<table>
<thead>
<tr>
<th></th>
<th>In Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Coinsurance (applies only to certain services)</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket (includes deductible, coinsurance, copays)</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**Office Visits**

<table>
<thead>
<tr>
<th>Service</th>
<th>In Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Primary Care Provider Visit (to treat an illness or injury)¹</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Obstetrics/Gynecology Visit</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Specialist Visit</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Chiropractic Visit</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Hearing Exam</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
</tbody>
</table>

**Diagnostic Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>In Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Diagnostic Laboratory Tests</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Diagnostic X-rays</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Imaging (MRI, MRA, PET and CT Services only)</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
</tbody>
</table>

**Mental/Behavioral Health & Substance Abuse**

<table>
<thead>
<tr>
<th>Service</th>
<th>In Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Outpatient - Office</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Outpatient - All Other Services</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Transitional</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Inpatient</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
</tbody>
</table>

**Emergency Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>In Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Emergency Room</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Physician Services</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Ambulance (ground and air)²</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
</tbody>
</table>

**Hospital Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>In Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Outpatient Surgical/Ambulatory Surgical Care Centers</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Reconstructive Surgery</td>
<td>Covered in Full</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>*Inpatient Hospital Services</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
</tbody>
</table>

**Maternity Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>In Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Prenatal Care</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Delivery and Inpatient Services</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
</tbody>
</table>

**Preventive Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>In Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Preventive Service³</td>
<td>Covered in Full</td>
<td>No Coverage</td>
</tr>
</tbody>
</table>

**Vision Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>In Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Children's Vision Exam (1 exam per year)</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Children's Eye Glasses (1 pair per year)</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Adult Vision Exam (1 exam per 2 years)</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Service</td>
<td>Coverage</td>
<td>Coverage</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Transplants</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Clinical Trials</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Habilitation Services</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Physical, Speech &amp; Occupational Therapy</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Cardiac/Pulmonary Rehabilitation</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Autism Spectrum Disorders</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Outpatient Chemotherapy</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Outpatient Radiation Therapy</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Hospice Services/End of Life Services</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Diabetes Education</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Dialysis</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Non-Surgical Treatment for Temporomandibular Joint (TMJ)</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Specified Oral Surgical Procedures</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Routine Dental Services</td>
<td>Please see below.</td>
<td>6</td>
</tr>
<tr>
<td>Accidental Dental Services</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
</tbody>
</table>

### Prescription Drugs, Supplies & Equipment

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Medicines:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Retail (30 day supply)</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Includes diabetic test strip</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mail Order (2 Copays per 90 day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes diabetic test strip</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive (30 day supply) Medications defined in our formulary as preventive.</td>
<td>Preventive - Covered in Full (see formulary for details)</td>
<td>Preventive - Covered in Full (see formulary for details)</td>
</tr>
<tr>
<td>*Specialty Drugs</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Prosthetic Devices</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Diabetic Equipment and Supplies</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>*Hearing Aids for Member over age 18 (Limited to one aid per ear every 36 months)</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Hearing Aids for Members under Age 18. (Limited to one aid per ear every 36 months)</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Cochlear Implants for Members under Age 18.</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
</tbody>
</table>

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4Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.
5Please refer to the Member Certificate to determine what oral surgeries procedures are covered.
6This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.
7Only certain Prescription Drug products are available through mail order.
<table>
<thead>
<tr>
<th></th>
<th>In Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Coinsurance (applies only to certain services)</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket (includes deductible, coinsurance, copays)</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Office Visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Primary Care Provider Visit (to treat an illness or injury)¹</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Obstetrics/Gynecology Visit</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Specialist Visit</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Chiropractic Visit</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Hearing Exam</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td><strong>Diagnostic Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Diagnostic Laboratory Tests</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Diagnostic X-rays</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Imaging (MRI, MRA, PET and CT Services only)</td>
<td>paycheck</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td><strong>Mental/Behavioral Health &amp; Substance Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Outpatient - Office</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Outpatient - All Other Services</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Transitional</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Inpatient</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Emergency Room</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Physician Services</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Urgent Care</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Ambulance (ground and air)²</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Outpatient Surgical/Ambulatory Surgical Care Centers</td>
<td>✔️ Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Reconstructive Surgery</td>
<td>✔️ Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>*Inpatient Hospital Services</td>
<td>✔️ Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td><strong>Maternity Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Prenatal Care</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Delivery and Inpatient Services</td>
<td>✔️ Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Preventive Service³</td>
<td>Covered in Full</td>
<td>No Coverage</td>
</tr>
<tr>
<td><strong>Vision Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Children’s Vision Exam (1 exam per year)</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Children’s Eye Glasses (1 pair per year)</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Adult Vision Exam (1 exam per 2 years)</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Other Services</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>*Transplants</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Clinical Trials</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>*Habilitation Services</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>*Physical, Speech &amp; Occupational Therapy (up to 20 visits each)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>*Cardiac/Pulmonary Rehabilitation (up to 36 visits per year)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>*Autism Spectrum Disorders</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>*Skilled Nursing Facility (up to 30 days per year)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Outpatient Chemotherapy</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Outpatient Radiation Therapy</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>*Hospice Services/End of Life Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Home Health Services (up to 60 visits per year)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Diabetes Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Non-Surgical Treatment for Temporomandibular Joint (TMJ)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Specified Oral Surgical Procedures</td>
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</tr>
<tr>
<td>Routine Dental Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Accidental Dental Services</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs, Supplies &amp; Equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Prescription Medicines:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail (30 day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes diabetic test strip</td>
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<tr>
<td>Preventive (30 day supply)</td>
<td></td>
<td></td>
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<tr>
<td>Medications defined in our formulary as preventive.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive - Covered in Full (see formulary for details)</td>
<td></td>
<td></td>
</tr>
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<td>Preventive - Covered in Full (see formulary for details)</td>
<td></td>
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</tr>
<tr>
<td>*Specialty Drugs</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>*Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>*Prosthetic Devices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic Equipment and Supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Hearing Aids for Member over age 18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to one aid per ear every 36 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Hearing Aids and (Limited to one aid per ear every 36 months)</td>
<td></td>
<td></td>
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<tr>
<td>*Cochlear Implants for Members under Age 18</td>
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### Gold 1000/90 NCS

<table>
<thead>
<tr>
<th>(✓) For Prior Authorization</th>
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<th>Out-of-Network (You Pay)</th>
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</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Coinsurance (applies only to certain services)</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket (includes deductible, coinsurance, copays)</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

#### Office Visits

| *Primary Care Provider Visit (to treat an illness or injury) | Covered in Full | Covered in Full |
| *Obstetrics/Gynecology Visit | Covered in Full | Covered in Full |
| *Specialist Visit | Covered in Full | Covered in Full |
| *Chiropractic Visit | Covered in Full | Covered in Full |
| *Hearing Exam | Covered in Full | Covered in Full |

#### Diagnostic Services

| *Diagnostic Laboratory Tests | Covered in Full | Covered in Full |
| *Diagnostic X-rays | Covered in Full | Covered in Full |
| *Imaging (MRI, MRA, PET and CT Services only) | Covered in Full | Covered in Full |

#### Mental/Behavioral Health & Substance Abuse

| *Outpatient - Office | Covered in Full | Covered in Full |
| *Outpatient - All Other Services | Covered in Full | Covered in Full |
| *Transitional | Covered in Full | Covered in Full |
| *Inpatient | Covered in Full | Covered in Full |

#### Emergency Services

| *Emergency Room | Covered in Full | Covered in Full |
| *Physician Services | Covered in Full | Covered in Full |
| *Urgent Care | Covered in Full | Covered in Full |
| *Ambulance (ground and air) | Covered in Full | Covered in Full |

#### Hospital Services

| *Outpatient Surgical/Ambulatory Surgical Care Centers | Covered in Full | Covered in Full |
| Reconstructive Surgery | Deductible/Coinsurance | Deductible/Coinsurance |
| *Inpatient Hospital Services | Covered in Full | Covered in Full |

#### Maternity Services

| *Prenatal Care | Covered in Full | Covered in Full |
| *Delivery and Inpatient Services | Covered in Full | Covered in Full |

#### Preventive Services

| *Preventive Service | Covered in Full | No Coverage |

#### Vision Services

| *Children's Vision Exam (1 exam per year) | Covered in Full | Covered in Full |
| *Children's Eye Glasses (1 pair per year) | Covered in Full | Covered in Full |
| *Adult Vision Exam (1 exam per 2 years) | Covered in Full | Covered in Full |
### Other Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplants</td>
<td>Covered in Full</td>
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</tr>
<tr>
<td>Clinical Trials</td>
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### Prescription Drugs, Supplies & Equipment

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<tr>
<th>Prescription Medicines:</th>
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<tr>
<td>Retail (30 day supply)</td>
<td>Preventive - Covered in Full (see formulary for details)</td>
<td>Preventive - Covered in Full (see formulary for details)</td>
</tr>
<tr>
<td>Mail Order (2 Copays per 90 day supply)</td>
<td>Prevention</td>
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<tr>
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Only certain Prescription Drug products are available through mail order.
# Bronze HSA 5650/90 NCS

## Prior Authorization

<table>
<thead>
<tr>
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<th>Out-of-Network (You Pay)</th>
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<td>Calendar Year Deductible</td>
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## Office Visits

<table>
<thead>
<tr>
<th>Visit Type</th>
<th>In Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
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</thead>
<tbody>
<tr>
<td>*Primary Care Provider Visit (to treat an illness or injury)²</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
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<tr>
<td>*Obstetrics/Gynecology Visit</td>
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<td>Covered in Full</td>
</tr>
<tr>
<td>*Specialist Visit</td>
<td>Covered in Full</td>
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<tr>
<td>*Chiropractic Visit</td>
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</tr>
<tr>
<td>*Hearing Exam</td>
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## Diagnostic Services

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<tr>
<th>Service Type</th>
<th>In Network (You Pay)</th>
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</thead>
<tbody>
<tr>
<td>*Diagnostic Laboratory Tests</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Diagnostic X-rays</td>
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<td>Covered in Full</td>
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<td>*Imaging (MRI, MRA, PET and CT Services only)</td>
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## Mental/Behavioral Health & Substance Abuse

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<tr>
<th>Service Type</th>
<th>In Network (You Pay)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>*Outpatient - Office</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Outpatient - All Other Services</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Transitional</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Inpatient</td>
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<td>Covered in Full</td>
</tr>
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</table>

## Emergency Services

<table>
<thead>
<tr>
<th>Service Type</th>
<th>In Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
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</thead>
<tbody>
<tr>
<td>*Emergency Room</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
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<tr>
<td>*Physician Services</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Urgent Care</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Ambulance (ground and air)³</td>
<td>Covered in Full</td>
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</table>

## Hospital Services

<table>
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<tr>
<th>Service Type</th>
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</thead>
<tbody>
<tr>
<td>*Outpatient Surgical/ Ambulatory Surgical Care Centers</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Reconstructive Surgery</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Inpatient Hospital Services</td>
<td>Covered in Full</td>
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## Maternity Services

<table>
<thead>
<tr>
<th>Service Type</th>
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<th>Out-of-Network (You Pay)</th>
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</thead>
<tbody>
<tr>
<td>*Prenatal Care</td>
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<td>Covered in Full</td>
</tr>
<tr>
<td>* Inpatient Services</td>
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</tbody>
</table>

## Preventive Services

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>*Preventive Service³</td>
<td>Covered in Full</td>
<td>No Coverage</td>
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</table>

## Vision Services

87418W10010051-02
<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Share</th>
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</thead>
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<tr>
<td>*Children's Vision Exam (1 exam per year)</td>
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<tr>
<td><strong>Other Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Transplants⁵</td>
<td>✓</td>
<td>Covered in Full</td>
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<tr>
<td>Clinical Trials</td>
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<tr>
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<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Urgent Care</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Ambulance (ground and air)</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Outpatient Surgical/ Ambulatory Surgical Care Centers</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Reconstructive Surgery</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>*Inpatient Hospital Services</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td><strong>Maternity Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Prenatal Care</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Inpatient Services</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Preventive Service</td>
<td>Covered in Full</td>
<td>No Coverage</td>
</tr>
<tr>
<td><strong>Vision Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Children’s Vision Exam (1 exam per year)</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>*Children's Eye Glasses (1 pair per year)</td>
<td>Covered in Full</td>
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</tr>
<tr>
<td>*Adult Vision Exam (1 exam per 2 years)</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td><strong>Other Services</strong></td>
<td></td>
<td></td>
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</tbody>
</table>
**Prescription Drugs, Supplies & Equipment**

<table>
<thead>
<tr>
<th>Description</th>
<th>Deductible/Coinsurance</th>
<th>Covered in Full</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Medicines:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Retail</strong> (30 day supply)</td>
<td></td>
<td>Preventive - Covered in Full</td>
</tr>
<tr>
<td>Includes diabetic test strip</td>
<td></td>
<td>(see formulary for details)</td>
</tr>
<tr>
<td><strong>Mail Order</strong> (2 Copays per 90 day supply)</td>
<td></td>
<td>Preventive - Covered in Full</td>
</tr>
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<td></td>
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<tr>
<td><strong>Preventive</strong> (30 day supply) Medications defined in our formulary as preventive.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td></td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)</td>
<td></td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td></td>
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<tr>
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<td>Cochlear Implants for Members under Age 18</td>
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## Silver 1800/80 NCS

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<th>Out-of-Network (You Pay)</th>
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<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket</td>
<td>None</td>
<td>None</td>
</tr>
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### Office Visits

- **Primary Care Provider Visit (to treat an illness or injury)**
  - Covered in Full
  - Covered in Full

- **Obstetrics/Gynecology Visit**
  - Covered in Full
  - Covered in Full

- **Specialist Visit**
  - Covered in Full
  - Covered in Full

- **Chiropractic Visit**
  - Covered in Full
  - Covered in Full

- **Hearing Exam**
  - Covered in Full
  - Covered in Full

### Diagnostic Services

- **Diagnostic Laboratory Tests**
  - Covered in Full
  - Covered in Full

- **Diagnostic X-rays**
  - Covered in Full
  - Covered in Full

- **Imaging (MRI, MRA, PET and CT Services only)**
  - Covered in Full
  - Covered in Full

- **Allergy Testing**
  - Deductible/Coinsurance
  - Deductible/Coinsurance

### Mental/Behavioral Health & Substance Abuse

- **Outpatient - Office**
  - Covered in Full
  - Covered in Full

- **Outpatient - All Other Services**
  - Covered in Full
  - Covered in Full

- **Transitional**
  - Covered in Full
  - Covered in Full

- **Inpatient**
  - Covered in Full
  - Covered in Full

### Emergency Services

- **Emergency Room**
  - Covered in Full
  - Covered in Full

- **Physician Services**
  - Covered in Full
  - Covered in Full

- **Ambulance (ground and air)**
  - Covered in Full
  - Covered in Full

### Hospital Services

- **Outpatient Surgical/Ambulatory Surgical Care Centers**
  - Covered in Full
  - Covered in Full

- **Reconstructive Surgery**
  - Deductible/Coinsurance
  - Deductible/Coinsurance

- **Inpatient Hospital Services**
  - Covered in Full
  - Covered in Full

### Maternity Services

- **Prenatal Care**
  - Covered in Full
  - Covered in Full

- **Delivery and Inpatient Services**
  - Covered in Full
  - Covered in Full

### Preventive Services

- **Preventive Service**
  - Covered in Full
  - No Coverage

### Vision Services

- **Children's Vision Exam (1 exam per year)**
  - Covered in Full
  - Covered in Full

- **Children's Eye Glasses (1 pair per year)**
  - Covered in Full
  - Covered in Full

- **Adult Vision Exam (1 exam per 2 years)**
  - Covered in Full
  - Covered in Full
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<tr>
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<th>Additional Details</th>
</tr>
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<tr>
<td><em>Transplants</em></td>
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</tr>
<tr>
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<td>Deductible/Coinsurance</td>
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</tr>
<tr>
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<td>*Physical, Speech &amp; Occupational Therapy (up to 20 visits each)</td>
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<td></td>
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<tr>
<td>*Hospice Services/End of Life Services</td>
<td>Covered in Full</td>
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</tr>
<tr>
<td>*Home Health Services (up to 60 visits per year)</td>
<td>Covered in Full</td>
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<tr>
<td>Diabetes Education</td>
<td>Deductible/Coinsurance</td>
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</tr>
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<td></td>
</tr>
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### Prescription Drugs, Supplies & Equipment

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<thead>
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<th>Additional Details</th>
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</thead>
<tbody>
<tr>
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</tr>
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</tr>
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<tr>
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</tr>
<tr>
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<tr>
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</tr>
<tr>
<td>per 3 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Prosthetic Devices</td>
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Please refer to the Member Certificate to determine what oral surgeries procedures are covered.

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Only certain Prescription Drug products are available through mail order.
Silver 2400/80 Copay 35 NCS

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</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Coinsurance (applies only to certain services)</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket (includes deductible, coinsurance, copays)</td>
<td>None</td>
<td>None</td>
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</table>

### Office Visits

- *Primary Care Provider Visit (to treat an illness or injury)¹: Covered in Full, Covered in Full
- *Obstetrics/Gynecology Visit: Covered in Full, Covered in Full
- *Specialist Visit: Covered in Full, Covered in Full
- *Chiropractic Visit: Covered in Full, Covered in Full
- *Hearing Exam: Covered in Full, Covered in Full

### Diagnostic Services

- *Diagnostic Laboratory Tests: Covered in Full, Covered in Full
- *Diagnostic X-rays: Covered in Full, Covered in Full
- *Imaging (MRI, MRA, PET and CT Services only): Covered in Full, Covered in Full
- Allergy Testing: Deductible/Coinsurance, Deductible/Coinsurance

### Mental/Behavioral Health & Substance Abuse

- *Outpatient - Office: Covered in Full, Covered in Full
- *Outpatient - All Other Services: Covered in Full, Covered in Full
- *Transitional: Covered in Full, Covered in Full
- *Inpatient: Covered in Full, Covered in Full

### Emergency Services

- *Emergency Room: Covered in Full, Covered in Full
- *Physician Services: Covered in Full, Covered in Full
- *Urgent Care: Covered in Full, Covered in Full
- *Ambulance (ground and air)²: Covered in Full, Covered in Full

### Hospital Services

- *Outpatient Surgical/Ambulatory Surgical Care Centers: Covered in Full, Covered in Full
- *Reconstructive Surgery: Covered in Full, Covered in Full
- *Inpatient Hospital Services: Covered in Full, Covered in Full
- *Inpatient Prenatal Care: Covered in Full, Covered in Full
- *Delivery and Inpatient Services: Covered in Full, Covered in Full

### Maternity Services

- *Prenatal Care: Covered in Full, Covered in Full
- *Delivery and Inpatient Services: Covered in Full, Covered in Full

### Preventive Services

- *Preventive Service³: Covered in Full, No Coverage

### Vision Services

- *Children’s Vision Exam (1 exam per year): Covered in Full, Covered in Full
- *Children’s Eye Glasses (1 pair per year): Covered in Full, Covered in Full
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<tr>
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<td>0%</td>
<td>0%</td>
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<tr>
<td>Maximum Out-of-Pocket (includes deductible, coinsurance, copays)</td>
<td>None</td>
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**Office Visits**

| *Primary Care Provider Visit (to treat an illness or injury) \(^1\) | Covered in Full | Covered in Full |
| *Obstetrics/Gynecology Visit | Covered in Full | Covered in Full |
| *Specialist Visit | Covered in Full | Covered in Full |
| *Chiropractic Visit | Covered in Full | Covered in Full |
| *Hearing Exam | Covered in Full | Covered in Full |

**Diagnostic Services**

| *Diagnostic Laboratory Tests | Covered in Full | Covered in Full |
| *Diagnostic X-rays | Covered in Full | Covered in Full |
| *Imaging (MRI, MRA, PET and CT Services only) \(✓\) | Covered in Full | Covered in Full |
| Allergy Testing | Deductible/Coinsurance | Deductible/Coinsurance |

**Mental/Behavioral Health & Substance Abuse**

| *Outpatient - Office | Covered in Full | Covered in Full |
| *Outpatient - All Other Services | Covered in Full | Covered in Full |
| *Transitional | Covered in Full | Covered in Full |
| *Inpatient \(✓\) | Covered in Full | Covered in Full |

**Emergency Services**

| *Emergency Room | Covered in Full | Covered in Full |
| *Physician Services | Covered in Full | Covered in Full |
| *Urgent Care | Covered in Full | Covered in Full |
| *Ambulance (ground and air) \(^2\) \(✓\) | Covered in Full | Covered in Full |

**Hospital Services**

| *Outpatient Surgical/Ambulatory Surgical Care Centers \(✓\) | Covered in Full | Covered in Full |
| Reconstrucitive Surgery \(✓\) | Deductible/Coinsurance | Deductible/Coinsurance |
| *Inpatient Hospital Services \(✓\) | Covered in Full | Covered in Full |

**Maternity Services**

| *Prenatal Care | Covered in Full | Covered in Full |
| *Delivery and Inpatient Services \(✓\) | Covered in Full | Covered in Full |

**Preventive Services**

| *Preventive Service \(^3\) | Covered in Full | No Coverage |

**Vision Services**

| *Children's Vision Exam (1 exam per year) | Covered in Full | Covered in Full |
| *Children's Eye Glasses (1 pair per year) | Covered in Full | Covered in Full |
| *Adult Vision Exam (1 exam per 2 years) | Covered in Full | Covered in Full |
### Other Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Covered/Coinsurance</th>
<th>Covered/Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplants</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Clinical Trials</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Habilitation Services</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Physical, Speech &amp; Occupational Therapy (up to 20 visits each)</td>
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<td>✓</td>
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<td>Cardiac/Pulmonary Rehabilitation (up to 36 visits per year)</td>
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<td>✓</td>
</tr>
<tr>
<td>Autism Spectrum Disorders</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Skilled Nursing Facility (up to 30 days per year)</td>
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<td>✓</td>
</tr>
<tr>
<td>Outpatient Chemotherapy</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Outpatient Radiation Therapy</td>
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<td>✓</td>
</tr>
<tr>
<td>Hospice Services/End of Life Services</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Home Health Services (up to 60 visits per year)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Diabetes Education</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Dialysis</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Non-Surgical Treatment for Temporomandibular Joint (TMJ)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Specified Oral Surgical Procedures</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Routine Dental Services</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Accidental Dental Services</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Prescription Drugs, Supplies &amp; Equipment</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Prescription Medicines:</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>*Retail (30 day supply)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Includes diabetic test strip</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>*Mail Order 7 (2 Copays per 90 day supply)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Includes diabetic test strip</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>*Preventive (30 day supply) Medications defined in our formulary as</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>preventive.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Durable Medical Equipment (Limited to a single purchase per DME type</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>per 3 years</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Diabetic Equipment and Supplies</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>*Hearing Aids for Member over age 18</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>(Limited to one aid per ear every 36 months)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>*Hearing Aids for Members under Age 18. (Limited to one aid per ear</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>every 36 months)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cochlear Implants for Members under Age 18</td>
<td>✓</td>
<td>✓</td>
</tr>
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</table>

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- ✓ Prior Authorization is required for these services. Call 1-877-779-7598 for Prior Authorization. Failure to obtain Prior Authorization when required will result in the Member receiving a lesser Benefit. For Durable Medical Equipment, Prior Authorization is only required if the item is over $1000.

- *These benefits have been identified as Essential Health Benefits but this does not mean all services under these categories will be subject to no cost sharing. In addition, all services must meet all other requirements for coverage. Members should call Customer Service to determine the benefits provided under the plan.

1 Primary Care Provider includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.
2 Prior Authorization is only required for non-emergent ground and air ambulance.
3 Federal Patient Protection and Affordable Care Act provides for coverage of certain Preventive Services based on age, gender and other health factors with no out-of-pocket expense to Member.
Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Please refer to the Member Certificate to determine what oral surgeries procedures are covered.

This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

Only certain Prescription Drug products are available through mail order.
Silver 3600/80 NCS

<table>
<thead>
<tr>
<th>(✓) For Prior Authorization</th>
<th>In Network (You Pay)</th>
<th>Out-of-Network (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Coinsurance (applies only to certain services)</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket (includes deductible, coinsurance, copays)</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

### Office Visits

| *Primary Care Provider Visit (to treat an illness or injury) | Covered in Full | Covered in Full |
| *Obstetrics/Gynecology Visit                               | Covered in Full | Covered in Full |
| *Specialist Visit                                          | Covered in Full | Covered in Full |
| *Chiropractic Visit                                        | Covered in Full | Covered in Full |
| *Hearing Exam                                              | Covered in Full | Covered in Full |

### Diagnostic Services

| *Diagnostic Laboratory Tests                              | Covered in Full | Covered in Full |
| *Diagnostic X-rays                                        | Covered in Full | Covered in Full |
| *Imaging (MRI, MRA, PET and CT Services only) ✓           | Covered in Full | Covered in Full |
| Allergy Testing                                           | Deductible/Coinsurance | Deductible/Coinsurance |

### Mental/Behavioral Health & Substance Abuse

| *Outpatient - Office                                      | Covered in Full | Covered in Full |
| *Outpatient - All Other Services                          | Covered in Full | Covered in Full |
| *Transitional                                             | Covered in Full | Covered in Full |
| *Inpatient ✓                                              | Covered in Full | Covered in Full |

### Emergency Services

| *Emergency Room                                           | Covered in Full | Covered in Full |
| *Physician Services                                       | Covered in Full | Covered in Full |
| *Urgent Care                                              | Covered in Full | Covered in Full |
| *Ambulance (ground and air) ✓                             | Covered in Full | Covered in Full |

### Hospital Services

| *Outpatient Surgical/Ambulatory Surgical Care Centers ✓   | Covered in Full | Covered in Full |
| Reconstructive Surgery ✓                                  | Deductible/Coinsurance | Deductible/Coinsurance |
| *Inpatient Hospital Services ✓                            | Covered in Full | Covered in Full |

### Maternity Services

| *Prenatal Care                                           | Covered in Full | Covered in Full |
| *Delivery and Inpatient Services ✓                       | Covered in Full | Covered in Full |

### Preventive Services

| *Preventive Service ✓                                     | Covered in Full | No Coverage    |

### Vision Services

| *Children’s Vision Exam (1 exam per year)                  | Covered in Full | Covered in Full |
| *Children’s Eye Glasses (1 pair per year)                  | Covered in Full | Covered in Full |
| *Adult Vision Exam (1 exam per 2 years)                    | Covered in Full | Covered in Full |
## Other Services

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<tr>
<th>Service</th>
<th>Coverage</th>
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</tr>
</thead>
<tbody>
<tr>
<td><em>Transplants</em></td>
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<tr>
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</tr>
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### Prescription Drugs, Supplies & Equipment

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<tr>
<th>Prescription Medicines:</th>
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</tr>
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<tr>
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<td></td>
</tr>
<tr>
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<td>Preventive - Covered in Full</td>
</tr>
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<td></td>
<td></td>
</tr>
<tr>
<td><em>Preventive (30 day supply)</em></td>
<td>(see formulary for details)</td>
<td>(see formulary for details)</td>
</tr>
<tr>
<td>Medications defined in our formulary as preventive.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Specialty Drugs</td>
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<td>Covered in Full</td>
</tr>
<tr>
<td><em>Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)</em></td>
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