ARTICLE II
MEDICAL BENEFITS SCHEDULE

Choice $0 RBP **MEDICAL BENEFITS SCHEDULE**	
Claims must be received by the Claims Administrator within ***365 days*** of the date from which service charges were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred.	
DEDUCTIBLE, PER CALENDAR YEAR	
Per Covered Person	$0
Per Family Unit	$0
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR	
Per Covered Person	$9,100
Per Family Unit	$18,200

The family maximum out-of-pocket includes Covered Expenses which are used to satisfy the maximum out-of-pocket amount for all family members combined. No one family member must satisfy more than the individual maximum out-of-pocket. The maximum out of pocket includes all Copayments and Deductibles. The following expenses do not count toward the maximum out of pocket limit outlined above:

- Charges in excess of benefit maximums (i.e. visit limits);
- Charges in excess of the Reasonable and Allowed Amount;
- Penalties assessed due to failure to preauthorization a given service; and
- Charges for non-Covered Service.

IMPORTANT INFORMATION

Covered Expenses are limited to the Reasonable and Allowed Amount as defined in this Plan; Covered Expenses are also subject to Medical Necessity and all other provisions, conditions, limitations and exclusions listed in this Plan.

The amounts listed below are the amounts the Covered Person is responsible for. For example, if this Benefits Schedule lists a $25 Copayment for a specialist visit, the Covered Person is responsible for the $25 Copayment. Similarly, if this Benefits Schedule lists a 40% Coinsurance for non-network specialist visits, the Covered Person is responsible for 40% Coinsurance (meaning 40% of the Reasonable and Allowed Amount), and the Plan would pay the remaining 60% up to the Reasonable and Allowed Amount.

DESCRIPTION	Preauthorization Required	NETWORK PROVIDER	NON-NETWORK PROVIDER
Preventive Care			
Routine Well Care – Non-Hospital Based	No	No cost to Covered Person.	Not covered.
For more details on preventive care services, see the Covered Expenses section.			
Physician Services			
Primary Care Office Visit – Includes In-Person & Virtual This is the encounter fee only. Limited to ten (10) visits per calendar year. This benefit includes Retail/Walk In Clinics.	No	$25 Copay/visit.	40% Coinsurance.*
Specialist Office Visit – Includes In-Person & Virtual	No	$50 Copay/visit.	40% Coinsurance.*

This is the encounter fee only. Limited to ten (10) visits per calendar year.			
Other Services Performed in the Physician's Office This Copay is in addition to the office visit Copay. Collectively, these services and the office visit count as a single visit toward the office visit limits.	No	$50 Copay/visit.	40% Coinsurance.*
Telemedicine Services w/ MDLive	No	No cost to Covered Person.	N/A
Diagnostic Services and Supplies			
Diagnostic Testing (Lab & Radiology) – Non-Hospital Based Limited to four (4) tests per calendar year.	No	**MedMo (Radiology Only):** No cost to Covered Person.	40% Coinsurance.*
	No	**Outside MedMo:** $50 Copay/test.	
Diagnostic Testing (Lab) – Hospital Based Limited to two (2) tests per calendar year. Hospital based radiology is not covered.	No	$150 Copay/test.*	
Diagnostic Testing (Advanced Imaging) – Non-Hospital Based Limited to two (2) tests per calendar year. Hospital based advanced imaging is not covered.	No	**MedMo:** No cost to Covered Person.	40% Coinsurance.*
	Yes	**Outside MedMo:** $350 Copay/test.	
Emergency Services			
Emergency Services Limited to one (1) visit per calendar year.	No	$750 Copay/visit.*	
Ambulance Services Ground ambulance only. Limited to one (1) transport per calendar year.	No	$500 Copay/trip.*	
Urgent Care Limited to three (3) visits per calendar year.	No	$75 Copay/visit.	40% Coinsurance.*
Inpatient Services			
Inpatient Services Limited to seven (7) days total per calendar year.	Yes	$750 Copay/admission.*	
Inpatient Professional Services	Yes	$350 Copay/admission.*	
Inpatient Surgery Limited to two (2) surgeries per calendar year. Includes anesthesia when Medically Necessary.	Yes	Included in the Inpatient Services Copay.*	
Outpatient Services			
Outpatient Services or Surgery – Non-Hospital Based Limited to two (2) services or surgeries per calendar year. Includes anesthesia when Medically Necessary.	Yes	$350 Copay/visit.	40% Coinsurance.*
Outpatient Services or Surgery – Hospital Based Limited to one (1) service or surgery per calendar year. Includes anesthesia when Medically Necessary.	Yes	$750 Copay/visit.*	
Therapy Services			

Applied Behavioral Analysis Limited to ten (10) visits per calendar year.	No	$75 Copay/visit.	Not covered.
Cardiac Rehabilitation	N/A	Not covered.	Not covered.
Chiropractic Care Limited to ten (10) visits per calendar year.	No	$75 Copay/visit.	Not covered.
Occupational, Physical & Speech Therapy Limited to ten (10) visits combined per calendar year.	Yes	$75 Copay/visit.	Not covered.
Other Medical Services			
Diabetic Supplies Glucose monitors must be obtained through ConnectDME.	No	$35 Copay/item.	Not covered.
Durable Medical Equipment (DME) Coverage is only provided for CPAP machines and must be obtained through ConnectDME.	No	$400 Copay/item.	Not covered.
Home Health Care Limited to fifteen (15) visits per calendar year.	Yes	$50 Copay/visit.	Not covered.
Sleep Studies (Home)	Yes	$300 Copay/study.	Not covered.
Any services not listed on this Medical Benefits Schedule are **not covered.**			

PREAUTHORIZATION

Preauthorization is required as listed in the above column.

All services requiring Preauthorization, are to be authorized in advance, except for emergencies, by contacting the utilization review administrator at the number listed on the Plan ID Card. **If Preauthorization is not obtained prior to treatment or care, the Plan payment for any expenses associated with the treatment or care may be *reduced by 50%* and such reduction will not go toward the maximum out-of-pocket amount.**

IMPORTANT INFORMATION REGARDING REIMBURSEMENT RATES

This Plan does not use a participating provider organization (PPO) for facility services; therefore, claims for facility services, and non-network services (as indicated with an asterisk (*) in the Medical Benefits Schedule) are paid at **reference-based pricing**. See the definition of Reasonable and Allowed Amount in this Plan for additional information regarding reference-based pricing and other reimbursement methodologies.

ARTICLE III
PRESCRIPTION DRUG BENEFITS SCHEDULE

PRESCRIPTION DRUG BENEFIT	PREFERRED PHARMACY	NON-PREFERRED PHARMACY
Retail Option – 30 Day Supply		
Preventive Drugs	$0 Copay/drug.	Not covered.
Tier 1 Drugs	$10 Copay/drug.	Not covered.
Tier 2 Drugs	$75 Copay/drug.	Not covered.
Tier 3 Drugs	$150 Copay/drug.	Not covered.
Mail Order Option – 90 Day Supply		
Tier 1 Drugs	$30 Copay/drug.	Not covered.
Tier 2 Drugs	$225 Copay/drug.	Not covered.
Tier 3 Drugs	$450 Copay/drug.	Not covered.
Refer to the Prescription Drug Benefits in this Plan for details on the Prescription Drug Program. Please note that not all drugs are covered. For additional information on Prescription Drugs, including a copy of the Plan's formulary, please call the phone number on the Plan ID card.		

ARTICLE X
MEDICAL PLAN EXCLUSIONS

The following charges are not covered under this Plan. All Exclusions related to Prescription Drugs are shown in the Prescription Drug benefits section.

1. **Abortion.** Charges in connection with an abortion except as outlined under Covered Expenses.

2. **Acupuncture.** Charges associated with acupuncture.

3. **Administrative Costs.** Charges for failure to keep scheduled appointments, completion of a claim form, obtaining medical records, late payments, telephone charges or information required to process a claim.

4. **Ambulance Services (Non-Ground).** Charges related to any ambulance service that is not considered ground transport, including but not limited to air or water ambulance services.

5. **Cardiac Rehabilitation.** Charges for cardiac rehabilitation services.

6. **Chemotherapy.** Charges associated with chemotherapy.

7. **Complications of Non-Covered Expenses.** Charges Incurred as a result of complications from a treatment not covered under the Plan.

8. **Cosmetic Components of Gender Dysphoria.** Charges for treatment performed as a component of gender transition that are considered cosmetic.

9. **Cosmetic Surgery.** Charges that are Incurred in connection with the care and/or treatment of surgical procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons. A treatment will be considered cosmetic for either of the following reasons; (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness or congenital abnormality.

10. **Custodial Care.** Charges provided mainly as a rest cure, maintenance or Custodial Care.

11. **Dental Care.** Charges for normal dental care benefits, including any dental, gum treatments, or oral surgery.

12. **Dialysis.** Charges associated with dialysis treatments.

13. **Educational or Vocational Testing.** Charges related to the education or training program, unless covered by other Plan provisions or required by applicable law.

14. **Excess Charges.** Charges for care and treatment of an Injury or Illness that is in excess of the Reasonable and Allowed Amount.

15. **Exercise Programs.** Charges for any exercise programs for treatment of any condition.

16. **Experimental and/or Investigational.** Charges for care and treatment that is either Experimental and/or Investigational, as defined by this Plan.

17. **Eye Care.** Charges for eye examinations, lenses radial keratotomy, Lasik surgery, or other eye surgery to correct refractive disorders.

18. **Foreign Travel.** Charges for care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

19. **Gender Affirming Surgery Reversal.** Charges for treatment, services, or supplies performed as part of reversal of gender affirming surgery used to treat gender dysphoria.

20. **Gene and Cell Therapy.** Charges associated with any gene and/or cell therapy even if recommended by a Physician and/or considered Medically Necessary.

21. **Genetic Counseling and Testing.** Charges associated with any genetic counseling and/or testing, unless required by applicable law.

22. **Government Coverage**. Charges for care, treatment or supplies furnished by a program or agency funded by any government. This Exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

23. **Hair Loss.** Charges for care and treatment for hair loss including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a Physician.

24. **Hazardous Activities.** Charges for services, supplies, care, or treatment of an Injury or Illness that results from engaging in a hazardous hobby or recreational activity. A hobby or recreational activity is hazardous if it is an uncommon activity which is characterizes by a constant or recurring threat of danger or risk of bodily harm. The Plan Administrator has the full discretionary authority to determine what is considered a hazardous activity under this Plan.

25. **Hearing Aids and Exams.** Charges for hearing aids or examinations for the prescription, fitting, and/or repair of hearing aids.

26. **Hospice Care.** Charges for hospice care services.

27. **Hospital-Based Medications.** Charges for drugs administered in a Hospital or any other Institution (i.e., J-codes).

28. **Illegal Acts.** Charges for any Injury or Illness resulting from, or in consequence of, taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that criminal charges be filed, or, if filed, that a conviction result be imposed for this Exclusion to apply. Proof beyond a reasonable doubt is not required. This Exclusion does not apply if the Injury or Illness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

29. **Illegal Drugs or Medications.** Charges for an Illness or Injury resulting from the Covered Person voluntarily taking or being under the influence of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a Physician. Expenses will be covered for Covered Persons other than the person using the controlled substance. This Exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

30. **Immunizations.** Charges for immunizations and vaccinations for the purpose of travel outside of the United States, unless covered by other Plan provisions or required by applicable law.

31. **Infertility.** Charges related to impregnation and infertility treatment: artificial insemination, fertility drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency drugs such as Viagra™, in-vitro fertilization, surrogate mother (unless the surrogate is a Covered Person, in which case the care will be covered in accordance with the Plan provisions), donor eggs, collection or purchase of donor semen (sperm) or oocytes (eggs), and freezing of sperm, oocytes, or embryos, or any type of artificial impregnation procedure, whether or not such procedure is successful.

32. **Infusion Therapy.** Charges associated with infusion therapy.

33. **Long Term Care.** Charges related to long term care.

34. **Mailing or Sales Tax.** Charges for mailing, shipping, handling, conveyance and sales tax.

35. **Massage Therapy.** Charges in connection with massage therapy.

36. **Medical Supplies.** Charges for medical supplies.

37. **Negligence.** Charges for Injuries or Illness resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.

38. **No Charge.** Charges for which there would not have been a charge if no coverage had been in force.

39. **Non-Compliance.** Charges in connection with treatments or medications where the Covered Person either is non-compliant with medical orders issued while an Inpatient at, or is discharged against medical advice.

40. **Non-Emergency Hospital Admissions.** Charges for non-medical emergency admissions for surgery on a Friday or a Saturday. This does not apply if surgery is performed within twenty-four (24) hours of admission.

41. **Non-Emergency Use of Emergency Room.** Charges associated with the use of the emergency room when the Covered Person is not experiencing an emergency.

42. **Not Medically Necessary.** Charges Incurred for services determined to not be Medically Necessary.

43. **Not Specified as Covered.** Charges for any treatments and supplies which are not specified as a Covered Expense under this Plan.

44. **Nutritional Supplements.** Charges for nutritional supplements and/or vitamins, unless covered by other Plan provisions or required by applicable law.

45. **Occupational Injury.** Charges for an Injury or Illness that is occupational – that is, arises from work for wage or profit including self-employment. This Exclusion applies even if the Covered Person:

    a. Has waived their rights to Workers' Compensation benefits;
    b. Was eligible for Workers' Compensation benefits and failed to properly file a claim for such benefits;
    c. The Covered Person is permitted to elect not to be covered under Workers' Compensation but has failed to properly file for such election.

46. **Outpatient Rehabilitation Services.** Charges associated with Outpatient therapy services such as cardiac rehabilitation and respiratory therapy.

47. **Personal Convenience Items.** Charges for certain personal convenience items including but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

48. **Private Duty Nursing**. Charges for private duty nursing.

49. **Professional (and Semi-Professional) Athletics.** Charges in connection with any Injury or Illness arising out of, or in the course of, any employment for wage or profit; or related to professional or semi-professional athletics, including practice.

50. **Radiation Services.** Charges associated with radiation therapy.

51. **Self-Inflicted.** Charges due to an intentionally self-inflicted Injury or Illness. This Exclusion does not apply if the Injury or Illness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

52. **Services Before or After Coverage.** Charges Incurred when the person was not a Covered Person under this Plan.

53. **Skilled Nursing Facility Care.** Charges Incurred for skilled nursing or in a Skilled Nursing Facility.

54. **Sleep Studies.** Charges for sleep studies performed outside of the Covered Person's home.

55. **Sterilization Services.** Charges for reversal of sterilization.

56. **Transplant Services.** Charges for any transplant.

57. **Travel or Accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician.

58. **War.** Charges as a result of war or any act of war, whether declared or undeclared, or any act of aggression, when the Covered Person is a member of the armed forces of any country, or during service by a Covered Person in the armed forces of any country.

This is not a contract of insurance. The benefit summaries contained in this document are intended to be brief descriptions of the benefits. Full plan details will be documented in the Summary Plan Description ("SPD") issued to the group. In the event of conflict between this document and the SPD, the SPD shall supersede.