SCHEDULE OF MEDICAL BENEFITS FOR
SEACOAST COMMUNITY CHURCH, INC.--PPO PLAN (MANAGED CARE TYPE: PPO)
Group #: 001R2636 Eff. Date: 3/1/2026 Status: NGF

Approved by:

TRU:	TRU Department	Date:Click here to enter a date.
Acct Manager:	Julie Elwell/Kate Gilpatrick	Date:Click here to enter a date.
Compliance:	Patrick Moore	Date: Click here to enter a date.

INTERNAL USE ONLY:

PPO Network: CIGNA

Out-of-Network Claims Pricing: Phia
UM: Cigna Payer Solutions
CM: MedWatch
DM: N/A Choose an item.
Customer Service: Karias Care Concierge

MCC Creditable: No

STANDARDLY COVERED SERVICES

- Breast Reduction Surgery, when Medically Necessary; *precertification required*
- Orthoptics, unless otherwise listed as excluded in the Plan Document
- For Breastfeeding Support, Supplies and Counseling: If there are no INN lactation providers, then OON providers should be covered at the INN level of benefits with no cost sharing. If the only reason for the visit with the provider is lactation, it should be with no cost-sharing.
- Coverage for Child/Adolescent MH/SU services includes, but is not limited to, CBAT and ICBAT, Intensive care coordination, in-home behavioral services and therapies as well as therapeutic monitoring services – coverage/cost varies based on where the services are rendered
- Transplant services include non-experimental human organ transplant of an organ or tissue from one person to another or grafting living tissue from its normal position to another site. Transplant procedures can include human tissue or human cartilage transplants, as well as transplants for permanent artificial heart when Medically Necessary and Covered Person is already on the transplant list.

STANDARDLY EXCLUDED SERVICES

- Sex therapy
- Xenotransplants (cross-species) transplants

PRESCRIPTION DRUG BENEFIT – ADMINISTERED BY TRUESCRIPTS	
Prescription Drug Expense & Mail Order Option Note: Prescription drug Co-payments and Coinsurance accumulate toward the Plan Year Out-of-Pocket Maximum (shown below). Once the Out-of-Pocket Maximums have been met, prescription drugs are covered at 100% for the balance of the Plan Year. Generic U.S. Food and Drug Administration (FDA) approved contraceptive medications and devices are covered at 100%. Preferred brand name and non-preferred brand name contraceptive medications are subject to as shown, unless the generic form is not available. In that case, the available preferred brand name drug (or non-preferred brand name if preferred brand name is not available) will be covered at 100% Tobacco cessations products are covered at 100%.	**Retail Card Program – You Pay:** (Up to a 30 day supply) $15 Co-Payment per generic drug; $40 Co-Payment per preferred brand name drug; $70 Co-Payment per non-preferred brand name drug **Retail Card Program – You Pay:** (Up to a 90 day supply) $45 Co-Payment per generic drug; (90 day supply not available at Retail for preferred/non-preferred brand name drugs) **Mail Order Pharmacy – You Pay:** (Up to a 90 day supply) $25 Co-Payment per generic drug; $90 Co-Payment per preferred brand name drug; $175 Co-Payment per non-preferred brand name drug **Specialty Drugs (Retail only) – You Pay:** (Up to a 30 day supply) $125 Co-Payment per Tier 1 Specialty drug; 20% Co-insurance up to a $550 maximum per Tier 2 Specialty drug; 20% Co-insurance up to a $2,000 maximum per Tier 3 Specialty drug; 20% Co-insurance per Tier 4 Specialty drug; 50% Co-insurance per Tier 5 Specialty drug; *See Covered Services, Prescription Drugs in the* Medical Benefits *section for coverage requirements and other limitation*s related to specialty drugs
Out-of-Network Pharmacy Coverage	Not Covered
Do Prescription Drug Costs count to a Separate Rx OOP Max or count toward Medical OOP Max?: **COMBINED** Are scripts subject to Deductibles?: **NO**	

MEDICAL BENEFITS		
BENEFIT LEVELS	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Medical Plan Year Deductible **INDIVIDUAL DEDUCTIBLE INCLUDED IN FAMILY COVERAGE: YES**	Single Plan (Employee only): $2,000 Family Plan (Employee & family): $2,000 per person, up to $4,000 per family	Single Plan (Employee only): $6,000 Family Plan (Employee & family): $6,000 per person, up to $12,000 per family
Note: The Family Plan contains both an individual Deductible and a family Deductible. Once an individual family member satisfies the individual Deductible, claims will be paid for that individual. Otherwise, the entire family Deductible must be satisfied before claims will be paid for any family members. The family Deductible may be met by any combination of family members.		
Medical Plan Year Deductible Carryover	**NO**	
Deductible Credit:	For the Plan Year starting 3/1/2026, any Deductible expenses incurred during the period 1/1/2026 through 2/28/2026 shall be credited and used to satisfy the Deductible for the Plan Year starting 3/1/2026 and ending 2/28/2027.	
Reimbursement Percentage ("Coinsurance")	70% of the Contracted Rate (after Deductible; unless otherwise stated) until the Out-of-Pocket Maximums has been reached, then 100% thereafter for the balance of the Plan Year	50% of the Allowed Amount* (after Deductible; unless otherwise stated) until the Out-of-Pocket Maximums has been reached, then 100% thereafter for the balance of the Plan Year
Plan Year Deductible & Coinsurance Maximums (Including Plan Year Deductible and Coinsurance and Prescription Drug Co-payments and Coinsurance) **INDIVIDUAL OOPM INCLUDED IN FAMILY COVERAGE: YES**	Single Plan (Employee only): $5,000 Family Plan (Employee & family): $5,000 per person, up to $10,000 per family	Single Plan (Employee only): $14,000 Family Plan (Employee & family): $14,000 per person, up to $28,000 per family
Plan Year Out-of-Pocket Maximums (Including all applicable Co-payments, Plan Year Deductible and Coinsurance, including those for prescription drugs) **INDIVIDUAL OOPM INCLUDED IN FAMILY COVERAGE: YES**	Single Plan (Employee only): $7,900 Family Plan (Employee & family): $7,900 per person, up to $15,800 per family	Single Plan (Employee only): Unlimited Family Plan (Employee & family): Unlimited per person, up to Unlimited per family
Note: The Family Plan contains both an individual Out-of-Pocket Maximums and a family Out-of-Pocket Maximums. Once an individual family member satisfies the individual Out-of-Pocket Maximum, claims will be paid for that individual at 100%. Otherwise, once the entire family Out-of-Pocket Maximums is satisfied, claims will be paid at 100% for all covered family members. The family Out-of-Pocket Maximums may be met by any combination of family members.		

MEDICAL BENEFITS		
BENEFIT LEVELS	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Out-of-Pocket Maximum Credit:	For the Plan Year starting 3/1/2026, any Out-of-Pocket Maximum expenses incurred during the period 1/1/2026 through 2/28/2026 shall be credited and used to satisfy the Deductible for the Plan Year starting 3/1/2026 and ending 2/28/2027.	

**Emergency services rendered by Out-of-Network Providers for "Emergency Care" as defined in the section titled "Definitions"; air ambulance services rendered by Out-of-Network Providers of air ambulance services; and non-emergency services rendered by Out-of-Network Providers on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, provided the Covered Person has not validly waived the applicability of the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA), will be paid at the In-Network Provider Deductible, Co-payment and Coinsurance levels, subject to the Qualifying Payment Amount.

When emergency services are rendered by an Out-of-Network Provider for Emergency Care, or air ambulance services are rendered by an Out-of-Network Provider of air ambulance services, the Out-of-Network Provider cannot balance bill the Covered Person. When non-emergency services are rendered by an Out-of-Network Provider on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, the Out-of-Network Provider cannot balance bill the Covered Person unless the Covered Person gives written consent and gives up their protections in accordance with the NSA. If a Covered Person waives their protections and agrees to balance billing per the NSA, Out-of-Network Providers will be paid according to the Plan's In-Network level of benefits, subject to the Allowed Amount.

When services are rendered by an Out-of-Network Provider in any instance other than the reasons listed above, Covered Persons may be responsible for any amount above the Allowed Amount when services are rendered by an Out-of-Network Provider.

The In-Network Provider and Out-of-Network Provider Deductible and Out-of-Pocket Maximums are separate and do not accumulate. Eligible expenses which track toward the In-Network Provider Deductible and Out-of-Pocket Maximums will not be credited toward the satisfaction of the Out-of-Network Deductible and Out-of-Pocket Maximums and vice versa.

In addition, Covered Services that contain dollar, frequency or visit limits are combined In-Network and Out-of-Network maximums.

In/Out-of-Network Deductibles are: SEPARATE
In/Out-of-Network Out-of-Pocket Maximums are: SEPARATE

The following expenses are excluded from the Out-of-Pocket Maximum:

- Precertification penalties

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010 (PPACA). The majority of the PPACA preventive care services recommendations are issued by the U.S. Preventive Service Task Force (USPSTF). These may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided, or a complete listing can be found here. New or updated A and B Recommendations generally go into effect on the first Plan Year one year after issuance of the revised recommendation.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
****Routine Physical Exams** (Including routine immunizations and flu shots)	100% (Deductible waived)	NOT COVERED
****Routine Well Child Care** (Including screenings, routine immunizations and flu shots)	100% (Deductible waived)	NOT COVERED
****Fluoride Varnish** (Up to age 6) Up to four (4) varnish treatments per person, per Plan Year	100% (Deductible waived)	NOT COVERED
****Breastfeeding Support, Supplies and Counseling** (During pregnancy and/or in the postpartum period and rental or purchase of breastfeeding equipment) Breast Pump Limits: • Hospital Grade Breast Pumps: rental covered up to 3 months; *precertification required* for rental in excess of 3 months • Electric Breast Pumps: rent or purchase, whichever is less; • Manual Breast Pumps: purchase	100% (Deductible waived)	NOT COVERED
**** Contraceptive Services and Supplies for Women** (FDA approved only; includes education and counseling)	100% (Deductible waived)	NOT COVERED

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
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Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
****Routine Gynecological/ Obstetrical Care** (Including preconception and prenatal services)	100% (Deductible waived)	NOT COVERED
****Routine Pap Smears**	100% (Deductible waived)	NOT COVERED
**** Breast Cancer Screening including Routine Mammograms and BRCA testing**	100% (Deductible waived)	NOT COVERED
****Routine Immunizations** (If not billed with an office visit; includes flu shots)	100% (Deductible waived)	NOT COVERED
****Routine Lab, X-rays, and Clinical Tests** (Including those related to maternity care)	100% (Deductible waived)	NOT COVERED
****Routine Colorectal Cancer Screening, including sigmoidoscopies and colonoscopies** (As recommended by the US Preventive Service Task Force)	100% (Deductible waived)	NOT COVERED
****Lung Cancer Screening, including Low-Dose Computed Tomography (LDCT)** (As recommended by the US Preventive Service Task Force) Up to one (1) per person, per Plan Year	100% (Deductible waived)	NOT COVERED
****Nutritional Counseling**	100% (Deductible waived)	NOT COVERED
****Smoking Cessation Counseling and Intervention** (Including smoking cessation clinics and programs)	100% (Deductible waived)	NOT COVERED

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
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Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Routine Hearing Exams	NOT COVERED	NOT COVERED
Routine Prostate Exams and Prostate-Specific Antigen (PSA) Screenings Up to one (1) exam per person per Plan Year	100% (Deductible waived)	NOT COVERED
****Abdominal Aortic Aneurysm Screening** (As recommended by the US Preventive Service Task Force) Up to one (1) per person, per lifetime	100% (Deductible waived)	NOT COVERED
****Bone Density Screening** • Women (as recommended by the US Preventive Service Task Force for Osteoporosis Screening) • All other Covered Persons	100% (Deductible waived) 100% (Deductible waived)	NOT COVERED NOT COVERED

VISION CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Routine Vision Exam	NOT COVERED	NOT COVERED
Routine Eyewear (Lenses, frames, and contact lenses)	NOT COVERED	NOT COVERED
Eyewear for Special Conditions (Initial purchase of non-routine eyewear following surgery; contact lenses needed to treat keratoconus (including the fitting of these contact lenses); intraocular lenses implanted after corneal transplant, cataract surgery or other covered eye surgery when the natural eye lens is replaced)	70% (after Deductible)	50% Allowed Amount (after Deductible)

PHYSICIAN SERVICES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Allergy Testing	70% (after Deductible)	50% Allowed Amount (after Deductible)
Allergy Treatment	$25 Primary Care or $50 Specialist Co-Payment, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Anesthesia (Inpatient/Outpatient)	70% (after Deductible)	50% Allowed Amount (after Deductible)
Chiropractic Services (Charges for lab and x-ray are paid based on services provided and are not subject to any office visit or dollar limits) Up to $1,000 per person per Plan Year	$50 Co-Payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Maternity –Employee & Spouse only • Prenatal care • Physician delivery charges (Including home births) • Postnatal care (Includes home visit with a Visiting Nurse following early discharge)	100% (Deductible waived) 70% (after Deductible) 70% (after Deductible)	50% Allowed Amount (after Deductible)
Physician Hospital Visits	70% (after Deductible)	50% Allowed Amount (after Deductible)
Physician Office Visits – Primary Care (Includes all related charges billed at time of visit)	$25 Co-Payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Physician Office Visits - Specialist (Includes all related charges billed at time of visit)	$50 Co-Payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)

PHYSICIAN SERVICES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Second Surgical Opinion	$50 Co-Payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Surgery (Inpatient)	70% (after Deductible)	50% Allowed Amount (after Deductible)
Surgery (Outpatient)	70% (after Deductible)	50% Allowed Amount (after Deductible)
Surgery (Physician's office)	$25 Primary Care or $50 Specialist Co-Payment, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)

HOSPITAL SERVICES – INPATIENT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan. **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Hospital Room & Board *(Precertification required)* Semi-private room or special care unit	70% (after Deductible)	50% Allowed Amount (after Deductible)
Maternity Services— Employee & Spouse only *(Precertification required for stays in excess of 48 hours[vaginal]; 96 hours [cesarean])* Semi-private room or special care unit	70% (after Deductible)	50% Allowed Amount (after Deductible)
Birthing Center— Employee & Spouse only	70% (after Deductible)	50% Allowed Amount (after Deductible)
Newborn Care (Includes Physician visits & circumcision) Semi-private room or special care unit	70% (after Deductible)	50% Allowed Amount (after Deductible)
Organ, Bone Marrow and Stem Cell Transplants *(Precertification required;* Managed through Cigna's LifeSOURCE Transplant Network®*; see* Medical Benefits *section for other limitations*) Semi-private room or special care unit Excludes transportation/food/lodging expenses	70% (after Deductible)	50% Allowed Amount (after Deductible)
Surgical Facility & Supplies	70% (after Deductible)	50% Allowed Amount (after Deductible)
Miscellaneous Hospital Charges	70% (after Deductible)	50% Allowed Amount (after Deductible)

HOSPITAL SERVICES – OUTPATIENT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency services rendered for "Emergency Care" as defined in the section titled "Definitions"; and Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Clinic Services (At a Hospital)	70% (after Deductible)	50% Allowed Amount (after Deductible)
Emergency Room Expenses (Includes Facility, Lab, X-ray & Physician services) Co-payment is waived if admitted on an inpatient basis to a Hospital.	$500 Co-Payment per visit, then 100% (Deductible waived)	$500 Co-Payment per visit, then 100% (Deductible waived)
Outpatient Department	70% (after Deductible)	50% Allowed Amount (after Deductible)
Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc.	70% (after Deductible)	50% Allowed Amount (after Deductible)
Preadmission Testing	70% (after Deductible)	50% Allowed Amount (after Deductible)
Urgent Care Facility/Walk-In Clinic	$50 Co-Payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)

MENTAL HEALTH/ SUBSTANCE USE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan. **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Inpatient Hospitalization *(Precertification required)*	70% (after Deductible)	50% Allowed Amount (after Deductible)
Partial Hospitalization/Intensive Outpatient Treatment	100% (Deductible waived)	50% Allowed Amount (after Deductible)
Inpatient Physician Visit	70% (after Deductible)	50% Allowed Amount (after Deductible)
Hospital Clinic Visit	70% (after Deductible)	50% Allowed Amount (after Deductible)
Office Visit	$25 Co-Payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Methadone Maintenance/ Treatment	NOT COVERED	NOT COVERED

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for air ambulance services rendered by an Out-of-Network Provider of air ambulance services; and Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Acupuncture	NOT COVERED	NOT COVERED
Alternative/Complementary Care Benefit (Chelation Therapy, Homeopathic treatment, Hypnosis/Hypnotherapy, Rolfing/Reiki)	NOT COVERED	NOT COVERED
Ambulance Services (*See* Medical Benefits *section for limitations*)	70% (after Deductible)	50% Allowed Amount (after Deductible)
Autism Spectrum Disorders Treatment (Includes Applied Behavioral Analysis (ABA); any benefit limits under the Plan for occupational, physical and speech therapies do not apply; *precertification is required* for ABA; s*ee* Medical Benefits *section for limitations*) Note: Screenings are covered under Preventive Care	Benefits are based on services provided	NOT COVERED
Bariatric Surgery	NOT COVERED	NOT COVERED
Biofeedback Therapy	NOT COVERED	NOT COVERED
Cardiac Rehabilitation (Phase 1 and 2 only (Phase 3 is excluded); *see* Medical Benefits *section for other limitations*)	70% (after Deductible)	50% Allowed Amount (after Deductible)

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Chemotherapy & Radiation Therapy	70% (after Deductible)	50% Allowed Amount (after Deductible)
Clinical Trials – Routine Services during Approved Clinical Trials (Limited to routine Covered Services under the Plan, including Hospital visits, laboratory, and imaging services; *see* Medical *Benefits section for other limitations*)	Benefits are based on services provided	Benefits are based on services provided
Cochlear Implants	70% (after Deductible)	50% Allowed Amount (after Deductible)
Dental/Oral Services (Excludes excision of impacted wisdom teeth; *see* Medical Benefits *section for other limitations*)	70% (after Deductible)	50% Allowed Amount (after Deductible)
Diabetes Self-Management Training and Education	$25 Co-Payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Diagnostic Imaging (MRI, CT Scan, PET Scan)	70% (after Deductible)	50% Allowed Amount (after Deductible)

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
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Diagnostic X-ray and Laboratory (Outpatient)	**Independent Facilities:** 100% (Deductible waived) **All Other Facilities:** 70% (after Deductible)	50% Allowed Amount (after Deductible)
Dialysis/Hemodialysis *(See* Medical Benefits *section for other limitations)*	70% (after Deductible)	50% Allowed Amount (after Deductible)
Durable Medical Equipment *(See* Medical Benefits *section for other limitations)*	70% (after Deductible)	NOT COVERED
Early Intervention Services (*See* Medical Benefits *section for limitations*) (Up to age 3)	70% (after Deductible)	50% Allowed Amount (after Deductible)
Erectile Dysfunction Treatment	NOT COVERED	NOT COVERED
Family Planning (Including but not limited to consultations and diagnostic tests) **For Women** (See also Prescription Drug Benefit and Preventive Care Section) **For Men**	 100% (Deductible waived) 100% (Deductible waived)	 50% Allowed Amount (after Deductible) 50% Allowed Amount (after Deductible)
Gender Dysphoria Treatment and Related Services	NOT COVERED	NOT COVERED

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
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Gene Therapy (*Precertification required* for inpatient hospitalization)	70% (after Deductible)	50% Allowed Amount (after Deductible)
Genetic Counseling, Testing and Related Services (Note: Coverage is provided for BRCA Testing – See Breast Cancer Screening in Preventive Care Services; precertification is not required)	NOT COVERED	NOT COVERED
Growth Hormones *(See* Medical Benefits *section for other limitations)*	70% (after Deductible)	50% Allowed Amount (after Deductible)
Hearing Aids	NOT COVERED	NOT COVERED
Home Health Care (*See* Medical Benefits *section for other limitations*) Up to 60 visits per person per Plan Year	70% (after Deductible)	50% Allowed Amount (after Deductible)

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
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Hospice Care (Inpatient/Outpatient) *(Precertification required for inpatient services; see* Medical Benefits *section for other limitations)*	70% (after Deductible)	50% Allowed Amount (after Deductible)
Infertility Treatment	NOT COVERED	NOT COVERED
Injectables	70% (after Deductible)	50% Allowed Amount (after Deductible)
Learning Deficiencies, Behavioral Problems/Developmental Delays *(Precertification and visit limits are based on services provided)*	70% (after Deductible)	50% Allowed Amount (after Deductible)
Marital Counseling	NOT COVERED	NOT COVERED
Massage Therapy	NOT COVERED	NOT COVERED
Medical and Enteral Formula	NOT COVERED	NOT COVERED
Modified Low Protein Food Products	NOT COVERED	NOT COVERED
Neuromuscular Stimulator Equipment including TENS	NOT COVERED	NOT COVERED
Occupational Therapy (For treatment due to Illness or Injury; *see* Medical Benefits *section for other limitations)* Up to 30 visits per person, per Plan Year, combined with Physical Therapy	70% (after Deductible)	50% Allowed Amount (after Deductible)
Oral Pharynx Procedures	70% (after Deductible)	50% Allowed Amount (after Deductible)

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Orthotics (Includes foot orthotics; s*ee* Medical Benefits *section for other limitations*)	70% (after Deductible)	NOT COVERED
Physical Therapy (For treatment due to Illness or Injury; *see* Medical Benefits *section for other limitation*) Up to 30 visits per person, per Plan Year, combined with Occupational Therapy	70% (after Deductible)	50% Allowed Amount (after Deductible)
Podiatry Care *(See* Medical Benefits *section for limitations*)	$50 Co-Payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Private Duty Nursing	NOT COVERED	NOT COVERED
Prosthetics *(See* Medical Benefits *section for limitations*)	70% (after Deductible)	NOT COVERED
Rehabilitation Hospital *(Precertification required*; s*ee* Medical Benefits *section for other limitations*)	70% (after Deductible)	50% Allowed Amount (after Deductible)
Respiratory Therapy	70% (after Deductible)	50% Allowed Amount (after Deductible)
Sleep Studies	**Independent Facilities:** 100% (Deductible waived) **All Other Facilities:** 70% (after Deductible)	50% Allowed Amount (after Deductible)
Skilled Nursing Facility/Extended Care Facility *(Precertification required; see* Medical Benefits *section for other limitations*) Up to 60 days per person, per Plan Year	70% (after Deductible)	50% Allowed Amount (after Deductible)

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Speech Therapy (For treatment due to Illness or Injury; s*ee* Medical Benefits *section for other limitations)* Up to 20 visits per person, per Plan Year,	70% (after Deductible)	50% Allowed Amount (after Deductible)
Telemedicine (Applies to medical and behavioral health services; *see* Medical Benefits *section for additional information*) **INCLUDES DOCTOR ON DEMAND**	$25 Co-Payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Temporomandibular Joint Disorders (TMJ) Treatment	NOT COVERED	NOT COVERED
Termination of Pregnancy (Covered only in circumstances in which the life of the mother would be endangered by continuing the pregnancy to term, as documented by the treating Physician)	70% (after Deductible)	50% Allowed Amount (after Deductible)
Travel Immunizations	NOT COVERED	NOT COVERED
Voluntary Sterilization **For Women** **For Men**	 100% (Deductible waived) 100% (Deductible waived)	 NOT COVERED NOT COVERED
Wigs	NOT COVERED	NOT COVERED

WELLNESS BENEFITS	ALL PROVIDERS
Childbirth Classes	NOT COVERED
Fitness Reimbursement Benefit	NOT COVERED
Weight Loss Reimbursement Benefit	NOT COVERED

This Internal Schedule is not a complete listing of all Plan benefits and exclusions. Please refer to the Medical Benefits Section and the Medical Limitations and Exclusions Section in the Plan Document/Summary Plan Description for a complete list of benefit and non-benefit type exclusions.

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