MEDICAL SCHEDULE OF BENEFITS

PPO PLAN

Benefit Period: January 1 – December 31

MEDICAL BENEFITS-PPO PLAN	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Deductible per benefit period		
Individual	$500	$500
Family (embedded)	$1,000	$1,000
Deductible does share between in-network and out-of-network.		
Generally, each ***covered person*** must pay all of the costs from providers up to the deductible amount before the ***Plan*** begins to pay. **Embedded family deductible**: Any number of covered family members may help to satisfy the family deductible, but no family member will incur more than the individual deductible embedded deductible amount.		
Out-of-Pocket Expense Limit per benefit period (includes deductible, ***coinsurance***, ***copays***, and prescription drug cost-share)		
Individual	$3,500	$6,500
Family (embedded)	$7,000	$13,000
Out-of-pocket expense limit does not share between in-network and out-of-network.		
The out-of-pocket expense limit is the most the ***covered person*** could pay in a year for ***covered expenses***. The ***Plan*** will pay the designated percentage of ***covered expenses*** until the out-of-pocket expense limits are reached, at which time the ***Plan*** will pay 100% of the remainder of ***covered expenses*** for the rest of the benefit period unless stated otherwise. **Embedded family out-of-pocket expense limit:** Any number of covered family members may help to satisfy the family out-of-pocket expense limit, but no family member will incur more than the individual embedded out-of-pocket expense limit. The following charges do not apply to the out-of-pocket expense limit and are never paid at 100%: • expenses not covered by the ***Plan*** • expenses in excess of amounts covered by the ***Plan*** • expenses in excess of ***customary and reasonable amount***, unless otherwise noted		
Standard *coinsurance* paid by the *Plan*	80%	60%

MEDICAL BENEFITS-PPO PLAN	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Acupuncture	\$25 ***copay*** deductible waived	\$25 ***copay*** deductible waived
	Maximum: Chiropractic, Massage Therapy and Acupuncture Care limited to \$5,000 per benefit period. ***Out-of-network providers'*** services are not subject to ***Customary and Reasonable Amount*** limitation.	
Allergy Services Allergy testing, injections and serum	80% after deductible	60% after deductible
Ambulance Land Air	\$200 ***copay*** deductible waived \$200 ***copay*** deductible waived	***In-network provider*** benefit applies ***In-network provider*** benefit applies
Applied Behavior Analysis Therapy (ABA)	\$25 ***copay*** deductible waived	60% after deductible
Biofeedback Therapy *(for the treatment of tension or migraine headaches)*	\$25 ***copay*** deductible waived	60% after deductible
	Maximum: Lifetime maxium of 12 visits.	
Birthing Center	80% after deductible	60% after deductible
Blood *(Blood storage and transfusions)*	80% after deductible	60% after deductible
Cardiac Rehabilitation ***Facility*** ***Physician***	 80% after deductible 80% after deductible	 60% after deductible 60% after deductible
Chemotherapy ***Facility*** ***Physician***	 80% after deductible 80% after deductible	 60% after deductible 60% after deductible
Chiropractic Care Office visits, spinal manipulation, adjustments **Diagnostic X-Ray and Lab** *(is not included in the \$5,000 benefit period maximum)*	\$25 ***copay*** deductible waived 80% deductible waived	\$25 ***copay*** deductible waived 80% deductible waived
	Maximum: Chiropractic, Massage Therapy and Acupuncture Care limited to \$5,000 per benefit period. ***Out-of-network providers'*** services are not subject to Reasonable and Customary Fee limitation.	
Colonoscopies *(regardless of diagnosis)*	100% deductible waived	60% after deductible
Contraceptives	See Women's Preventive Services	

MEDICAL BENEFITS-PPO PLAN	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Diagnostic Services – Major *(such as MRI, CT Scan, PET Scan)*		
Hospital	80% after deductible	60% after deductible
Freestanding Facility	80% deductible waived	60% after deductible
Mammograms *(including 3D mammograms), regardless of diagnosis*	100% deductible waived	60% after deductible
Diagnostic Services – Minor (Outpatient)		
Laboratory and X-ray services	80% deductible waived	60% after deductible
Other diagnostic services *(limited to electrocardiogram, duplex scans, and stress tests).*	80% deductible waived	60% after deductible
Dialysis Therapy or Treatment		
First 90 days	80% after deductible	60% after deductible
Days 91-365	100% deductible waived	100% deductible waived
Durable Medical Equipment	80% after deductible	60% after deductible
Emergency Services – (for an ***emergency***)		
Facility (***copay*** waived if admitted)	$200 ***copay*** deductible waived	***In-network provider*** benefit applies
Physician	80% after deductible	***In-network provider*** benefit applies
Emergency Services – (not for an ***emergency***)		
Facility	$200 ***copay*** deductible waived	***In-network provider*** benefit applies
Physician	80% after deductible	***In-network provider*** benefit applies
Extended Care Facility	80% after deductible	60% after deductible
	Maximum: Limited to 60 days per benefit period	
Fertility Services		
Office Visit	$25 ***copay*** deductible waived	$25 ***copay*** deductible waived
Initial diagnostic testing to determine infertility	100% after deductible	100% after deductible
Fertility treatments	Not Covered	Not Covered
	Maximum: Limited to $15,000 maximum per benefit period. ***Out-of-network providers'*** services are not subject to ***Customary and Reasonable Amount*** limitation. **Note:** LAIKA, LLC also provides an inclusive family forming and fertility benefit through CARROT, https://www.get-carrot.com.	

MEDICAL BENEFITS-PPO PLAN	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Gender Reaffirming Care	80% after deductible	80% after deductible
	Out-of-network providers' services are not subject to ***Customary and Reasonable Amount*** limitation.	
Hearing		
Routine Exam	80% deductible waived	80% after deductible
Hearing Aids	80% after deductible	80% after deductible
	Maximum: Limited to 1 hearing exam per 48 months. Hearing aids limited to $5,000 maximum every 48 months for person under age 26 and limited to a $5,000 lifetime maximum for person age 26 and over.	
Home Health Care		
Home health care visits	80% after deductible	60% after deductible
Home health care supplies & services	80% after deductible	60% after deductible
IV therapy	80% after deductible	60% after deductible
	Maximum: Limited to 140 visits per benefit period	
Hospice Care	80% after deductible	60% after deductible
	Maximum: Inpatient is limited to 12 days per lifetime, and respite care is limited to 170 hours maximum per 3 month period.	
Hospital – Inpatient		
Facility	80% after deductible	60% after deductible
Physician/Surgeon	80% after deductible	60% after deductible
Anesthesia, Radiology, Pathology, Lab	80% after deductible	60% after deductible
Hospital – Outpatient & Ambulatory Surgical Facility		
Facility	80% after deductible	60% after deductible
Physician/Surgeon	80% after deductible	60% after deductible
Radiology, Pathology, Lab	80% deductible waived	60% after deductible
Anesthesia	80% after deductible	60% after deductible
Infusion Therapy		
Facility	80% after deductible	60% after deductible
Physician	80% after deductible	60% after deductible
Injectables *(See Allergy Services for allergy shots)*		
Office	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Inpatient Rehabilitation	80% after deductible	60% after deductible
	Maximum: Limited to 60 days per benefit period.	

MEDICAL BENEFITS-PPO PLAN	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Massage Therapy	$25 ***copay*** deductible waived	$25 ***copay*** deductible waived
Diagnostic X-Ray and Lab *(is not included in the $5,000 benefit period maximum)*	80% deductible waived	80% deductible waived
	Maximum: Chiropractic, Massage Therapy and Acupuncture Care limited to $5,000 per benefit period. ***Out-of-network providers'*** services are not subject to Reasonable and Customary Fee limitation.	
Naturopathic Services	$25 ***copay*** deductible waived	$25 ***copay*** deductible waived
Diagnostic x-rays and lab	80% deductible waived	80% deductible waived
Vitamins and Minerals (oral, injectable and transdermal) – included in the $5,000 maximum for Chiropractic, Massage Therapy and Acupuncture Care)	80% deductible waived	80% deductible waived
Chinese Herbs and remedies – (included in the $5,000 maximum for Chiropractic, Massage Therapy and Acupuncture Care)	100% deductible waived	100% deductible waived
Other Office Supplies	80% deductible waived	80% deductible waived
	Out-of-network providers' services are not subject to Reasonable and Customary Fee limitation.	

MEDICAL BENEFITS-PPO PLAN	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Office Visit & Other Services (one ***copay*** per provider per date of service)		
Office visit		
Primary care physician	$25 ***copay*** deductible waived	60% after deductible
Specialist *(no referral required)*	$25 ***copay*** deductible waived	60% after deductible
Telemedicine services with a ***primary care physician***	$25 ***copay*** deductible waived	60% after deductible
Telemedicine services with a specialist	$25 ***copay*** deductible waived	60% after deductible
Note: LAIKA, LLC also provides telemedicine services through Telehealth provider First Stop Health, https://www.fshealth.com/.		
Surgery		
Primary care physician	80% after deductible	60% after deductible
Specialist	80% after deductible	60% after deductible
X-ray and Lab	80% deductible waived	60% after deductible
Minor Diagnostics		
Primary care physician	80% deductible waived	60% after deductible
Specialist	80% deductible waived	60% after deductible
Other Services	80% after deductible	60% after deductible
Mental Health & Substance Abuse		
Office Visits	100% deductible waived	$25 ***copay*** deductible waived ***Out-of-network providers'*** services are not subject to ***Customary and Reasonable Amount*** limitation.
Diagnostic Services	80% deductible waived	80% deductible waived ***Out-of-network providers'*** services are not subject to ***Customary and Reasonable Amount*** limitation.
Hospital – Inpatient	80% after deductible	80% deductible waived ***Out-of-network providers'*** services are not subject to ***Customary and Reasonable Amount*** limitation.
Orthotics	80% after deductible	60% after deductible

MEDICAL BENEFITS-PPO PLAN	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Podiatry Services	Based on service provided	Based on service provided
Pregnancy		
Initial pre-natal visit and urinalysis	100% deductible waived	60% after deductible
Subsequent pre-natal visits/care and breastfeeding services and supplies (as required by the ***Affordable Care Act***)	100% deductible waived	60% after deductible
	Breast Pumps purchased at a retail locations are subject to In-Network rate, meaning members will be reimbursed at 100% of the purchase price.	
Global Maternity Fee	80% after deductible	60% after deductible
Post-natal care and other non-routine/non-preventive pregnancy related care.	Based on service provided	Based on service provided
Delivery	80% after deductible	60% after deductible
Private Duty Nursing		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
	Covered only when ***medically necessary*** and the ***Hospital*** Intensive Care Unit (ICU) is filled or when there is no ICU.	
Prostheses	80% after deductible	60% after deductible
Radiation Therapy		
Facility	80% after deductible	60% after deductible
Physician	80% after deductible	60% after deductible
Respiratory Therapy		
Facility	80% after deductible	60% after deductible
Physician	80% after deductible	60% after deductible
Retail Clinic Visits	$25 ***copay*** deductible waived	60% after deductible
Routine Preventive Care/Wellness Benefits Includes all evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF). For additional information visit: http://www.uspreventiveservicestaskforce.org	100% deductible waived	60% after deductible
Routine Prostate Examinations	100% deductible waived	60% after deductible
Second Surgical Opinion	Based on service provided	Based on service provided

MEDICAL BENEFITS-PPO PLAN	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Temporomandibular Joint Syndrome (TMJ) Treatment *(includes intraoral orthotics, prosthetics and therapy)* Orthodontia services not covered	Based on service provided	Based on service provided
	Maximum Benefit: Limited to $3,000 lifetime maximum.	
Therapy Services *(physical, speech and occupational)*		
Facility	$25 ***copay*** deductible waived	60% after deductible
Physician	$25 ***copay*** deductible waived	60% after deductible
	Maximum: Limited to 60 visits combined per benefit period.	
Transplants (Organ or Tissue)		
Participation in the INTERLINK TransplantELITE Program	100% deductible waived	100% deductible waived
Travel Expenses	100% deductible waived	100% deductible waived
Non - Participation in the INTERLINK TransplantELITE Program	Based on service provided	Based on service provided
	Maximum: Transportation $10,000 maximum per transplant. $10,000 maximum per transplant for a donor who is not a covered person and the transplant is performed at a non – network provider.	
Oncology Services (CancerCare) *(See CancerCare Program section for additional details)*		
Participation in the CancerCare Program through INTERLINK	100% deductible waived	100% deductible waived
Travel and Lodging Expenses	100% deductible waived	100% deductible waived
Non-Participation in the CancerCare Program through Interlink	Based on service provided	Based on service provided
	Maximum: Travel and Lodging expenses limited to $10,000 lifetime maximum	
Urgent Care Center		
Visit	$25 ***copay*** deductible waived	60% after deductible
All other services	80% after deductible	60% after deductible
X-ray and Lab services	80% deductible waived	60% after deductible

MEDICAL BENEFITS-PPO PLAN	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Weight Loss Services		
Surgical treatment	Not Covered	Not Covered
Non-surgical treatment and programs	Based on service provided	Based on service provided
Wigs *(Required due to chemotherapy)*	80% after deductible	60% after deductible
	Maximum: One wig while covered by the ***Plan.***	
Women's Preventive Services As required by the ***Affordable Care Act***	100% deductible waived	60% after deductible
All Other C*overed Expenses*	80% after deductible	60% after deductible

VISION BENEFITS	PPO & THE PARTNER CLINIC PLAN
Vision Examination	
Covered Person age 19 or older	$15 ***copay*** deductible waived
Covered Person up to age 19	100% deductible waived
Materials	
Covered Person age 19 or older combined lenses, frames and contact lenses	100% deductible waived limited to $200 every two calendar years
Covered Person up to age 19	
Lenses – limited to 1 pair per benefit period. **Frames** – limited to 1 frame per benefit period. **Contacts** (in lieu of lenses and frames) – limited to a 12 month supply per benefit period.	100% deductible waived
	Maximum: Vision exam limited to 1 exam per benefit period
LASIK Eye Care	100% up to a Lifetime Maximum payment of $1,000