MEDICAL BENEFIT SCHEDULE – CORE PLAN

	NETWORK	NON-NETWORK
Lifetime Maximum Benefit	Unlimited	Unlimited
Annual Deductible (Single/Family)[1] The Family Amount Can Be Any Combination Of Family Members But An Individual Would Never Satisfy More Than Their Own Individual Amount. Deductibles Apply to Out-of-Pocket Maximum	$1,000/$2,000	$2,000/$4,000
Maximum Out-Of-Pocket (Single/Family)[2] The Family Amount Can Be Any Combination Of Family Members But An Individual Would Never Satisfy More Than Their Own Individual Amount. Maximum Excludes: • Cost Containment Penalties • Charges Over the Allowed Amount • Exclusions and Limitations • Pharmacy Charges • Non-Network Transplant Services • Copayments	$4,000/$8,000	$8,000/$16,000
COVERED BENEFITS		
PHYSICIAN SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Physician Office Services • Office Visit Copayment (PCP/SCP) • Allergy Injection • Allergy Serum • Allergy Testing • Imaging Services (MRI, MRA, PETS, C- SCAN) • Diagnostic Test (Lab and X-Ray)	 $30/$30 Copayment $5 Copayment 20% Deductible waived 20% After Deductible 20% After Deductible No Cost Share	 40% After Deductible 40% After Deductible 40% After Deductible 40% After Deductible 40% After Deductible 40% After Deductible
Preventive Care Services Office Visit Copayment Services include, but are not limited to: • Routine Exams (PCP/SCP) • Colonoscopy • Contraceptives • Mammogram[3] • PAP/PSA Testing • Immunizations • Annual Diabetic Eye Exam • Diabetic Education • PCP Vision/Hearing Screening • Breast Pumps – Not Covered	$30/$30 Copayment	40% After Deductible
Live Health Online	$20 Copayment	N/A
Telehealth Consultations	$30/$30 Copayment	40% After Deductible

COVERED BENEFITS		
FACILITY SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Behavioral Health & Substance Abuse Covered As Outlined In The Medical Benefits Section		
• Inpatient Facility Services	20% After Deductible	40% After Deductible
• Inpatient Professional Services	20% After Deductible	40% After Deductible
• Other Outpatient Services	20% After Deductible	40% After Deductible
Emergency Room Covered As Outlined In The Medical Benefits Section		
• Emergency Room Services	$75 Copayment	Covered at In-Network Level
• Emergency Room Physician	No Cost Share	Covered at In-Network Level
• Non-Emergent Emergency Room Services	Not A Covered Benefit	Not A Covered Benefit
NOTE: Copayment Waived If Admitted To Hospital		
Hospice Care Covered As Outlined In The Medical Benefits Section	No Cost Share	Cover at In-Network Level
Hospital Inpatient Services **Precertification Required** Covered As Outlined In The Medical Benefits Section		
• Room & Board (Semiprivate or ICU/CCU)	20% After Deductible	40% After Deductible
• Hospital Services & Supplies	20% After Deductible	40% After Deductible
Inpatient Hospital Professional Services		
• Surgeon	20% After Deductible	40% After Deductible
• Anesthesiologist	20% After Deductible	40% After Deductible
• Radiologist	20% After Deductible	40% After Deductible
• Pathologist	20% After Deductible	40% After Deductible
NOTE: The In-Network Benefit Applies To Non-Network Providers In The Following Situations: • Professional Services (Radiologist, Pathologist or Anesthesiologist) When Services Are Rendered At An In-Network Facility • Services Are Not Available At An In-Network Facility/Provider • Covered Individuals Traveling Outside The United States • Medical Emergency Treatment • Diagnostic Procedures Performed In An In-Network Physician's Office & Sent To An Outside Diagnostic Facility For Evaluation		
Inpatient Facility Services (Other Than Hospital) Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
NOTE: Skilled Nursing Facility 90 Day Annual Limit Combined In-Network/Non-Network		
Outpatient Surgery/Alternative Care Facility Covered As Outlined In The Medical Benefits Section Services Include, But Not Limited To: • Surgery • Administration of General Anesthesia	20% After Deductible	40% After Deductible
NOTE: The In-Network Benefit Applies To Non-Network Providers In The Following Situations: • Professional Services (Radiologist, Pathologist or Anesthesiologist) When Services Are Rendered At An In-Network Facility • Services Are Not Available At An In-Network Facility/Provider • Covered Individuals Traveling Outside The United States • Medical Emergency Treatment • Diagnostic Procedures Performed In An In-Network Physician's Office & Sent To An Outside Diagnostic Facility For Evaluation		
Urgent Treatment Center • Urgent Treatment Center Services[4]	$35 Copayment	Covered at In-Network Level

COVERED BENEFITS		
SPECIALIZED SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Abortion Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30/$30 Copayment 20% After Deductible	 40% After Deductible 40% After Deductible
Accidental Dental Injury Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30/$30 Copayment 20% After Deductible	 40% After Deductible 40% After Deductible
Ambulance Services (Land / Air) Covered As Outlined In The Medical Benefits Section	20% After Deductible	Covered at In-Network Level
Attention Deficit Disorder (ADD) **Attention Deficit Hyperactivity Disorder (ADHD)** Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30/$30 Copayment 20% After Deductible	 40% After Deductible 40% After Deductible
Autism (ages 1-21) Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30/$30 Copayment 20% After Deductible	 40% After Deductible 40% After Deductible
Bariatric Surgery/Morbid Obesity	Not A Covered Benefit	Not A Covered Benefit
Behavioral Health & Substance Abuse Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30 Copayment 20% After Deductible	 40% After Deductible 40% After Deductible
Cardiac Rehabilitation Therapy Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30/$30 Copayment 20% After Deductible	 40% After Deductible 40% After Deductible
NOTE: Limited to 36 visits, Combined In and Non-Network per Calendar Year		
Chemotherapy/Infusion Therapy Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
Chiropractic/Spinal Manipulation Covered As Outlined In The Medical Benefits Section	$30 Copayment	40% After Deductible
NOTE: Chiropractic/Spinal Manipulation Has A Maximum of 12 Visits Per Plan Benefit Year Inclusive Of Both In-Network & Non-Network Providers.		

COVERED BENEFITS		
SPECIALIZED SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Clinical Trials Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30/$30 Copayment 20% After Deductible	 40% After Deductible 40% After Deductible
Hearing Services/Cochlear Implants Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
NOTE: Hearing Aids Are Limited To One Hearing Aid Per Hearing Impaired Ear Every 36 Months To Age 18.		
Home Health Care Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
NOTE: Limited to 90 visits per Calendar Year Maximum Combined In-network and Non-Network		
Infertility Services/Treatment	Not A Covered Benefit	Not A Covered Benefit
Inpatient & Outpatient Professional Services Covered As Outlined In The Medical Benefits Section Services Include, But Not Limited To: • Medical Care Visit (One Per Day) • Intensive Medical Care • Concurrent Care • Surgery • Anesthesia Administration • Newborn Exams	20% After Deductible	40% After Deductible
NOTE: The In-Network Benefit Applies To Non-Network Providers In The Following Situations: • Professional Services (Radiologist, Pathologist or Anesthesiologist) When Services Are Rendered At An In-Network Facility • Services Are Not Available At An In-Network Facility/Provider • Covered Individuals Traveling Outside The United States • Medical Emergency Treatment • Diagnostic Procedures Performed In An In-Network Physician's Office & Sent To An Outside Diagnostic Facility For Evaluation		
Maternity/Pregnancy Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Hospital/Birthing Center	 $30 Copayment 20% After Deductible	 40% After Deductible 40% After Deductible
NOTE: Dependent Daughters Are Covered		
Medical Supplies and Equipment Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
Nutritional Counseling Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30 Copayment $30 Copayment	 Not a Covered Benefit Not a Covered Benefit

COVERED BENEFITS		
SPECIALIZED SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Occupational Therapy Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30 Copayment $30 Copayment	 40% After Deductible 40% After Deductible
NOTE: Occupational Therapy Has A Maximum Of 20 Visits Per Calendar Year Combined Both In-Network & Non-Network Providers.		
Oral Surgery Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30 Copayment 20% After Deductible	 40% After Deductible 40% After Deductible
Organ Transplant Services Covered As Outlined In The Transplant Benefit Section	No Cost Share	50% After Deductible
Orthotic/Pulmonary Devices Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
Physical Therapy Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30 Copayment $30 Copayment	 40% After Deductible 40% After Deductible
NOTE: Physical Therapy Has A Maximum Of 20 Visits Per Calendar Year Combined Both In-Network & Non-Network Providers.		
Private Duty Nursing Covered Only With Home Health Care Benefit	20% After Deductible	40% After Deductible
NOTE: Limited to 90 visits per Calendar Year Maximum Combined In-network and Non-Network		
Respiratory Therapy Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place of Service	 $30 Copayment 20% After Deductible	 40% After Deductible 40% After Deductible
NOTE: Limited to 20 Visits per Calendar Year Combined Both In-Network & Non-Network Providers		
Sleep Disorder Therapy Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
Speech Therapy Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30 Copayment $30 Copayment	 40% After Deductible 40% After Deductible
NOTE: Speech Therapy Has A Maximum Of 20 Visits Per Calendar Year Combined Both In-Network & Non-Network Providers.		
Sterilization (Reversal Excluded) Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
NOTE: Female Participants Covered At 100% Per ACA Guidelines		
Temporomandibular Joint Dysfunction (TMJ) Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
Tobacco Cessation Programs Covered As A Standard Preventive Care Benefit Through A Network Provider	$30/$30 Copayment	40% After Deductible

COVERED BENEFITS		
PRESCRIPTION DRUGS	**YOUR COST SHARE RESPONSIBILITY**	
Retail Pharmacy (30 Day Supply) Generic Formulary Brand Name Non-Formulary Brand Name NOTE: *$200 Deductible applies – Tiers II and III only, network and non-network	$10 Copayment $30 Copayment $60 Copayment	50% coinsurance, minimum $60 copayment
Mail Order Pharmacy (90 Day Supply) Generic Formulary Brand Name Non-Formulary Brand Name	$20 Copayment $75 Copayment $150 Copayment	Not Covered
NOTE: Member may be responsible for additional cost when not selecting the available generic drug. Specialty medications must be obtained via Specialty Pharmacy network to receive network level benefits. Specialty drugs are to a 30-day supply, regardless of whether they are retail or mail		

COVERED BENEFITS		
HUMAN ORGAN TRANSPLANTS		
Transplant Services – Human Organ & Tissue Transplant Covered As Outlined In The Transplant Benefits Section Any Medically Necessary Human Organ & Stem Cell/Bone Marrow Transplant And Transfusion As Determined By The Claims Administrator, Including Necessary Acquisition Procedures, Harvest And Storage, Including Medically Necessary Preparatory Myeloablative Therapy. A Blue Distinction Center Requirement Does Not Apply To Cornea Or Kidney Transplants, Or For Any Covered Charges Related To A Covered Transplant Procedure Prior To Or After The Transplant Benefit Period.		
NOTE: Even If A Hospital Is A Network Provider For Other Services, It May Not Be A Network Transplant Provider For These Services. Prior To Seeking Care Please Contact Aspirant Care Coordination At (855) 984-2583 To Determine Which Hospitals Are Network Transplant Providers.		
TRANSPLANT BENEFIT	**IN-NETWORK**	**NON-NETWORK**
	YOUR COST SHARE RESPONSIBILITY	
Transplant Benefit	No Cost Share	50% After Deductible
Transplant Benefit – Blue Distinction Center Facility	No Cost Share	N/A
Transportation & Lodging Covered As Outlined In The Transplant Benefits Section	$10,000 Maximum Benefit Per Transplant For Travel & Lodging Expenses	
NOTE: The Plan Will Provide Assistance With Reasonable And Necessary Travel Expenses As Determined By The Plan When You Obtain Prior Approval And Are Required To Travel More Than 75 Miles From Your Residence To Reach The Facility Where The Covered Transplant Procedure Will Be Performed. Assistance With Travel Expenses Includes Transportation To And From The Facility And Lodging For The Transplant Recipient And One Adult Companion For An Adult Transplant Recipient Or Two Adult Companions For A Child Transplant Recipient Under Age 18. The Member Must Submit Itemized Receipts For Transportation And Lodging Expenses In A Form Acceptable To The Plan. Internal Revenue Service (IRS) Guidelines Will Be Applied In Determining Which Expenses May Be Paid By The Plan.		
Donor Searches Maximum Benefit $30,000 Per Transplant Donor Benefits Are Limited To Benefits Not Available To The Donor From Any Other Source.	No Cost Share	50% After Deductible
NOTE: Medically Necessary Charges For Procurement Of An Organ From A Live Donor Are Covered To The Maximum Allowable Amount Including Complications From The Donor Procedure For Up To Six Weeks From The Date Of Procurement.		
All Other Transplant Services Covered As Outlined In The Transplant Benefits Section	No Cost Share	50% After Deductible

Benefit Schedule Notes:

All Copayments Are Not Included In The Out-Of-Pocket Limits.

Cost Containment Penalties and Non-Network Transplant Services are excluded for the Out-Of-Pocket Limits.

Deductibles apply only to Covered Medical Services listed with a Coinsurance Percentage and do not apply where a fixed dollar copayment is required unless otherwise denoted.

Network and Non-Network Deductibles, Copayments, Coinsurance and Out-of-Pocket Maximums are separate and accumulate separately.

Dependent Coverage to the end of the birthdate month in which Child attains age 26.

No Deductible/Copayment/Coinsurance means No Cost Share up to the Maximum Allowable Amount.

PCP Is a Network Provider who is a Practitioner that specializes in Family Practice, General Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology, Geriatrics or Any Other Network Provider as allowed by The Plan.

SCP Is a Network Provider, other than a Primary Care Physician (PCP), who provides services within a designated Specialty Area of Practice.

All Specialty Medications must be obtained via the Specialty Pharmacy network in order to receive network level benefits.

Physician Office Visit Copayment is applicable if the Office Visit is billed with Allergy Injections.

Benefit Period is on a Calendar Year Basis beginning January 1st and ending December 31st.

[1] Charges in excess of the Maximum Allowed Amount do not contribute to the deductible. Deductible Amounts accumulate separately for In Network and Out of Network.

[2] Out of Pocket amounts accumulate separately for In Network and Out of Network Charges.

[3]Diagnostic Mammograms and Preventive Mammograms are covered at 100% after a $30 Copayment In-Network.

[4]Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs received in an Urgent Care Center and billed alone are subject to the Other Outpatient Services Copayment / Coinsurance.