



## SCHEDULE OF BENEFITS

## YOU PAY

<b>Preventive Care Under PPACA</b>	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
<b>Teladoc</b>	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
<b>Plan Year Deductible</b> Individual Family	An individual within family coverage will only be required to meet the indicated individual deductible amount before coinsurance benefits begin.	\$6,650 per Individual \$13,300 per Family
<b>Out of Pocket Maximum</b> Individual Family	All in network covered cost sharing including copays, deductible and coinsurance combine to meet this OOP maximum.	\$6,650 per Individual \$13,300 per Family
<b>Professional Outpatient Office Visits</b> Primary Care Specialist Mental Health & Substance Use Disorder		0% after the Deductible 0% after the Deductible 0% after the Deductible
<b>Office Based Diagnostic Tests, Labs &amp; X-Ray</b>		0% after the Deductible
<b>Outpatient Surgical, Diagnostic &amp; Therapeutic Procedures</b> Medical Services Facility Charges		0% after the Deductible 0% after the Deductible
<b>Vision</b>	Any optometrist; member must submit claim for reimbursement. Copay waived for children under 5.	0% after the Deductible
<b>Short Term Rehabilitation Services</b>	Physical, chiropractic, speech and occupational therapy. (Includes therapies performed in a provider's office or other non-hospital billed facility only).	0% after the Deductible
<b>Emergency Services</b> Hospital Emergency Room Urgent Care/Physician Ambulance	\$250 penalty for non-emergency use of a hospital emergency room.	0% after the Deductible 0% after the Deductible 0% after the Deductible
<b>Allergy Treatment</b> Testing & Injections Serum		0% after the Deductible 0% after the Deductible
<b>Prescription Drug Coverage</b> Generics Preferred Brand Non-Preferred Brand Expensive Specialty & Injectables		0% after the Deductible 0% after the Deductible 0% after the Deductible 0% after the Deductible
<b>Inpatient Hospitalization</b> Medical Services & Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Use Disorder		0% after the Deductible 0% after the Deductible 0% after the Deductible
<b>Home Health Care &amp; Skilled Nursing Facilities</b>		0% after the Deductible
<b>Durable Medical Equipment</b>		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 are increased to \$8,650 for individual and \$17,300 for coverage with dependents. 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.