are met, the Plan pays all covered expenses with no cost share for the rest of the year, whether a Network or Non-Network provider is used.

These Out-of-Pocket Maximum amounts apply to both medical and prescription drug benefits.

The following table identifies what does and does not apply toward the Network and Non-Network out-of-pocket maximums:

PLAN FEATURES	APPLIES TO THE NETWORK OUT-OF-POCKET MAXIMUM?	APPLIES TO THE NON-NETWORK OUT-OF-POCKET MAXIMUM?
Payments toward the annual deductible	Yes	N/A
Coinsurance payments, even for covered services available under "Prescription Drug Benefits," except for covered health services identified in the Summary of Benefits that do not apply to the out-of-pocket maximum	Yes	N/A
Copayments (Copays)	Yes	N/A
Prescription drug expenses	Yes	N/A
Charges for non-covered services	No	N/A
The amounts of any penalties	No	N/A
Charges that exceed allowable expenses	No	N/A

The following covered medical expenses are "per Participant per year." All Covered Expenses are subject to the Maximum Allowable Charge. If a Covered Expense has a Copay, that Copay is "per visit," unless indicated otherwise.

Pre-certification is required for certain services. Please refer to the Utilization Management section of this SPD for a detailed list. Participants and providers are responsible for verifying whether a particular service requires pre-certification before it is received by calling the number on the Participant's ID card. If pre-certification is not received, $250 penalty will apply.

Covered Medical Expenses	Network	Non-Network	Limits, Exceptions & Important Information
ALLERGY SERVICES			
Office Visit	$25 Copay (deductible waived)	Not Covered	
Injections	Included in Office Visit		$5 Copay without Office Visit
Serum	Included in Office Visit		
AMBULANCE	70% after deductible	Not Covered	
AMBULATORY SURGICAL CENTER	70% after deductible	Not Covered	Pre-certification is required for some surgeries and procedures.
Ambulatory Physician / Surgeon Fees	70% after deductible	Not Covered	
ANESTHESIA	70% after deductible	Not Covered	
BIRTHING CENTER	70% after deductible	Not Covered	
BLOOD AND PLASMA	70% after deductible	Not Covered	
BREAST PUMP	100% (deductible waived)	Not Covered	Limited to 1 per pregnancy.
CHEMOTHERAPY AND RADIATION THERAPY	70% after deductible	Not Covered	Pre-certification is required for radiation therapy.
CHIROPRACTIC CARE	$25 Copay (deductible waived)	Not Covered	Limited to 35 visits per calendar year.
CONTRACEPTIVE METHODS, STERILIZATION PROCEDURES AND COUNSELING FOR WOMEN WITH REPRODUCTIVE CAPACITY - Must be FDA-approved	100% (deductible waived)	Not Covered	
DURABLE MEDICAL EQUIPMENT	70% after deductible	Not Covered	Covered up to the purchase price. Pre-certification is required for durable medical equipment over $1,000.

Covered Medical Expenses	Network	Non-Network	Limits, Exceptions & Important Information
GLAUCOMA, CATARACT SURGERY AND LENSES - One set	70% after deductible	Not Covered	
HEARING AIDS	70% after deductible	Not Covered	Limited to 1 per ear each 36-consecutive months.
HOME HEALTH CARE	70% after deductible	Not Covered	Limited to 45 visits per calendar year. Pre-certification is required.
HOSPICE CARE			
Inpatient	70% after deductible	Not Covered	
Outpatient	70% after deductible	Not Covered	
Family Bereavement Counseling	100% (deductible waived)	Not Covered	Limited to 6 visits and must be utilized within 6 months of death.
HOSPITAL			
Inpatient	$300 Copay per admission, then 70% after deductible	Not Covered	Pre-certification is required for inpatient hospital admissions.
Inpatient Surgeon Fee	70% after deductible	Not Covered	
Outpatient	70% after deductible	Not Covered	
INFERTILITY TREATMENT	Not covered	Not covered	Coverage is limited to diagnosing the underlying cause of infertility.
LACTATION COUNSELING - By a trained provider during pregnancy or in the postpartum period	100% (deductible waived)	Not Covered	

Covered Medical Expenses	Network	Non-Network	Limits, Exceptions & Important Information
MATERNITY **Prenatal and Postnatal Care**	PCP / OBGYN: $15 Copay (deductible waived) Specialist: $25 Copay (deductible waived)	Not Covered	Copay applies to initial visit only.
Delivery and all Inpatient Services	70% after deductible	Not Covered	Pre-certification is required for inpatient hospital admissions for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay.
Provider Services	70% after deductible	Not Covered	
Hospital Services	$300 Copay per admission, then 70% after deductible	Not Covered	
MEDICAL SUPPLIES **- Supplies that are deemed to be medically necessary**	70% after deductible	Not Covered	
MENTAL HEALTH DISORDER **Inpatient Treatment**	$300 Copay per admission, then 70% after deductible	Not Covered	Pre-certification is required for inpatient hospital admissions and residential treatment centers.
Outpatient Office Visit	$15 Copay (deductible waived)	Not Covered	
Outpatient Facility	70% after deductible	Not Covered	Pre-certification is required for intensive outpatient and partial hospitalization.
NEWBORN CARE	70% after deductible	Not Covered	
OUTPATIENT ADVANCED IMAGING – (CT/PET SCAN/MRI)	70% after deductible	Not Covered	
OUTPATIENT DIAGNOSTIC LAB	100% (deductible waived)	Not Covered	
OUTPATIENT DIAGNOSTIC X-RAY	100% (deductible waived)	Not Covered	

Covered Medical Expenses	Network	Non-Network	Limits, Exceptions & Important Information
OUTPATIENT EMERGENCY SERVICES			
Emergency Care	$500 Copay, then 70% after deductible	$500 Copay, then 70% after Network deductible	Copay waived if admitted.
Non-Emergency Care	$500 Copay, then 70% after deductible	Not Covered	Copay waived if admitted.
PHYSICIAN OFFICE SURGERY	70% after deductible	Not Covered	
PHYSICIAN SERVICES: DIAGNOSIS & TREATMENT OF AN ILLNESS OR INJURY *(Except Preventive Care)*			
Primary Care (PCP) Office Visit	$15 Copay (deductible waived)	Not Covered	
Specialist (SPC) Office Visit	$25 Copay (deductible waived)	Not Covered	
Labs & X-rays in Physician's Office	100% (deductible waived)	Not Covered	
PREVENTIVE CARE - Well adult care			
Exams	100% (deductible waived)	Not Covered	
Colonoscopies	100% (deductible waived)	Not Covered	
Immunizations	100% (deductible waived)	Not Covered	
Mammograms	100% (deductible waived)	Not Covered	
Pap Smears	100% (deductible waived)	Not Covered	
Prostate Exams & Prostate-Specific Antigen (PSA) Screenings	100% (deductible waived)	Not Covered	
PREVENTIVE CARE - Well child care			
Exams	100% (deductible waived)	Not Covered	
Immunizations	100% (deductible waived)	Not Covered	

Visit www.healthcare.gov/coverage/preventive-care-benefits for a complete list of preventive services required by the ACA, along with USPSTF age and frequency recommendations.

Covered Medical Expenses	Network	Non-Network	Limits, Exceptions & Important Information
PROSTHETICS, ORTHOTICS, SUPPLIES AND SURGICAL DRESSINGS	70% after deductible	Not Covered	Applies to custom molded prosthetics and orthotics (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance; orthotic devices, but not including orthopedic shoes and other supportive devices for the feet. Pre-certification is required for prosthetics and orthotics over $1,000.
SECOND SURGICAL OPINIONS	70% after deductible	Not Covered	
SKILLED NURSING FACILITY	70% after deductible	Not Covered	Limited to 45 days per calendar year. Pre-certification is required.
SUBSTANCE USE DISORDER			
Inpatient Treatment	$300 Copay per admission, then 70% after deductible	Not Covered	Pre-certification is required for inpatient hospital admissions and residential treatment centers.
Outpatient Office Visit	$15 Copay (deductible waived)	Not Covered	
Outpatient Facility	70% after deductible	Not Covered	Pre-certification is required for intensive outpatient and partial hospitalization.
SURGERY	70% after deductible	Not Covered	Pre-certification is required for some surgeries and procedures.
TELEMEDICINE	100% (deductible waived)		Entire household covered when utilizing telemedicine vendor.

Covered Medical Expenses	Network	Non-Network	Limits, Exceptions & Important Information
THERAPY			
Cardiac Therapy	Office Visit: PCP- $15 Copay SPC- $25 Copay All Other Services: 70% after deductible	Not Covered	
Habilitative Therapy	Office Visit: PCP- $15 Copay SPC- $25 Copay All Other Services: 70% after deductible	Not Covered	
Occupational Therapy	Office Visit: PCP- $15 Copay SPC- $25 Copay All Other Services: 70% after deductible	Not Covered	
Physical Therapy	Office Visit: PCP- $15 Copay SPC- $25 Copay All Other Services: 70% after deductible	Not Covered	
Pulmonary Therapy	Office Visit: PCP- $15 Copay SPC- $25 Copay All Other Services: 70% after deductible	Not Covered	
Respiratory Therapy	Office Visit: PCP- $15 Copay SPC- $25 Copay All Other Services: 70% after deductible	Not Covered	
Speech Therapy	Office Visit: PCP- $15 Copay SPC- $25 Copay All Other Services: 70% after deductible	Not Covered	

Covered Medical Expenses	Network	Non-Network	Limits, Exceptions & Important Information
TRANSPLANTS	70% after deductible	Not Covered	Pre-certification is required.
URGENT CARE	$45 Copay (deductible waived)	Not Covered	If you receive services in addition to the Urgent Care visit, additional Copays, deductibles, or coinsurance may apply e.g., surgery.
ALL OTHER COVERED SERVICES	70% after deductible	Not Covered	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – GROUP #79417/EPO $1,000 PLAN

Prescription Drug Plan	Out-of-Pocket Maximum Per Plan, Combined with Medical		
INDIVIDUAL	$4,000		
FAMILY	$12,000		
Covered Prescription Drug*	**Participating Pharmacy**	**Non-Participating Pharmacy**	**Limits, Exceptions & Important Information**
PHARMACY OPTION - Retail 30-day supply			
Generic Drugs	$10 Copay	Not Covered	
Preferred Brand Drugs	$30 Copay	Not Covered	
Non-Preferred Brand Drugs	$50 Copay	Not Covered	
PHARMACY OPTION - Retail 90-day supply			
Generic Drugs	$20 Copay	Not Covered	
Preferred Brand Drugs	$60 Copay	Not Covered	
Non-Preferred Brand Drugs	$100 Copay	Not Covered	
MAIL ORDER OPTION - 90-day supply			
Generic Drugs	$20 Copay	Not Covered	
Preferred Brand Drugs	$60 Copay	Not Covered	
Non-Preferred Brand Drugs	$100 Copay	Not Covered	
SPECIALTY DRUG OPTION - Limited to 30-day supply	10% Copay, up to $100 maximum	Not Covered	

Deductibles do not apply to prescription drug benefits.

This Plan covers certain preventive care drugs listed on the Plan's preventive drug list at 100% when obtained from a Network pharmacy.