

Schedule of Benefits

Health Choice Essential Platinum - Standard

Policy Number: [Your Policy Number]

Policy Effective Date: [Your Effective Date]

Policyowner: [Your Subscriber Name]

Policy Anniversary Date: [Your Anniversary Date]

Benefit Period: Calendar Year

Type of Coverage: [Your Type of Coverage]

This Schedule has been prepared to assist you in identifying copayments, maximum benefits and other important information about your Health Plan. This Schedule should be used with your Evidence of Coverage for a complete description of your benefits, exclusions, limitations and plan provisions. If coverage has an Advance Premium Tax Credit, any deductible, copayment, coinsurance and/or annual out-of-pocket maximum shown below may change without notice. The Health Insurance Marketplace ("HIM") will determine if a change is to be made. We will make the change as directed by the "HIM".

Please call Health Choice Insurance Co. Member Services at 1-855-452-4242 for more information.

Medical and Prescription drug deductible:	You Pay
Individual deductible (per covered person per calendar year)	\$0
Family deductible (per family per calendar year)	\$0
Out-of-pocket maximum:	
Individual maximum (per covered person per year)	\$2,000
Family maximum (per family per calendar year)	\$4,000

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Covered Services:

Covered Benefit Information	You Pay
Primary Care Visit to Treat an Injury or Illness	\$15 Copay per visit, after deductible
Specialist Visit	\$35 Copay per visit, after deductible
Other Practitioner Office Visit (Nurse, Physician Assistant)	\$15 Copay per visit, after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$100 Copay per visit, after deductible
Outpatient Surgery Physician/Surgical Services	\$100 Copay per visit, after deductible
Hospice Services	\$15 Copay per visit, after deductible
Routine Eye Exam (Adult) 1 Visit(s) per Year	\$15 Copay per visit, after deductible
Urgent Care Centers or Facilities	\$55 Copay per visit, after deductible
Home Health Care Services 42 Visit(s) per Year	\$15 Copay per visit, after deductible
Emergency Room Services	\$100 Copay per visit, after deductible
Emergency Transportation/Ambulance	\$100 Copay per visit, after deductible
Inpatient Hospital Services (e.g., Hospital Stay)	\$500 Copay per Stay
Inpatient Physician and Surgical Services	\$100 Copay per visit, after deductible
Bariatric Surgery	\$100 Copay per visit, after deductible
Skilled Nursing Facility	\$500 Copay per Stay
Prenatal and Postnatal Care	No Charge after deductible
Delivery and All Inpatient Services for Maternity Care	\$100 Copay per visit, after deductible
Mental/Behavioral Health Outpatient Services	\$15 Copay per visit, after deductible
Mental/Behavioral Health Inpatient Services	\$500 Copay per visit, after deductible

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Covered Benefit Information	Member Cost
Substance Abuse Disorder Outpatient Services	\$15 Copay per visit, after deductible
Substance Abuse Disorder Inpatient Services 2 Treatments per Year	\$500 Copay per visit, after deductible
Outpatient Rehabilitation Services 60 Visit(s) per Year	\$25 Copay per visit, after deductible
Chiropractic Care 20 Visit(s) per Year	\$35 Copay per visit, after deductible
Durable Medical Equipment	10% Coinsurance after deductible
Hearing Aids	10% Coinsurance after deductible
Imaging (x-rays, diagnostic imaging, CT/ CAT/ PET scans, MRI, ECT, BEAM, and multi-dimensional imaging)	\$35 Copay per visit, after deductible
Preventive Care/Screening/Immunization	No Charge
Routine Foot Care	\$35 Copay per visit, after deductible
Dental Check-Up for Children 1 Visit(s) per 6 Months	No Charge
Rehabilitative Speech Therapy	\$35 Copay per visit, after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$35 Copay per visit, after deductible
Well Baby Visits and Care	No Charge
Laboratory Outpatient and Professional Services	\$35 Copay per visit, after deductible
X-rays and Diagnostic Imaging	\$35 Copay per visit, after deductible
Orthodontia – Adult	\$35 Copay per visit, after deductible
Transplant	\$35 Copay per visit, after deductible
Accidental Dental	\$35 Copay per visit, after deductible
Dialysis	10% Coinsurance after deductible
Allergy Testing	No Charge after deductible
Chemotherapy	10% Coinsurance after deductible
Habilitative Services 60 Visit(s) per Year	\$25 Copay per visit, after deductible

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Covered Benefit Information	You Pay
Radiation	\$35 Copay per visit, after deductible
Diabetes Education	\$15 Copay per visit, after deductible
Prosthetic Devices	10% Coinsurance after deductible
Treatment for Temporomandibular Joint Disorders	\$35 Copay per visit, after deductible
Nutritional Counseling	\$15 Copay per visit, after deductible
Reconstructive Surgery	\$100 Copay per visit, after deductible
Cancer Clinical Trials	\$35 Copay per visit, after deductible
Diabetes Care Management	\$15 Copay per visit, after deductible

Health Choice Insurance Co. will cover fifty per cent of the cost of medical foods prescribed to treat inherited metabolic disorders. The limit to the maximum annual benefit for medical foods under this section is five thousand dollars, which applies to the cost of all prescribed modified low protein foods and metabolic formula.

Health Choice Insurance Co. will cover amino acid-based formula that is ordered by a physician or a registered nurse practitioner to treat Eosinophilic Gastrointestinal Disorder. This policy covers seventy five per cent of the amino acid-based formula cost. The limit to the maximum annual benefit for medical formula under this section is twenty thousand dollars.

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Prescription Services:

Prescription Covered Benefit Information	You Pay
Diabetic Supplies includes insulin, lancets, syringes, needles, pre-filled cartridges, blood glucose testing monitors and test strips, and alcohol swabs.	No Charge
Retail Pharmacy (up to 30-day supply): Generic (Tier 1) Preferred Brand (Tier 2) Non-preferred Brand (Tier 3) Specialty (Tier 4)	<u>No deductible</u> \$8 \$30 \$60 \$60
Mail Order Pharmacy (up to a 90-day supply): Generic (Tier 1) Preferred Brand (Tier 2) Non- preferred Brand(Tier 3) Specialty (Tier 4)	<u>No deductible</u> \$25 \$75 \$150 \$150
Health Care Reform preventive health products including: vaccines, prescription birth control products, and specific over the drug products (aspirin, fluoride, iron and folic acid).	\$0

Vision Services:

Covered Benefit Information	You Pay
Routine Eye Exams (including dilation, if professionally indicated)	\$0
Standard Eyeglass Lenses (Contact lenses may be obtained in lieu of glasses)	\$0
Optional Lens Treatments	May have additional cost (see Evidence of Coverage for details)
Frames Collection Frames Non-Collection Frame	\$0 Member pays for charges over \$150.
Contact Lenses	Member pays for charges over \$150.

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Premium Payments:

Premium payments are due on the first day of the month for which the member is purchasing Coverage. Payments must be made by credit card, check, money order or automatic bank withdrawal. See Grace Periods and Termination of Coverage in Evidence of Coverage for more information.

This Schedule of Benefits has been prepared as a summary of the health care benefits that are currently provided under Health Choice Insurance Co.. It is a summary only. For a complete description of the health care benefits, exclusions and limitations applicable to your health plan please refer to the Evidence of Coverage. In the event of conflict, the Evidence of Coverage shall prevail.

Please call 1-855-452-4242 for assistance on your Coverage.