MEDICAL SCHEDULE OF BENEFITS

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE		
Single Family	$200 $600	
CALENDAR YEAR MEDICAL OUT-OF-POCKET MAXIMUM (includes medial Deductible, medical Copays and Coinsurance)	Providers and Participating Provider Facilities	Non-Participating Provider Facilities
Single Family	$1,200 $3,600	Unlimited Unlimited
TOTAL OVERALL CALENDAR YEAR MEDICAL AND PRESCRIPTION DRUG OUT-O-POCKET MAXIMUM (includes Deductible, Copays and Coinsurance-combined with Prescription Drug Card)	Providers and Participating Provider Facilities	Non-Participating Provider Facilities
Single Family	$2,100 $5,400	Unlimited Unlimited
MEDICAL BENEFITS		
Acupuncture	80% after Deductible	Paid at the Participating Provider level of benefits
Calendar Year Maximum Benefit	12 visits	
Allergy Services (all)	80% after Deductible	Paid at the Participating Provider level of benefits
Ambulance Services		
Ground Ambulance Services	80% after Deductible	Paid at the Participating Provider level of benefits
Air Ambulance Services Other Than Through Guardian Flight: Emergency Medical Condition	80% after Deductible	Paid at the Participating Provider level of benefits
Non-Emergency Medical Condition	80% after Deductible	40% after Deductible
Air Ambulance Services Provided Through Guardian Flight: Emergency Medical Condition	N/A	80% of the allowable amount identified below after Deductible
Non-Emergency Medical Condition	N/A	40% of the allowable amount identified below after Deductible
One way transport (fixed wing or rotary)		225% of Medicare/CMS Rural rate
Fixed wing air mileage per statue mile		600% of the Medicare/CMS Rural rate
Rotary wing air mileage, per statue mile		200% of the Medicare/CMS Rural rate

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Ambulatory Surgical Center	80% after Deductible	Constant 40% after Deductible
Chiropractic Care/Spinal Manipulation	80% after Deductible	Paid at the Participating Provider level of benefits
Calendar Year Maximum Benefit	24 visits	
Diabetic Education	100%; Deductible waived	100%; Deductible waived
Diagnostic Testing, X-Ray and Lab Services (Outpatient)		
X-Ray and Lab Services	80% after Deductible	Paid at the Participating Provider level of benefits
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy)	80% after Deductible	Constant 40% after Deductible
Emergency Services/Emergency Room Services	80% after Deductible	Paid at the Participating Provider level of benefits
Foot Orthotics	80% after Deductible	Paid at the Participating Provider level of benefits
Calendar Year Maximum Benefit	$300 (Maximum does not apply to diabetics)	
Hearing Examination, Hearing Aids and Related Supplies		
Hearing Examination	80%; Deductible waived	Paid at the Participating Provider level of benefits
Maximum Benefit	1 exam every 3 Calendar Years	
Hearing Aids and Related Supplies	80%; Deductible waived	Paid at the Participating Provider level of benefits
Maximum Benefit	$800 every 3 Calendar Years	
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Home Health Care	80% after Deductible	Paid at the Participating Provider level of benefits
Calendar Year Maximum Benefit	130 visits	
Hospice Care		
Inpatient	80% after Deductible	Constant 40% after Deductible
Calendar Year Maximum Benefit	10 days	
Outpatient	80% after Deductible	Paid at the Participating Provider level of benefits
Respite Care	80% after Deductible	Paid at the Participating Provider level of benefits
Calendar Year Maximum Benefit	240 hours	
Overall Hospice Lifetime Maximum Benefit	6 months	

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	80% after Deductible	Constant 40% after Deductible
Room and Board Allowance*	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	80% after Deductible	Constant 40% after Deductible
Outpatient	80% after Deductible	Constant 40% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Maternity (Professional Fees)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	100%; Deductible waived
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	80% after Deductible	Paid at the Participating Provider level of benefits
* See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient		
Facility	80% after Deductible	Constant 40% after Deductible
Professional Fees	80% after Deductible	Paid at the Participating Provider level of benefits
Outpatient	80% after Deductible	Paid at the Participating Provider level of benefits
NOTE: Emergency care (ambulance and Emergency Services) will be paid the same as the benefits for ambulance services and Emergency Services listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Nutritional Therapy	100%; Deductible waived	100%; Deductible waived
Outpatient Therapies: Cardiac Rehab — Occupational Chronic Pain — Physical Massage — Pulmonary Neurodevelopmental — Speech	80% after Deductible	Paid at the Participating Provider level of benefits
Combined Calendar Year Maximum Benefit	45 visits	

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Physician's Services		
Inpatient/Outpatient Services	80% after Deductible	Paid at the Participating Provider level of benefits
Office Visits	80% after Deductible	Paid at the Participating Provider level of benefits
Physician Office Surgery	80% after Deductible	Paid at the Participating Provider level of benefits
Teladoc	100%; Deductible waived	N/A
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item received at the same time as the preventive service, whether billed at the same time or separately)	100%; Deductible waived	100%; Deductible waived
Routine Care (includes any routine care item or service not otherwise covered under the preventive service provision above)	100%; Deductible waived	100%; Deductible waived
Rehabilitation Facility	80% after Deductible	Constant 40% after Deductible
Calendar Year Maximum Benefit	30 days	
Skilled Nursing Facility	80% after Deductible	Constant 40% after Deductible
Surgical Procedures (BridgeHealth Surgery Benefit™)	100%; Deductible waived	N/A
NOTE: Certain Surgical Procedures are covered at 100% (Deductible waived) when they are received through the BridgeHealth Surgery Benefit option. Not all Surgical Procedures are eligible for coverage under this option. Please refer to the BridgeHealth Surgery Benefit section for a more detailed description of this benefit.		
Transplants	80% after Deductible (Aetna IOE Program)* Not Covered (All Other Network Providers)	Not Covered
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.		
Transportation (Air or Surface)	100%; Deductible waived (subject to additional limitations – see Eligible Medical Expenses for details)	
Calendar Year Maximum Benefit	limited to 3 coach fare round trips	
Urgent Care Facility	80% after Deductible	Paid at the Participating Provider level of benefits
All Other Eligible Medical Expenses	80% after Deductible	Paid at the Participating Provider level of benefits

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	BENEFIT
NOTE: The Covered Person will be reimbursed the amount that would have been paid to a Participating Provider less the applicable Copay if Prescription Drugs are obtained from a Non-Participating Provider.	
CALENDAR YEAR PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM (includes Prescription Drug Copays) Single Family	 $900 $1,800
TOTAL OVERALL CALENDAR YEAR MAJOR MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM (includes Deductible, Copays and Coinsurance- combined with major medical) Single Family	 $2,100 $5,400
Retail Pharmacy: 30-day supply	
Generic Drug	$10 Copay
Formulary Drug	$30 Copay
Non-Formulary Drug	$50 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Mail Order Pharmacy: 90-day supply	
Generic Drug	$20 Copay
Formulary Drug	$60 Copay
Non-Formulary Drug	$100 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)

Dispense as Written
The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Formulary or Non-Formulary Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Formulary or Non-Formulary Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Formulary or Non-Formulary Drug in addition to the Formulary or Non-Formulary Drug Copay. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

DENTAL SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	BENEFIT (Subject to Usual and Customary Charges)
PRE-DETERMINATION LIMIT	$450
CALENDAR YEAR DEDUCTIBLE Single Family	 $50 $100
CLASS A AND B EXPENSES COMBINED CALENDAR YEAR MAXIMUM BENEFIT	$3,000 per Covered Person Maximum does not apply to Class A-Preventive Services for Covered Persons up to age 19
CLASS C EXPENSES CALENDAR YEAR MAXIMUM BENEFIT	$2,000 per Covered Person
CLASS D ORTHODONTIC LIFETIME MAXIMUM BENEFIT	$1,000 per Covered Person
DENTAL BENEFITS	
Class A-Preventive Services	100%; Deductible waived
Class B-Basic Services	80% after Deductible
Class C-Major Services	80% after Deductible
Class D-Orthodontic Services	100%; Deductible waived

VISION SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	BENEFIT
Routine Eye Exam	100%
Calendar Year Maximum Benefit	1 exam
Vision Hardware	100%
Calendar Year Maximum Benefit	
Up to Age 19	N/A
Age 19 and Over	$400