Medical-Surgical and Behavioral Health/Substance Abuse Disorder Schedule of Coverage

The following information summarizes the benefits described in your Evidence of Coverage. It is important that you carefully read it so you are aware of plan requirements, provisions and limitations and exclusions.

Note: This Consumer Choice Health Benefit Plan does not include all state mandated health insurance benefits. Some benefits are provided at a reduced level from what is mandated. Reduced benefits are indicated in the chart below and in the separate Benefit Disclosure Form.

This Schedule of Coverage is not a Medicare Supplement. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

Overall Payment Provisions	**In-Network Benefits**	**Out-of-Network Benefits**
Calendar Year Deductibles (applies to all Eligible Expenses including Pharmacy)	$[0 – 3,850] Individual/$[0 - 7,700] Family (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)	
Out-of-Pocket Limits (applies to all Eligible Expenses including Pharmacy	$[0 – 7,350] Individual/$[0 - 14,700] Family (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)	
Maximum Lifetime Benefits – per participant	Unlimited (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)	
Physician office visit/consultation to treat an injury or illness	100% of Allowed Amount after a $[0-20] Copayment per Visit	No coverage for Out-of-Network Services
Preventive Care/Screening/Immunization	100% of Allowed Amount	No coverage for Out-of-Network Services
Specialist office visit/consultation	100% of Allowed Amount after a $[0-60] Copayment per Visit	No coverage for Out-of-Network Services
Other practitioner office visits	100% of Allowed Amount after a $[0-10] Copayment per Visit	No coverage for Out-of-Network Services
Urgent Care Center visit	100% of Allowed Amount after a $[0-60] Copayment per Visit	No coverage for Out-of-Network Services
Outpatient Hospital emergency room/treatment room visit	100% of Allowed Amount after a $[0-350] Copayment per Visit with Calendar Year Deductible	100% of Allowed Amount after a $[0-350] Copayment per Visit with Calendar Year Deductible

Emergency Medical Transportation	100% of Allowed Amount after a $[0-150] Copayment per Visit with Calendar Year Deductible	100% of Allowed Amount after a $[0-150] Copayment per Visit with Calendar Year Deductible
Inpatient Hospital Expenses – All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	100% of Allowed Amount after a $[0-500] Copayment per Stay with Calendar Year Deductible	No coverage for Out-of-Network Services
Inpatient Visits (Physician/surgeon)	100% of Allowable Amount	No coverage for Out-of-Network Services
Diagnostic testing (X-ray , blood work)	100% of Allowed Amount after a $[0-30] Copayment per Visit.	No coverage for Out-of-Network Services
The administration of whole blood including cost of blood, blood plasma, and blood plasma expanders are covered services	100% of Allowed Amount after a $[0-30] Copayment per Visit.	No coverage for Out-of-Network Services
Imaging (CT/PET scans, MRIs)	100% of Allowed Amount after a $[0-300] Copayment per Visit.	No coverage for Out-of-Network Services
Laboratory Outpatient and Professional Services	100% of Allowed Amount after a $[0-30] Copayment per Visit.	No coverage for Out-of-Network Services
Home Infusion Therapy	[0 to 20]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Outpatient Surgery Facility fee (ambulatory surgery center)	[0 to 25]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Physician surgical services performed in an outpatient setting	[0 to 25]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Skilled Nursing Facility Limited to 25 days per year.	100% of Allowed Amount after a $[0-300] Copayment per Stay with Calendar Year Deductible	No coverage for Out-of-Network Services
Home Health Care Limited to 60 visits per year.	[0 to 20]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services

Hospice	[0 to 20]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Mental Health Care Inpatient Hospital Services	100% of Allowed Amount after a $[0-500] Copayment per Stay with Calendar Year Deductible	No coverage for Out-of-Network Services
Mental Health Care Outpatient Hospital Services	100% of Allowed Amount after a $[0-20] Copayment per Visit	No coverage for Out-of-Network Services
Substance Use Disorder Inpatient Hospital Services	100% of Allowed Amount after a $[0-500] Copayment per Stay with Calendar Year Deductible	No coverage for Out-of-Network Services
Substance Use Disorder Outpatient Hospital Services	100% of Allowed Amount after a $[0-20] Copayment per Visit	No coverage for Out-of-Network Services
Annual Vision Exam – Children and Adults (1 per year)	100% of Allowed Amount after a $[0-45] Copayment per Visit	No coverage for Out-of-Network Services
Annual Prescription Eyewear – Children (1 set of frames with lenses or contact lenses per year)	[0 to 20]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Prenatal and Postnatal Care	100% of Allowed Amount after a $[0-10] Copayment for the initial Prenatal Visit	No coverage for Out-of-Network Services
Delivery and all inpatient services	100% of Allowed Amount after a $[0-500] Copayment per delivery with Calendar Year Deductible	No coverage for Out-of-Network Services
Annual Well Woman Exam – including cervical cancer screening (age 18 and over)	100% of Allowed Amount	No coverage for Out-of-Network Services
Annual screening by low-dose mammography for the presence of occult breast cancer for female participants age 35 and over – Outpatient facility or imaging center and Physician component	100% of Allowed Amount	No coverage for Out-of-Network Services

Bone Mass measurement for the detection of low bone mass to determine risk of osteoporosis and fractures associated with osteoporosis for qualified individuals	100% of Allowed Amount	No coverage for Out-of-Network Services
Routine annual physical exam for males; a prostate-specific antigen test used for the detection of prostate cancer for males who are at least 50 years of age and asymptomatic or at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor	100% of Allowed Amount	No coverage for Out-of-Network Services
Rehabilitation: Chiropractors, Physical Therapist (PT), Occupational Therapists (OT) and Speech Therapist (ST). Habilitation services include: Autism services, and the benchmark plan does not impose age or maximums on autism coverage.	100% of Allowed Amount after a $[0-65] Copayment per visit with Calendar Year Deductible	No coverage for Out-of-Network Services
Durable Medical Equipment	[0 to 20]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Hearing Aids for Adults (1 per ear every 3 years)	[0 to 20]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Hearing Aid or Cochlear Implant, related services and supplies for a covered individual **18 years of age or younger**, if medically necessary.	[0 to 20]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Amino Acid-Based Formula	[0 to 20]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services
Phenylketonuria (PKU) management products	[0 to 20]% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services