Maximum Out of Pocket for Medical EHB Benefits  NA  Maximum Out of Pocket for Drug EHB Benefits  NA  Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)  \$9,10	Network	Out-of-Network
Maximum Out of Pocket for Drug EHB Benefits  NA  Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)  \$9,10	Α	
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) \$9,10		NA
	4	NA
Medical EHB Deductible (Embedded) \$500	,100/\$18,200	\$15,000/\$30,000
	00/\$1,000	\$4,000/\$8,000
Drug EHB Deductible \$0/\$	/\$0	Limited to In Network
Combined Medical and Drug EHB Deductible NA	4	NA
Coinsurance 0%	6	30%
Primary Care Visit to Treat an Injury or Illness \$20	0	30% after deductible
Specialist - Office Visit \$40	0	30% after deductible
Other Practitioner Office Visit (Nurse, Physician Assistant) \$20	0	30% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center) \$250	50 copay after deductible	30% after deductible
Outpatient Surgery Physician/Surgical Services 0% at	6 after deductible	30% after deductible
	sidential - \$40 per visit, cility - \$100 per day	30% after deductible
Infertility Treatment (Note Exclusions)  0% as	á after deductible	30% after deductible
Routine Eye Exam (Adult) Not C	ot Covered	Not Covered
Urgent Care Centers or Facilities \$20	0	\$20
Home Health Care Services (60 visits per year - visit limits do not apply to mental health/substance use disorder benefits) \$0		30% after deductible
Emergency Room Services \$250	50	\$250
Emergency Transportation (Ambulance/Air) \$0	1	\$0
Inpatient Hospital Services (e.g., Hospital Stay) \$200	00 per stay after deductible	30% after deductible
Inpatient Physician and Surgical Services 0% at	6 after deductible	30% after deductible
Skilled Nursing Facility (120 days per year)  0% a	6 after deductible	30% after deductible
Prenatal and Postnatal Care (Office Visit) \$0	١	30% after deductible
Delivery and All Inpatient Services for Maternity Care 0% at	6 after deductible	30% after deductible
Mental/Behavioral Health Outpatient Services \$20	0	30% after deductible
Mental/Behavioral Health Inpatient Services \$200	00 per stay after deductible	30% after deductible
Substance Abuse Disorder Outpatient Services \$20	0	30% after deductible
Substance Abuse Disorder Inpatient Services \$200	00 per stay after deductible	30% after deductible
Tier 2 - Preferred Generic Drugs \$5		Limited to In Network
Tier 3 - Non-Preferred Generic Drugs \$15	5	Limited to In Network
Tier 4 - Preferred Brand Drugs \$30	0	Limited to In Network
Tier 5 - Non-Preferred Brand Drugs \$60	0	Limited to In Network
Tier 6 - Specialty Drugs 40%	% coinsurance up to \$150	Limited to In Network
Tier 1 - \$0 Rx \$0		Limited to In Network
Mail-Order Rx 1x cc	copay	Limited to In Network
90-Day Retail 2x cc	copay	Limited to In Network
Outpatient Rehabilitation Services \$40	.0	30% after deductible

Controller Nationary Rehab/Respiratory Rehab Services (36 visits per benefit period)         50         50% start eduction           Habilitation Services         440         30% after deductible           Habilitation Services         440         30% after deductible           Habilitation Services         440         30% after deductible           Habilitation Services         520         Lond 100         What reductible           Habilitation Services         520         Lond 100         What reductible           Chromatic Cac (20 visits per benefit period)         \$250 copey after deductible         Clinicated to In Network           Durable Medical Equipment front sharing does not apply to mental besith/substance use disorder         \$20         United to In Network           Recentive Care/Screening/Immunication         \$40         United to In Network           Recentive Care/Screening/Immunication         \$40         United to In Network           Refeatled the Speech Therapy         \$40         United to In Network           Rehabilitative Corpational and Rehabilitative Physical Therapy         \$40         United to In Network           Rehabilitative Corpational and Rehabilitative Physical Therapy         \$40         United to In Network           Rehabilitative Corpational and Rehabilitative Physical Therapy         \$40         United to In Network           <	Outpatient Cardiac Rehabilitation Services (36 visits per benefit period)	\$0	30% after deductible
Habilitative Speech Therapy		· ·	
Habilitative Speech Therapy		· ·	
Habilitative Occupational and Physical Therapy		· ·	
Chropractic Care (20 visits per henefit period)  Dranble Medical Equipment (cost sharing does not apply to mental health/substance use disorder (algenment)  Imaging (CT/ET Scan, MRIs)  Presentive Care/Screening/Immunization  So So Copay after deductible  Presentive Care/Screening/Immunization  So S		· ·	
Durable Medical Equipment (cost sharing does not apply to mental health/substance use disorded diagnosis of the deductible diagnosis of the preventive Carco-Screening/Immunization 50 united to In Network Routine Eye Exam for Children 50% 50% 50% 50% 50% 50% 50% 50% 50% 50%		•	
diagnosis)         Visitatr consustation         Unitable to in Network           Imaging (CT/PET Scana, MRIs)         5250 copay after deductible         3014 deductible           Powenshive Cara/Screening/Immunization         50         Lunited to in Network           Routine Eye Sam for Children         50%         50%           Spalplasses for Children         50%         50%           Rothalilitative Spench Therapy         40         30% after deductible           Robbilitative Occupational and Rehabilitative Physical Therapy         40         30% after deductible           Well Baby Vibits and Care         50         Lunited to In Network           Well Baby Vibits and Care         0% after deductible         30% after deductible           X-rays         0% after deductible         30% after deductible           Basic Destal Care - Child         50% coinsurance after deductible         40% after deductible           Basic Destal Care - Child         50% coinsurance after deductible         40% after deductible           Major Dental Care - Child         50% coinsurance after deductible         50% after deductible           Major Dental Care - Child         50% coinsurance after deductible         50% after deductible           Major Dental Care - Child         50% coinsurance after deductible         50% after deductible           Ma		\$20	Limited to in Network
Preventive Care/Screening/Innumization         50         Limited to In Network           Routine Eye Exam for Children         \$40         Limited to In Network           Eyeglasses for Children         50%         50%           Rehabilitative Speech Therapy         \$40         30% after deductible           Rehabilitative Occupational and Rehabilitative Physical Therapy         \$40         30% after deductible           Well Baby Visits and Care         30% after deductible         30% after deductible           Action of Limited to In Network         30% after deductible         30% after deductible           Dental Cheekup for Children         \$0         Limited to In Network           Basic Dental Care - Child         \$00% coinsurance after deductible         Limited to In Network           Christod Medically necessary)         \$00% coinsurance after deductible         Limited to In Network           Major Dental Care - Child         \$00% coinsurance after deductible         \$00% after deductible           Accidental Dental (medically necessary)         \$00% coinsurance after deductible         \$00% after deductible           Accidental Dental (medically necessary)         \$00% after deductible         \$00% after deductible           Accidental Dental (medically necessary)         \$00% after deductible         \$00% after deductible           Dialysis         \$00% after d		0% after deductible	Limited to In Network
Routine Eye Exam for Children	Imaging (CT/PET Scans, MRIs)	\$250 copay after deductible	30% after deductible
Eyeglasses for Children         50%         50%           Rehabilitative Speech Therapy         \$40         30% after deductible           Rehabilitative Occupational and Rehabilitative Physical Therapy         \$40         30% after deductible           Well Baby Visits and Care         \$0         Limited to In Network           Laboratory Outpatient         0% after deductible         30% after deductible           X-rays         0% after deductible         30% after deductible           Dental Checkup for Children         \$0         Limited to In Network           Basic Dental Care - Child         teductible         Limited to In Network           O'thodontia - Child (Medically necessary)         50% coinsurance after         Limited to In Network           Major Dental Care - Child         50% coinsurance after         Limited to In Network           Accidental Dental (medically necessary)         0% after deductible         30% after deductible           Accidental Dental (medically necessary)         0% after deductible         30% after deductible           Dialysis         0% after deductible         30% after deductible           Allergy Testing         0% after deductible         30% after deductible           Chemotherapy         0% after deductible         30% after deductible           Rediation         90         <	Preventive Care/Screening/Immunization	\$0	Limited to In Network
Rehabilitative Speech Therapy         \$40         30% after deductible           Rehabilitative Occupational and Rehabilitative Physical Therapy         \$40         30% after deductible           Well Baby Visits and Care         \$0         Limited to In Network           Laboratory Outpatient         30% after deductible         30% after deductible           X-rays         0% after deductible         30% after deductible           Dental Checkup for Children         \$0         Limited to In Network           Basic Dental Care - Child         cductible         Limited to In Network           Orthodontia - Child (Medically necessary)         cductible         Limited to In Network           Major Dental Care - Child         50% coinsurance after         Limited to In Network           Accidental Dental (Medically necessary)         0% coinsurance after         Limited to In Network           Accidental Dental (medically necessary)         0% after deductible         30% after deductible           Allery Testing         0% after deductible         30% after deductible           Allery Testing         0% after deductible         30% after deductible           Rediation         0% after deductible         30% after deductible           Reliability         50         Limited to In Network           Presentive Education         50	Routine Eye Exam for Children	\$40	Limited to In Network
Rehabilitative Occupational and Rehabilitative Physical Therapy       \$40       30% after deductible         Well Baby Visits and Care       \$0       Limited to In Network         Laboratory Outpatient       0% after deductible       30% after deductible         X-rays       0% after deductible       30% after deductible         Beack Dental Care - Child       \$00 colinsurance after deductible       Limited to In Network         Basic Dental Care - Child       \$0% colinsurance after deductible       Limited to In Network         Chrhodontia - Child (Medically necessary)       \$0% colinsurance after deductible       Limited to In Network         Major Dental Care - Child       \$200 copay after deductible       30% after deductible         Transplant       \$200 copay after deductible       30% after deductible         Accidental Dental (medically necessary)       0% after deductible       30% after deductible         Dialysis       0% after deductible       30% after deductible         Allery Testing       0% after deductible       30% after deductible         Chemotherapy       0% after deductible       30% after deductible         Radiation       0% after deductible       30% after deductible         Diabetes Education       \$0       Limited to In Network         Prosthetic Devices       \$0       30% after deductibl	Eyeglasses for Children	50%	50%
Well Baby Visits and Care Laboratory Outpatient O% after deductible 30% after deductible X-rays O% after deductible Office of the Children Soft Colinsurance after deductible Cherkup for Children Soft Colinsurance after deductible Orthodontia - Child (Medically necessary) Children Soft Colinsurance after deductible Orthodontia - Child (Medically necessary) Children Soft Colinsurance after deductible Soft Colinsurance after deductible Collectible Collectible Soft Colinsurance after deductible Soft Colinsurance after deductible Collectible Col	Rehabilitative Speech Therapy	\$40	30% after deductible
Laboratory Outpatient 0% after deductible 30% after deductible Xrays 0% after deductible 30% after deductible 50% coinsurance after deductible 50% aft	Rehabilitative Occupational and Rehabilitative Physical Therapy	\$40	30% after deductible
X-rays     0% after deductible     30% after deductible       Dental Checkup for Children     \$0     Limited to In Network       Basic Dental Care - Child     \$50% coinsurance after deductible     Limited to In Network       Orthodontia - Child (Medically necessary)     \$50% coinsurance after deductible     Limited to In Network       Major Dental Care - Child     \$50% coinsurance after deductible     Limited to In Network       Transplant     \$200 coppay after deductible     30% after deductible       Accidental Dental (medically necessary)     0% after deductible     30% after deductible       Dialysis     0% after deductible     30% after deductible       Allergy Testing     0% after deductible     30% after deductible       Chemotherapy     0% after deductible     30% after deductible       Radiation     0% after deductible     30% after deductible       Diabetes Education     \$0     Limited to In Network       Prosthetic Devices     0% after deductible     Limited to In Network       Infusion Therapy     \$0     30% after deductible       Nutritional Counseling     \$40     30% after deductible       Reconstructive Surgery     \$200 coppy after deductible     30% after deductible       Preventive - Physical (1 per benefit period)     \$0     Limited to In Network       Preventive - Pag Smears     \$0     Limit	Well Baby Visits and Care	\$0	Limited to In Network
Dental Checkup for Children  Basic Dental Care - Child  Basic Dental Care - Child  Corthodontia - Child (Medically necessary)  Major Dental Care - Child  Sow coinsurance after deductible  Combination of the deductible  Sow coinsurance after deductible  Sow coinsurance after deductible  Sow coinsurance after deductible  Sow after	Laboratory Outpatient	0% after deductible	30% after deductible
Basic Dental Care - Child  Crthodontia - Child (Medically necessary)  Major Dental Care - Child  Major Mater deductible  Major After deductib	X-rays	0% after deductible	30% after deductible
Basic Pental Care - Child  Orthodontia - Child (Medically necessary)  Major Dental Care - Child  Sööc coinsurance after deductible  5ööc coinsurance after deductible  3ow after deductible  4	Dental Checkup for Children	\$0	Limited to In Network
Major Dental Care - Child  Solva coinsurance after deductible  Accidental Dental (medically necessary)  Major Dental Care - Child  Solva coinsurance after deductible  Accidental Dental (medically necessary)  Major Dental Care - Child  Maccidental Dental (medically necessary)  Major Dental Care - Child  Maccidental Dental (medically necessary)  Major Dental Care - Child  Maccidental Dental (medically necessary)  Major Dental Care - Child  Maccidental Dental (medically necessary)  Major Dental Care - Child  Maccidental Dental (medically necessary)  Major Dental Care - Child  Major Dental Care - Child  Major Dental Care - Child  Maccidental Dental (medically necessary)  Major Dental Care deductible  Maccidental Dental (medically deductible  Maccidental Dental (medically deductible)  Maccidental Dental (medically deductible)  Major Dental Care deductible  Maccidental Dental (medically deductible)  Major Dental Care deductible  Maccidental Dental (medically deductible)  Maccidental Dental (me	Basic Dental Care - Child		Limited to In Network
Major Dental Care - Child  Transplant  \$200 copay after deductible  30% after deductible  Accidental Dental (medically necessary)  0% after deductible  30% after deductible  40% after deductible  40	Orthodontia - Child (Medically necessary)		Limited to In Network
Accidental Dental (medically necessary)  Dialysis  O% after deductible  Imited to In Network  O% after deductible  Limited to In Network  Preventive - Pap Smears  O% Limited to In Network  Preventive - Cholesterol  O% Limited to In Network  Preventive - Diabetes  O% Limited to In Network  Preventive - Diabetes  O% Limited to In Network  Preventive - Diabetes  O% Limited to In Network  Preventive - Lipid Panel	Major Dental Care - Child		Limited to In Network
Dialysis Allergy Testing O% after deductible Uimited to In Network Infusion Therapy \$0 0% after deductible Uimited to In Network Infusion Therapy \$40 0% after deductible Reconstructive Surgery \$200 copay after deductible O% after deductible Uimited to In Network O% after deductible O%	Transplant	\$200 copay after deductible	30% after deductible
Allergy Testing 0% after deductible 30% after deductible Chemotherapy 0% after deductible 30% after deductible Radiation 0% after deductible 30% after deductible Diabetes Education 90 after deductible 1Limited to In Network Prosthetic Devices 0% after deductible 1Limited to In Network Infusion Therapy 90 a0% after deductible 30% after deductible 1Mutritional Counseling 540 a0% after deductible 540 a0% after deductible 540 a0% after deductible 640 and 540 and	Accidental Dental (medically necessary)	0% after deductible	30% after deductible
Chemotherapy  Radiation  0% after deductible  30% after deductible  30% after deductible  30% after deductible  10% after deductible	Dialysis	0% after deductible	30% after deductible
Radiation 0% after deductible 30% after deductible Diabetes Education \$0 Limited to In Network Prosthetic Devices 0% after deductible Limited to In Network Infusion Therapy \$0 30% after deductible Nutritional Counseling \$40 30% after deductible Reconstructive Surgery \$200 copay after deductible 30% after deductible Preventive - Physical (1 per benefit period) \$0 Limited to In Network Preventive - Mammograms \$0 Limited to In Network Preventive - Pap Smears \$0 Limited to In Network Preventive - Cholesterol \$0 Limited to In Network Preventive - Diabetes \$0 Limited to In Network Preventive - Diabetes \$0 Limited to In Network Preventive - Lipid Panel \$0 Limited to In Network	Allergy Testing	0% after deductible	30% after deductible
Diabetes Education \$0 Limited to In Network  Prosthetic Devices 0% after deductible Limited to In Network  Infusion Therapy \$0 30% after deductible  Nutritional Counseling \$40 30% after deductible  Reconstructive Surgery \$200 copay after deductible 30% after deductible  Preventive - Physical (1 per benefit period) \$0 Limited to In Network  Preventive - Mammograms \$0 Limited to In Network  Preventive - Pap Smears \$0 Limited to In Network  Preventive - Cholesterol \$0 Limited to In Network  Preventive - Diabetes \$0 Limited to In Network  Preventive - Diabetes \$0 Limited to In Network  Preventive - Lipid Panel \$0 Limited to In Network	Chemotherapy	0% after deductible	30% after deductible
Prosthetic Devices 0% after deductible Limited to In Network Infusion Therapy \$0 30% after deductible Nutritional Counseling \$40 30% after deductible Reconstructive Surgery \$200 copay after deductible 30% after deductible Preventive - Physical (1 per benefit period) \$0 Limited to In Network Preventive - Mammograms \$0 Limited to In Network Preventive - Pap Smears \$0 Limited to In Network Preventive - Cholesterol \$0 Limited to In Network Preventive - Diabetes \$0 Limited to In Network Limited to In Network Preventive - Diabetes \$0 Limited to In Network Limited to In Network Preventive - Lipid Panel \$0 Limited to In Network Limited to In Network	Radiation	0% after deductible	30% after deductible
Infusion Therapy  \$0 30% after deductible  Nutritional Counseling  Reconstructive Surgery  \$200 copay after deductible  \$0 Limited to In Network  Preventive - Physical (1 per benefit period)  \$0 Limited to In Network  Preventive - Pap Smears  \$0 Limited to In Network  Preventive - Cholesterol  \$0 Limited to In Network  Preventive - Diabetes  \$0 Limited to In Network  Limited to In Network  Preventive - Diabetes  \$0 Limited to In Network  Limited to In Network  Preventive - Diabetes  \$0 Limited to In Network  Limited to In Network  Preventive - Lipid Panel	Diabetes Education	\$0	Limited to In Network
Nutritional Counseling \$40 30% after deductible  Reconstructive Surgery \$200 copay after deductible 30% after deductible  Preventive - Physical (1 per benefit period) \$0 Limited to In Network  Preventive - Mammograms \$0 Limited to In Network  Preventive - Pap Smears \$0 Limited to In Network  Preventive - Cholesterol \$0 Limited to In Network  Preventive - Diabetes \$0 Limited to In Network  Preventive - Lipid Panel \$0 Limited to In Network	Prosthetic Devices	0% after deductible	Limited to In Network
Reconstructive Surgery \$200 copay after deductible 30% after deductible  Preventive - Physical (1 per benefit period) \$0 Limited to In Network  Preventive - Mammograms \$0 Limited to In Network  Preventive - Pap Smears \$0 Limited to In Network  Preventive - Cholesterol \$0 Limited to In Network  Preventive - Diabetes \$0 Limited to In Network  Preventive - Lipid Panel \$0 Limited to In Network	Infusion Therapy	\$0	30% after deductible
Preventive - Physical (1 per benefit period)  Preventive - Mammograms  \$0  Limited to In Network  Preventive - Pap Smears  \$0  Limited to In Network  Preventive - Cholesterol  \$0  Limited to In Network  Preventive - Diabetes  \$0  Limited to In Network  Preventive - Diabetes  \$0  Limited to In Network  Limited to In Network  Preventive - Lipid Panel  \$0  Limited to In Network	Nutritional Counseling	\$40	30% after deductible
Preventive - Mammograms \$0 Limited to In Network  Preventive - Pap Smears \$0 Limited to In Network  Preventive - Cholesterol \$0 Limited to In Network  Preventive - Diabetes \$0 Limited to In Network  Preventive - Lipid Panel \$0 Limited to In Network	Reconstructive Surgery	\$200 copay after deductible	30% after deductible
Preventive - Pap Smears \$0 Limited to In Network  Preventive - Cholesterol \$0 Limited to In Network  Preventive - Diabetes \$0 Limited to In Network  Preventive - Lipid Panel \$0 Limited to In Network	Preventive - Physical (1 per benefit period)	\$0	Limited to In Network
Preventive - Cholesterol \$0 Limited to In Network  Preventive - Diabetes \$0 Limited to In Network  Preventive - Lipid Panel \$0 Limited to In Network	Preventive - Mammograms	\$0	Limited to In Network
Preventive - Diabetes \$0 Limited to In Network  Preventive - Lipid Panel \$0 Limited to In Network	Preventive - Pap Smears	\$0	Limited to In Network
Preventive - Lipid Panel \$0 Limited to In Network	Preventive - Cholesterol	\$0	Limited to In Network
	Preventive - Diabetes	\$0	Limited to In Network
Specialist - Procedure     0% after deductible       30% after deductible	Preventive - Lipid Panel	\$0	Limited to In Network
	Specialist - Procedure	0% after deductible	30% after deductible

Colorectal - Fecal Occult and Flexible Sigmoidoscopy	\$0	Limited to In Network
Colorectal - Colonoscopy	\$0	Limited to In Network
Maternity - Office diagnostic services procedures	0% after deductible	30% after deductible
Correction for Obesity - Facility	Not Covered	Not Covered
Ostomy Supplies	0% after deductible	Limited to In Network
Urology Supplies	0% after deductible	Limited to In Network
Diabetic Services/Supplies - Eye Exam	\$0	Limited to In Network
Diabetic Services/Supplies - Rx Supplies	Rx copay applies	Limited to In Network
Diabetic Services/Supplies - Foot Orthotics	0% after deductible	Limited to In Network
Diabetic Services/Supplies - Home Blood Glucose Monitor	Rx copay applies	Limited to In Network
Diabetic Services/Supplies - Medical Equipment	0% after deductible	Limited to In Network
Implanted Devices (Medical) - Drug Delivery	0% after deductible	30% after deductible
Implanted Devices (Medical) - All other non-contraceptive implanted devices	0% after deductible	30% after deductible
Orthotic Devices	0% after deductible	Limited to In Network
Outpatient Opioid Detoxification	0% after deductible	30% after deductible
Abortion (Elective)	Not Covered	Not Covered
High Cost Specialty Drugs/Select Injectables	\$150	30% after deductible
Injectable Drugs - Physician	\$0	30% after deductible
Injectable Drugs - Facility	0% after deductible	30% after deductible
Spinal Injections	0% after deductible	Limited to In Network
Dental Anesthesia	0% after deductible	30% after deductible
Impacted Wisdom Teeth	0% after deductible	30% after deductible
Medical Foods/PKU	\$0	Limited to In Network
Pulmonary Function Tests	0% after deductible	30% after deductible
Spirometry	\$0	30% after deductible
Scheduled Transportation (Ambulance/Air)	\$0	Limited to In Network
Contact Lenses	50%	50%
Well Child Office Visits (0-21)	\$0	Limited to In Network
Well Woman Exam	\$0	Limited to In Network
Telehealth (PCP Services)	\$5	30% after deductible
Telehealth (Behavioral Health Services)	\$5	30% after deductible
Telehealth (Specialist Services)	\$10	30% after deductible
Gender-Affirming Care	\$200 per stay after deductible	30% after deductible
Mental Health/Substance Abuse Urgent Care Services	\$0	\$0