	eASE I	eASE II	eASE III
DEDUCTIBLE (Individual | Family) **OUT OF POCKET MAXIMUM** (Individual | Family)	$0 | $0 $8,550 | $17,100	$0 | $0 $8,550 | $17,100	$0 | $0 $8,550 | $17,100
PREVENTIVE & WELLNESS SERVICES	$0 Copay (Plan pays 100% of covered preventive and wellness services)	$0 Copay (Plan pays 100% of covered preventive and wellness services)	$0 Copay (Plan pays 100% of covered preventive and wellness services)
TELEMEDICINE SERVICES	$0 Copay	$0 Copay	$0 Copay
PRIMARY CARE OFFICE VISIT	$10 Copay	$10 Copay	$10 Copay
SPECIALIST OFFICE VISIT	Not Covered	$75 Copay	$50 Copay (Limited to 8 visits per plan year)
LABORATORY SERVICE & RADIOLOGY	Not Covered	$50 Copay Per Panel Tested/ Per Image Billed	$50 Copay (Combined limit of 3 visits per plan year)
CT/MRI/MRA/PET SCAN	Not Covered	$500 Copay Per Image Billed	$350 Copay (Limited to 1 per plan year)
URGENT CARE	$25 Copay	$25 Copay	$25 Copay
OUTPATIENT HOSPITAL OR FREE-STANDING FACILITY SERVICES AND SURGERY	Not Covered	$75 Copay	$350 Copay (Limited to 1 visit per plan year)
INPATIENT HOSPITALIZATION & INPATIENT SURGERY	Not Covered	Not Covered	$350 Copay per admission (Limited to 5 days and 2 Surgeries per plan year)
EMERGENCY ROOM SERVICES	Not Covered	Not Covered	$350 Copay (Limited to 1 visit per plan year)
PHARMACY BENEFITS (Subject to Formulary)	Generic - $0 Copay (Limited to Preventive Generic drugs. Plan pays 100% of covered preventive drugs. In addition, a discount pharmacy program is provided that allows other drugs to be obtained at payments ranging from $0 to $50).	Generic - $0 Copay (Limited to Preventive Generic drugs. Plan pays 100% of covered preventive drugs. In addition, a discount pharmacy program is provided that allows other drugs to be obtained at payments ranging from $0 to $50).	Generic - $0 Copay (Limited to Preventive Generic drugs. Plan pays 100% of covered preventive drugs. In addition, a discount pharmacy program is provided that allows other drugs to be obtained at payments ranging from $0 to $50).
TREATMENT FOR CHEMICAL ABUSE & DEPENDENCY	Not Covered	Not Covered	Outpatient: $25 Copay per day Inpatient: $250 Copay per day (Both limited to 5 days per plan year)
HOME HEALTH CARE	Not Covered	Not Covered	$25 Copay (Limited to 10 visits per plan year)
SUPPLEMENTAL HOSPITAL BENEFIT	Not Covered	$5,000 Limited to $1,000 per day; maximum of 5 days of hospitalization or 4 days of hospitalization and 1 emergency room visit.	Not Covered

PLEASE NOTE:

Out of Network services, and services provided at a hospital, will not be covered, unless otherwise specified.

Refer to the Schedule of Benefits for a more in-depth list of Benefits Coverage, Limitations and Exclusions. If this document differs from the Schedule of Benefits the Schedule of Benefits will govern.