



# GLORY EZ

## 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>Virtual Care / Telemedicine</b> 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
<b>Plan Year Deductible</b> Individual Family	Only one deductible amount applies regardless of dependent status.	\$3,500 per Individual \$3,500 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.	\$5,000 per Individual \$5,000 per Family
<b>Professional Outpatient Office Visits</b> 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
<b>Office Based Diagnostic Tests, Labs &amp; X-Ray</b>	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
<b>Outpatient Surgical, Diagnostic &amp; Therapeutic Procedures</b> 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
<b>Vision</b> Annual Exam Only	Any optometrist; member must submit claim for reimbursement. Copay waived for children under 5.	\$30 Copay 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).	\$40 Copay after the Deductible
<b>Emergency Services</b> 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
<b>Allergy Treatment</b> Testing & Injections Serum		\$20 Copay after the Deductible \$150 Copay after the Deductible
<b>Prescription Drug Coverage</b> 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 after the Deductible \$20 after the Deductible \$75 after the Deductible \$150 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: \$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.



# BANNER

## 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>Virtual Care / Telemedicine</b> 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
<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.	\$5,000 per Individual \$10,000 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.	\$5,000 per Individual \$10,000 per Family
<b>Professional Outpatient Office Visits</b> 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.	0% after the Deductible 0% after the Deductible 0% after the Deductible
<b>Office Based Diagnostic Tests, Labs &amp; X-Ray</b>	Includes diagnostic tests performed in a physician's office and billed by such physician or a freestanding non-hospital billed facility only.	0% after the Deductible
<b>Outpatient Surgical, Diagnostic &amp; Therapeutic Procedures</b> 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
<b>Vision</b> Annual Exam Only	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	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.	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> 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 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 \$7,000 for individual and \$14,000 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.



# STARS 2500

## 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>Virtual Care / Telemedicine</b> 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
<b>Plan Year Deductible</b> Individual Family	For coverage that includes dependents, the full family deductible must be met before benefits are provided.	\$2,500 per Individual \$5,000 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.	\$8,500 per Individual \$17,000 per Family
<b>Professional Outpatient Office Visits</b> 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
<b>Office Based Diagnostic Tests, Labs &amp; X-Ray</b>	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
<b>Outpatient Surgical, Diagnostic &amp; Therapeutic Procedures</b> 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 after the Deductible \$60 Copay after the Deductible
<b>Vision</b> Annual Exam Only	Any optometrist; member must submit claim for reimbursement. Copay waived for children under 5.	\$30 Copay 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).	\$40 Copay after the Deductible
<b>Emergency Services</b> 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
<b>Allergy Treatment</b> Testing & Injections Serum		\$20 Copay after the Deductible \$150 Copay after the Deductible
<b>Prescription Drug Coverage</b> 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 after the Deductible \$20 after the Deductible \$75 after the Deductible \$150 after the Deductible
<b>Inpatient Hospitalization</b> Medical Services & Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Use Disorder		\$500 Copay after the Deductible \$60 Copay after the Deductible \$500 Copay after the Deductible
<b>Home Health Care &amp; Skilled Nursing Facilities</b>		\$40 Copay after the Deductible
<b>Durable Medical Equipment</b>		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. 20% after the deductible. Maximum Out of Pocket Expenses are increased to \$10,500 for individual and \$21,000 for coverage with dependents. Please refer to the Summary Plan Description (SPD) for details. The SPD is the final determination of all benefits. The SPD is the final determination of all benefits. Out-of-Network benefits are subject to usual and customary limitations.



# STRIPES

## 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>Virtual Care / Telemedicine</b> 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
<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> Annual Exam Only	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> Tier 1 Tier 2 Tier 3 Tier 4		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.



# UNION

## 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>Virtual Care / Telemedicine</b> 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
<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.	\$8,500 per Individual \$17,000 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.	\$8,500 per Individual \$17,000 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> Annual Exam Only	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> Tier 1 Tier 2 Tier 3 Tier 4		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 \$10,500 for individual and \$21,000 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.