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Schedule of Benefits & Plan Design Medical Services Deductible Information		
Deductible	**Participating Providers**	**Non-Participating Providers**
	(In-Network)	**(Out of Network)**
Individual	**$5,000**	$10,000
Familly	**$10,000**	$20,000
Out of Pocket Information		
Out of Pocket Maximum	**Participating Providers**	**Non-Participating Providers**
	(In-Network)	**(Out of Network)**
Individual	**$7,350**	$14,700
Familly	**$14,700**	$29,400
Coinsurance Information		
Coinsurance	**Participating Providers**	**Non-Participating Providers**
	(In-Network)	**(Out of Network)**
After Deductible	**20%**	40%
UNLIMITED ANNUAL MAXIMUM BENEFIT		

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Schedule of Benefits				
The following table represents the medical services currently covered under the **5000 CLASSIC** plan as well as the permitted interval and any requirements of such medical services.				
Plan Provisions	**Prior Auth Required1**	**Participating Providers (In-Network)**	**Non-Participating Providers (Out of Network)**	**Plan Limitations & Intervals**
Preventive & Wellness Services		**Member Pays**		
(Non-Hospital Based)	No	**$0 Copay**	Deductible & Coinsurance	
(Hospital Based)	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member	
Physician Services		**Member Pays**		
Telemedicine Services	No	**$0 Copay**	N/A	Provided through **EVO**
Office Visit - Primary Care	No	**$45.00 Copay**	40% Coinsurance after deductible	
Specialist Office Visit	No	**$90.00 Copay**	40% Coinsurance after deductible	
Other Physicians Services performed in the office (Non Surgical)	No	**$45.00 Copay**	40% Coinsurance after deductible	
Other Physicians Services performed in the office (Surgical)	**Yes**	**$45.00 Copay**	40% Coinsurance after deductible	Service may need pre-certification.

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Schedule of Benefits				
Plan Provisions	**Prior Auth Required1**	**Participating Providers (In-Network)**	**Non-Participating Providers (Out of Network)**	**Plan Limitations & Intervals**
Urgent Care	No	**$90.00 Copay**	40% Coinsurance after deductible	
Acupuncture	No	**$20.00 Copay**	40% Coinsurance after deductible	20 visits per year.
Chiropractic Services	No	**$20.00 Copay**	40% Coinsurance after deductible	20 visits per year.
HOSPITAL/FACILITY SERVICES		**Member Pays**		
Hospital Inpatient	**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Some Hospital/Facility Services may need pre-certification.
Inpatient Physician & Ancillary Services	**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Some Hospital/Facility Services may need pre-certification.
Inpatient Surgery – Physician Charges	**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Some Hospital/Facility Services may need pre-certification.
Outpatient Hospital or Free-Standing Facility Services and Surgery	**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Some Hospital/Facility Services may need pre-certification.
Anesthesia	**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Some Hospital/Facility Services may need pre-certification.

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Schedule of Benefits					
Plan Provisions		**Prior Auth Required 1**	**Participating Providers (In-Network)**	**Non-Participating Providers (Out of Network)**	**Plan Limitations & Intervals**
EMERGENCY SERVICES			**Member Pays**		
Emergency Room Facilities and Covered Services		No	**20% Coinsurance after deductible**	20% Coinsurance after deductible	Some Emergency Services may need pre-certification.
Ambulance / Emergency Medical Transportation		No	**20% Coinsurance after deductible**	20% Coinsurance after deductible	Some Emergency Services may need pre-certification.
Diagnostic Services			**Member Pays**		
Laboratory Services	**Freestanding Laboratory**	No	**No Charge**	40% Coinsurance after deductible	
	Laboratory / Diagnostics	**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Some Diagnostic Services may need pre-certification.
Radiology		No	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Some Diagnostic Services may need pre-certification.
CT/MRI/MRA/PET Scan		**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Some Diagnostic Services may need pre-certification.
Maternity & Infertility Services			**Member Pays**		
Office Visit - OBGYN		No	**$45.00 Copay**	40% Coinsurance after deductible	
Pregnancy: Childbirth/Delivery		**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Some Procedures may need pre-certification.
Infertility		**Yes**	Not Covered 100% paid by Member	Not Covered 100% paid by Member	

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Schedule of Benefits				
Plan Provisions	**Prior Auth Required1**	**Participating Providers (In-Network)**	**Non-Participating Providers (Out of Network)**	**Plan Limitations & Intervals**
Mental Health Services		**Member Pays**		
Outpatient Mental Health	**Yes**	**$45.00 Copay**	40% Coinsurance after deductible	
Inpatient Mental Health	**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	
Other Services		**Member Pays**		
Injections	**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Some Injections may need pre-certification.
Adult Eye Exam	No	**$45.00 Copay**	40% Coinsurance after deductible	1 visit per year.
Cardiac Rehabilitiation	**Yes**	**$45.00 Copay**	40% Coinsurance after deductible	36 visits per year. Some Rehabilitation may need pre-certification.
Durable Medical Equipment	**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Some Durable Medical Equipment may need pre-certification.
Habilitation Services	**Yes**	**$45.00 Copay**	40% Coinsurance after deductible	20 visits per year. Some Habilitation Services may need pre-certification.
Hearing Aids	No	Not Covered	Not Covered	
Home Health Care	**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	60 visits per year. Some Home Health Care Services may need pre-certification.
Hospice Care	**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Service may need pre-certification.
Other services	**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Service may need pre-certification.
Private Duty Nursing	**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Service may need pre-certification.

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Schedule of Benefits					
Plan Provisions		**Prior Auth Required1**	**Participating Providers (In-Network)**	**Non-Participating Providers (Out of Network)**	**Plan Limitations & Intervals**
Radiation and Chemotherapy		**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Some service may need pre-certification.
Rehabilitation Services (occupational, physical, and speech therapy)		**Yes**	**$45.00 Copay**	40% Coinsurance after deductible	20 visits per year. Some Home Health Care Services may need pre-certification.
Skilled Nursing Facility		**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	60 days per year.
Treatment for Chemical Abuse & Dependency	**(In-Patient)**	**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Pre-certification Required.
Treatment for Chemical Abuse & Dependency	**(Out-Patient)**	**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Pre-certification Required.
Inpatient Care Substance Abuse Detoxification Facility (7 Day Maximum)		**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Pre-certification Required.
Colonoscopy (Diagnostic Purposes)		**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Pre-certification Required.
Transplant - Facility		**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Pre-certification Required.
Transplant - Physician and Anesthesiologist Charges during Inpatient Hospitalization		**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Pre-certification Required.
Dialysis		**Yes**	**20% Coinsurance after deductible**	40% Coinsurance after deductible	Pre-certification Required.

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Pharmacy Benefits				
Plan Provisions		Member Pays		
		Participating Providers (In-Network)	Non-Participating Providers (Out of Network)	Plan Limitations & Intervals
Preventive Generic	(30 day supply)	**$0 Copay**	Not Covered	**If a Plan Participant requests a Brand or Specialty name drug when a Generic equivalent is available, then the Plan Participant must pay the Brand or Specialty name drug copayment plus the difference in cost between the Brand or Specialty name drug and the Generic drug. This expense will not apply to the maximum out-of-pocket amount.**
	(90 day supply)	**$0 Copay**	Not Covered	
Generic	(30 day supply)	**$15 Copay**	Not Covered	
	(90 day supply)	**$45 Copay**	Not Covered	
Preferred Brand	(30 day supply)	$65 Copay	Not Covered	
	(90 day supply)	$90 Copay	Not Covered	
Non-Preferred Brand	(30 day supply)	$100 Copay	Not Covered	
	(90 day supply)	$150 Copay	Not Covered	
Specialty	(30 day supply)	50% Coinsurance	Not Covered	
	(90 day supply)	Not Covered	Not Covered	