PRO PLAN BENEFIT SPECIFICATION

Plan Features	Network Care	Out-Of-Network Care
Primary Care Physician Selection	Not required	Not applicable
Deductible (per plan year)	$0 Individual $0 Family	Not applicable
Member Coinsurance (applies to all expenses unless otherwise stated)	0%	Not applicable
Medical Out-of-Pocket (OOP) Maximum (per plan year, includes deductible)	$400 Individual $800 Family	Not applicable
Pharmacy Out-of-Pocket (OOP) Maximum	$5,000 Individual $10,000 Family	Not applicable
All covered expenses accumulate separately toward the network and out-of-network OOP limit. Pharmacy co-payment expenses apply towards the OOP limit. Only those OOP expenses resulting from the application of coinsurance percentage, deductibles, and co-pays may be used to satisfy the OOP maximum.Once the family payment limit is met, all family members will be considered as having met their payment limit for the remainder of the plan year.		
Payment for Out-of-Network Care	Not applicable	Not applicable
Referral Requirement	Not required	Not applicable
Physician Services	**Network Care**	**Out-Of-Network Care**
Virtual Urgent Care Powered by HealthWallet	Included	Not applicable
Office Visits to Non-Specialist Limit of 8 utilizations** combined with non-specialists, specialists, and urgent care.	$25 co-payment	Not applicable
Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury.		
Specialist Office Visits Limit of 8 utilizations** combined with non-specialists, specialists, and urgent care	$35 co-payment	Not applicable
Prenatal Maternity and Post-Partum Care (office visit)	Not covered	Not applicable
Maternity - Delivery	Not covered	Not applicable
Preventive Care	**Network Care**	**Out-Of-Network Care**
Preventive care services are covered in accordance with Health Care Reform. Services subject to change as guidelines are revised.		
Routine Adult Physical Exams and Immunizations Includes routine tests and related lab fees. Limited to 1 exam every 12 months.	Included	Not applicable
Well Child Exams and Immunizations Limited to 1 exam every 12 months. Immunizations will be subject to age and developmentally appropriate frequency limitations determined by ACIP.	Included	Not applicable
Routine Gynecological Exams Includes routine tests and related lab fees. Limited to 1 exam every 12 months.	Included	Not applicable
Routine Mammograms For covered females age 40 and over. Limited to 1 exam every 12 months.Complex imaging not covered.	Included	Not applicable
Women's Health Includes: Screening for gestational diabetes, HPV, counseling for sexually transmitted infections, counseling and screening for HIV, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies, and counseling. Contraceptive methods, patient education and counseling. Limitations may apply.	Included	Not applicable
Colorectal Cancer Screening For all members age 45 and over. Limited to 1 exam every 12 months.	Included	Not applicable
Routine Eye Exams (Refraction) For covered children age 3 to 5. Coverage is limited to 1 exam every 12 months.	Included	Not applicable
Voluntary Sterilization - Tubal Ligation Covered as a preventive care service in accordance with Health Care Reform.	Included	Not applicable
COVID-19 Testing Swab only. Limited to 1 exam every 12 months.	Included	Not applicable