

Schedule of Benefits 2027

(Benefit Coverage Plans A and B)

	Benefit	Benefit Coverage Plan A		Benefit Coverage Plan B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Financial	Deductible	None	\$250 Individual; \$500 Family	None	\$300 Individual; \$600 Family
	Maximum out-of-pocket cost (does not include charges in excess of allowed amount or noncovered benefits)	\$1,000 Individual; \$2,000 Family copayment/coinsurance maximum	None	\$1,000 Individual; \$2,000 Family copayment/coinsurance maximum	None
	Coinsurance	None	70%/30%	None	70%/30%
	Reimbursement rate	None	70th percentile	None	70th percentile
Preventive Care	Well-child and well-adult visits	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met
	Well-woman visits	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met
	Immunizations	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met

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Maternity Care	Routine obstetrical, prenatal care, delivery, and postnatal care for mother*	\$10 copayment for initial visit only	Paid at 70% of the allowed amount after deductible is met	\$10 copayment for initial visit only	Paid at 70% of the allowed amount after deductible is met
Inpatient Care	Room and board *	No cost	\$500 copay/admission up to \$1,000 max per individual or up to \$2,000 max per family (deductible does not apply) Paid at 70%	No cost	\$500 copay/admission up to \$1,500 max per individual (deductible does not apply) Paid at 70%
	Physician's services*	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of allowed amount after deductible is met
	Surgery (Physician's services)*	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met
	Restorative physical and occupational therapy*	No cost	\$500 copay/admission up to \$1,000 max per individual or up to \$2,000 max per family (deductible does not apply) Paid at 70%	No cost	\$500 copay/admission up to \$1,500 max per individual (deductible does not apply) Paid at 70%
	Skilled nursing facility (for up to 60 days per calendar year)*	No cost	\$500 copay/admission up to \$1,000 max per individual or up to \$2,000 max per family (deductible does not apply) Paid at 70%	No cost	\$500 copay/admission up to \$1,500 max per individual (deductible does not apply) Paid at 70%

* Prior authorization may be required

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Outpatient Care	Office visits	\$10 copay/visit PCP; \$25 copay/visit specialist	Paid at 70% of the allowed amount after deductible is met	\$10 copay/visit PCP; \$30 copay/visit specialist	Paid at 70% of the allowed amount after deductible is met
	Chiropractic care*	\$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met	\$30 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Acupuncture	\$25 copayment per visit	Paid at 70% of the allowed amount after deductible is met	\$30 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Allergy treatment	\$25 copayment per visit	Paid at 70% of the allowed amount after deductible is met	\$30 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Restorative physical and occupational therapy*	\$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met	\$30 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Cardiac rehabilitation*	\$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met	\$30 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Radiology/imaging*	No cost	Paid at 70% of the allowed amount after deductible is met	\$25 copayment	Paid at 70% of the allowed amount after deductible is met
	Laboratory tests*	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met
	Restorative speech therapy for up to 30 visits per calendar year	\$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met	\$30 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Surgery (physician's services)*	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met
	Surgery (facility charges)*	No cost	Paid at 70% after deductible is met	No cost	Paid at 70% after deductible is met

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Other Services	Physician house calls	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met
	Home health care services*	No cost	Paid at 70% up to 140 visits per calendar year (deductible does not apply)	No cost	Paid at 70% up to 140 visits per calendar year (deductible does not apply)
	Home hospice care (up to 210 days max combined with inpatient hospice care)*	No cost	Paid at 70% (deductible does not apply)	No cost	Paid at 70% (deductible does not apply)
	Inpatient hospice care (up to 210 days max combined with home hospice care)*	No cost	\$500 copay/admission up to \$1,000 max per individual or up to \$2,000 max per family (deductible does not apply) Paid at 70%	No cost	\$500 copay/admission up to \$1,500 max per individual (deductible does not apply) Paid at 70%
	Durable medical equipment and supplies*	Paid at 80% of contracted amount	Paid at 70% of the cost of the covered item (deductible does not apply)	Paid at 80% of contracted amount	Paid at 70% of the cost of the covered item (deductible does not apply)
	In vitro fertilization services or covered fertility drugs ⁺ (up to a \$5,000 lifetime maximum benefit. May elect to use the \$5,000 max for prescriptions, if desired.)* ⁺	No cost for IVF services; prescription copays may apply	Paid at 70% of the allowed amount after deductible is met	No cost for IVF services; prescription copays may apply	Paid at 70% of the allowed amount after deductible is met
ER	At hospital emergency room (waived if admitted)	\$75 copayment per visit		\$100 copayment per visit	

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Behavioral Health	Outpatient behavioral health	\$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met	\$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Inpatient behavioral health*	No cost	\$500 copay/admission up to \$1,000 max per individual or up to \$2,000 max per family (deductible does not apply) Paid at 70%	No cost	\$500 copay/admission up to \$1,500 max per individual (deductible does not apply) Paid at 70%
Substance Abuse	Outpatient medical rehabilitative care for substance abuse/alcohol addiction	\$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met	\$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Inpatient medical rehabilitative care for substance abuse/alcohol addiction*	No cost	\$500 copay/admission up to \$1,000 max per individual or up to \$2,000 max per family (deductible does not apply) Paid at 70%	No cost	\$500 copay/admission up to \$1,500 max per individual (deductible does not apply) Paid at 70%
Applied Behavior Analysis (ABA)	Outpatient ABA office visits*	\$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met	\$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Outpatient facility care for ABA*	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met

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