

Effective Date 1/1/2027	Health Plan Core HMO	Ref QR-116851
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This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	Inside Network
Plan deductible	Individual deductible: \$3,500 per calendar year Family deductible: \$7,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply
Plan coinsurance	No plan coinsurance
Out-of-pocket limit	Individual out-of-pocket limit: \$3,500 Family out-of-pocket limit: \$7,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) waiting period	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	No copay, deductible applies
Hospital services	Inpatient services: Deductible applies Outpatient surgery: No copay, deductible applies
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Generic/Brand/Non-Preferred/Specialty Deductible applies
Prescription mail order	2x prescription cost share per 90 day supply
Acupuncture	Covered up to 20 visits per calendar year No copay, deductible applies
Ambulance services	Deductible applies
Chemical dependency	Inpatient: Deductible applies Outpatient: No copay, deductible applies
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras • Ostomy supplies • Prosthetic devices	Deductible applies, includes Orthotics
Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic lab and X-ray services	Inpatient: Covered under Hospital services Outpatient: Deductible applies High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	\$0 copay Deductible applies
Hearing exams (routine)	No copay, deductible applies
Hearing hardware	1 aid per ear every 36 months; Deductible applies

Home health services	Covered up to 130 visits total per calendar year; Deductible applies
Hospice services	Deductible applies
Infertility services	Specific diagnostic services, medical and surgical treatment, artificial insemination and drug therapy. Deductible applies
Manipulative therapy	Covered up to 20 visits per calendar year without prior authorization No copay, deductible applies
Massage services	See Rehabilitation services
Maternity services	Inpatient: Deductible applies Outpatient: No copay, deductible applies
Mental Health	Inpatient: Deductible applies Outpatient: No copay, deductible applies
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan No copay, deductible applies
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Covered at cost shares when medical criteria is met
Organ transplants	Unlimited, no waiting period Inpatient: Deductible applies Outpatient: No copay, deductible applies
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women's contraception is covered as preventive, and Men's contraception is covered in full after annual deductible has been satisfied
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	Inpatient: No limit. Services with mental health diagnoses are covered with no limit. Deductible applies Outpatient: 90 visits per calendar year. Services with mental health diagnoses are covered with no limit. No copay, deductible applies
Skilled nursing facility	Up to 100 days per calendar year, deductible applies
Sterilization (vasectomy, tubal ligation)	Women's sterilization is covered as preventive, and Men's sterilization is covered in full after the annual deductible has been satisfied.
Temporomandibular Joint (TMJ) services	Inpatient: Deductible applies Outpatient: No copay, deductible applies
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	No copay, deductible applies
Optical hardware Lenses, including contact lenses and frames	Not covered
Virtual Care Including Telemedicine, Telephone Services and Online (E-Visits)	Deductible applies