BCN HRA SM HMO Platinum $5000

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract**. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificate and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

Preauthorization for Select Services – Services listed in this summary are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCN except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo**. Select ***Approving covered services.***

Member's Responsibility: Deductible, Copays, Coinsurance and Dollar Maximums

Note: The Deductible will apply to certain services as defined below.

Deductible **Note:** Coinsurance and select fixed dollar copays apply once the deductible has been met.	$5,000 per individual/$10,000 per family per benefit year HRA $1500/$3000
Fixed dollar copays **Note:** If you have a deductible, the deductible must be met first for certain services as listed below.	$20 for office visits, $40 for specialist visits, $50 for urgent care visits, $150 for emergency room visits, $150 for high tech imaging and $5 for allergy injections
Coinsurance	20% and 50% for select services as noted below
Annual Coinsurance Maximum	None
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug cost-sharing amounts	$6,350 per member/$12,700 per family per benefit year

Preventive Services – as defined by the Affordable Care Act and included in your Certificate of Coverage

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%
Routine Colonoscopy	Covered – 100%
Mammography Screening	Covered – 100%
Voluntary Female Sterilization	Covered – 100%
Breast Pumps	Covered – 100%
Routine Maternity Prenatal and Postnatal Care	Covered – 100%

Physician Office Services

PCP Office Visits **Note:** Applicable cost sharing applies when other services are received in the office	Covered – $20 copay
Medical Online Visits - when performed by a BCN participating provider or BCN designated online vendor	Covered – 100%
Consulting Specialist Care – when referred for other than preventive services **Note:** Applicable cost sharing applies when other services are received in the office	Covered – $40 copay

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered – $150 copay after deductible
Urgent Care Center	Covered – $50 copay
Retail Health Clinic	Covered – $50 copay
Ambulance Services – medically necessary	Covered – 80% after deductible

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100%
Diagnostic Tests and X-rays	Covered – 80% after deductible
High Technology Imaging (MRI, CAT, PET)	Covered – $150 copay after deductible
Radiation Therapy	Covered – 80% after deductible

Maternity Services Provided by a Physician

Routine Prenatal and Postnatal Care visits	Covered - 100%
Delivery and Nursery Care	Covered – 100% after deductible for professional services; see Hospital Care for facility charges

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 80% after deductible; unlimited days
Outpatient Surgery – See member certificate for select surgical coinsurance	Covered – 80% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 80% after deductible up to 45 days per benefit year
Hospice Care	Covered – 100% after deductible when authorized
Home Health Care	Covered – $40 copay after deductible

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 80% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – 50% after deductible
Elective Abortion (One procedure per two-year period of membership)	Not Covered
Human Organ Transplants (subject to medical criteria)	Covered – 80% after deductible
Reduction mammoplasty (subject to medical criteria)	Covered – 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 50% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)

Inpatient Mental Health Care and Residential Substance Use Disorder	Covered – 80% after deductible
Outpatient Mental Health Care includes online and telemedicine visits **Note:** For diagnostic and therapeutic services, see the	Covered – $20 copay

Diagnostic Services section above for applicable cost sharing.	
Outpatient Substance Use Disorder	Covered – $20 copay

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCN approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered – $20 copay
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder Unlimited visits for physical, speech and occupational therapy with autism spectrum disorder diagnosis	Covered – $40 copay after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visits and preventive benefit

Other Services

Allergy Testing and serum	Covered – 50% after deductible
Allergy office visits	Covered – 50%
Allergy Injections	Covered – $5 copay
Chiropractic Spinal Manipulation – when referred	Covered – $40 copay; up to 30 visits per benefit year
Rehabilitative Services – subject to meaningful improvement within 90 days • Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per calendar year • Outpatient Speech Therapy – limited to 30 visits per calendar year	Covered – $40 copay after deductible
Habilitative Services • Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per calendar year • Outpatient Speech Therapy – limited to 30 visits per calendar year	Covered – $40 copay after deductible
Outpatient Cardiac and Pulmonary Rehabilitation	Covered – $40 copay after deductible; limited to a benefit maximum of 30 visits per benefit year
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible on all associated costs
Durable Medical Equipment	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%
Diabetic Supplies Note: Certain diabetic supplies are covered through the pharmacy benefit. Applicable pharmacy cost-sharing will apply.	Covered – 80%
Pediatric Vision • Eye Exam – Limited to once per calendar year through the last day of the year in which an individual turns age 19 • Prescription Glasses – Frames (chosen from a select collection) and lenses are covered once in a calendar year through the last day of the year in which an individual turns age 19	Covered – 100%

Prescription Drugs

Preferred Generic Tier	Covered – $6 copay
Non-Preferred Generic Tier	Covered – $25 copay
Preferred Brand Tier	Covered – $50 copay
Non-Preferred Brand Tier	Covered – $80 copay
Preferred Specialty Tier	Covered – 20% Coinsurance of the BCN Approved Amount (Maximum Copayment $200) - Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.
Non-Preferred Specialty Tier	Covered – 20% Coinsurance of the BCN Approved Amount (Maximum Copayment $300) – Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.
Drugs for sexual dysfunction, weight loss, cough & cold	Not Covered
Diabetic Supplies	Select diabetic supplies and equipment are covered – applicable cost sharing will apply. Cost-sharing may not apply to certain preferred glucometers as defined on the drug list.
Contraceptives	Covered – Preferred Generic Tier – 100% , Non-Preferred Generic Tier – $25 copay, Preferred Brand Tier - $50 copay, Non-Preferred Brand Tier - $80 copay
Preventive Drugs	Covered – 100%
90 Day Retail: 84-90 day supply	Covered – Three times applicable copay minus $10 **Note:** If you have a Coinsurance, your Coinsurance will be based on the BCN Approved Amount for the quantity dispensed. If your Coinsurance includes a minimum and maximum Copayment, the minimum and maximum Copayment amounts are three times the 30-day supply minus $10.
Out-of-Pocket Maximum	Applies to deductibles, copays and coinsurance amounts for all covered medical and prescription drug services. See medical section above for out-of-pocket maximum limits. **Note:** Your benefit requires you to take advantage of BCN-approved coupon program for select medications. When a manufacturer coupon is used through the BCN high-cost drug discount program, the amount paid after the discount applies toward the out- of-pocket maximum.

CLSSSM, D5000, WDRPOV, CI20%, 6350PM, CO20, 40RP, ER150, UR50, IMG150, DSR20%, BENYR, ONVCW, PVSN, P625CS, 90D3X, RXVAR

Optional Rider:

- VACR50 – Elective Abortion 50% Coinsurance Rider

Catastrophic plan

BCN HSA℠ HMO Bronze $6,900 High Deductible Health Plan for Medical and Prescription Drug Coverage

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Preauthorization for Select Services – Services listed in this summary are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCN except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo**. Select ***Approving covered services.***

Member's Responsibility: Deductible, Copays, Coinsurance and Out of Pocket Maximums

Note: The **Deductible** will apply to all services except preventive services

Deductible **Note:** Deductible is combined for both medical and prescription drug coverage. The Deductible paid by all Members will be combined to satisfy the family Deductible. However, one individual Member cannot contribute more than the individual Deductible amount toward the family Deductible.	$6,900 per member, $13,800 per contract per calendar year (No 4th quarter carryover)
Fixed Dollar Copay **Note**: Copay amounts apply once the deductible has been met	None
Coinsurance **Note**: Coinsurance amounts apply once the deductible has been met	0% and 50% for select services as noted below
Out of Pocket Maximum – Total amount paid toward medical and pharmacy services including deductible, copays and coinsurance. For Members with more than one person on the contract, if the one Member maximum is met even if the family maximum is not, that Member does not pay any more Cost-Sharing for the rest of the year.	$6,900 per member, $13,800 per contract per calendar year

Preventive Services – as defined by the Affordable Care Act and included in your Certificate of Coverage

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%
Routine Colonoscopy	Covered – 100%
Mammography Screening	Covered – 100%
Voluntary Female Sterilization	Covered – 100%
Breast Pumps	Covered – 100%
Routine Maternity Prenatal and Postnatal Care	Covered – 100%

Physician Office Services

PCP Office Visits Note: Applicable cost sharing applies when other services are received in the office	Covered – 100% after deductible
Medical Online Visits - when performed by a BCN participating provider or BCN designated online vendor	Covered – 100% after deductible
Consulting Specialist Care – when referred	Covered – 100% after deductible

Emergency Medical Care

Hospital Emergency Room	Covered – 100% after deductible
Urgent Care Center	Covered – 100% after deductible
Retail Health Clinic	Covered – 100% after deductible
Ambulance Services – medically necessary	Covered – 100% after deductible

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100% after deductible
Diagnostic Tests and X-rays	Covered – 100% after deductible
Radiation Therapy	Covered – 100% after deductible

Maternity Services Provided by a Physician

Routine Prenatal and Postnatal Care visits	Covered - 100%
Delivery and Nursery Care	Covered – 100% after deductible

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 100% after deductible; unlimited days
Outpatient Surgery – see member certificate for specific surgical coinsurance	Covered – 100% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100% after deductible up to 45 days per calendar year
Hospice Care	Covered – 100% after deductible
Home Health Care	Covered – 100% after deductible

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 100% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – Male - 50% after deductible
Elective Abortion (One procedure per two-year period of membership)	Not Covered
Human Organ Transplants (subject to medical criteria)	Covered – 100% after deductible
Reduction Mammoplasty (subject to medical criteria)	Covered – 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 50% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)

Inpatient Mental Health Care	Covered – 100% after deductible
Residential Substance Use Disorder	Covered – 100% after deductible
Outpatient Mental Health Care includes online and telemedicine visits **Note:** For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	Covered – 100% after deductible
Outpatient Substance Use Disorder	Covered – 100% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCN approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered – 100% after deductible
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder Unlimited visits for physical, speech and occupational therapy with autism spectrum disorder diagnosis	Covered – 100% after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visits and preventive benefit

Other Services

Allergy Testing and Therapy	Covered – 100% after deductible
Allergy office visits	Covered – 100% after deductible
Allergy Injections	Covered – 100% after deductible
Chiropractic Spinal Manipulation – when referred	Covered – 100% after deductible; up to 30 visits per calendar year
Rehabilitative Services – subject to meaningful improvement within 90 days • Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per calendar year • Outpatient Speech Therapy – limited to 30 visits per calendar year	Covered – 100% after deductible
Habilitative Services • Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per calendar year • Outpatient Speech Therapy – limited to 30 visits per calendar year	Covered – 100% after deductible
Outpatient Cardiac and Pulmonary Rehabilitation	Covered – 100% after deductible; limited to a benefit maximum of 30 visits per calendar year
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible
Durable Medical Equipment	Covered – 50% after deductible
Prosthetic and Orthotic Supplies	Covered – 50% after deductible
Diabetic Supplies Note: Certain diabetic supplies are covered through the pharmacy benefit. Applicable pharmacy cost-sharing will apply.	Covered – 100% after deductible

Pediatric Vision • Eye Exam – Limited to once per calendar year through the last day of the year in which an individual turns age 19 • Prescription Glasses – Frames (chosen from a select collection) and lenses are covered once in a calendar year through the last day of the year in which an individual turns age 19	Covered – 100%

Prescription Drugs

Preferred Generic Tier	Covered in full after Deductible
Non-Preferred Generic Tier	Covered in full after Deductible
Preferred Brand Tier	Covered in full after Deductible
Non-Preferred Brand Tier	Covered in full after Deductible
Preferred Specialty Tier	Covered in full after Deductible – Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.
Non-Preferred Specialty Tier	Covered in full after Deductible – Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.
Drugs for sexual dysfunction, weight loss, cough & cold	Not Covered
Diabetic Supplies	Select diabetic supplies and equipment are covered – applicable cost sharing will apply. Cost-sharing may not apply to certain preferred glucometers as defined on the drug list.
Contraceptives	Covered – Preferred Generic Tier – Covered in full; Deductible does not apply, Non-Preferred Generic Tier – Covered in full after deductible, Preferred Brand Tier - Covered in full after deductible, Non-Preferred Brand Tier - Covered in full after deductible
Preventive Drugs	Covered – 100%
90 Day Retail: 84-90 day supply	Covered in full after deductible
Out-of-Pocket Maximum	Applies to deductibles, copays and coinsurance amounts for all covered medical and prescription drug services. See medical section above for out-of-pocket maximum limits. **Note:** Your benefit requires you to take advantage of BCN-approved coupon program for select medications. When a manufacturer coupon is used through the BCN high cost drug discount program, the amount paid after the discount applies toward the out- of-pocket maximum.

HDHPSM, 6900HD, 690MHD, EDEPM, PVSN, P0CSHD, MOPD0, RXVAR

Optional Rider:

- VACR50 – Elective Abortion 50% Coinsurance Rider

Delta Dental of Michigan
Dental Benefit Highlights for
Concord Academy #5515

DELTA DENTAL

Delta Dental PPO™ (Point-of-Service) ***Non-EHB Benefit Highlights*** *Coverage effective* ***September 1, 2023***	**Delta Dental PPO™ Dentist** **Plan Pays**	**Delta Dental Premier® Dentist** **Plan Pays**	**Nonparticipating Dentist** **Plan Pays***
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment - to temporarily relieve pain	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services - fillings and crown repair	80%	80%	80%
Oral Surgery Services - extractions and dental surgery	80%	80%	80%
Other Basic Services - misc. services	80%	80%	80%
Relines and Repairs - to prosthetic appliances	80%	80%	80%
Major Services			
Endodontic Services - root canals	50%	50%	50%
Periodontic Services - to treat gum disease	50%	50%	50%
Major Restorative Services - crowns	50%	50%	50%
Prosthodontic Services - bridges, implants, dentures, and crowns over implants	50%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	through age 18 and under	through age 18 and under	through age 18 and under

** When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.*

Maximum Payment – $1,000 per Member total per Benefit Year on all services except orthodontic services. $1,000 per Member total per lifetime on orthodontic services.

Deductible – $50 Deductible per Member total per Benefit Year limited to a maximum Deductible of $150 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, and orthodontic services.

Benefit Waiting Period – There is a 12-month waiting period for certain services. Endodontic Services, Periodontic Services, Major Restorative Services, and Prosthodontic Services will not be covered until after a Member is enrolled in the dental plan for 12 consecutive months. Orthodontic Services will not be covered until after a Member is enrolled in the dental plan for 24 consecutive months.

Note - *This document is only intended to provide a brief description of your benefits. Please refer to your Certificate and summary for a complete description of benefits, exclusions, and limitations.*

Welcome to Michigan's largest dental benefits family!

As a member of Delta Dental of Michigan, you have access to the nation's largest dental networks: Delta Dental PPO and Delta Dental Premier.

- It's easy to find a dentist! Four out of five dentists nationwide participate in our network.
- You have superior access to care and fee savings because of our agreements with participating dentists.
- Our dentists cannot balance bill you, which means more money in your pocket!
- No troublesome paperwork! Network dentists will fill out and file your claims.
- Pay only your copayments and/or deductibles when you receive care from network dentists -- there are no hidden fees.
- You can still visit nonparticipating dentists, but you may be billed the full amount at the time of service and then have to wait to be reimbursed.

Quality Dental Program

With our quick and accurate claims processing, *we pay more than 90% of claims in 10 days or less.* Delta Dental also offers world-class customer service from our BenchmarkPortal Certified Center of Excellence call center.

Online Access

Our online Member Portal lets you access your dental plan securely over the Internet. You can find a dentist, check benefits, select paperless notices, review claims and amounts used toward maximums, print ID cards, and more -- all at your own convenience.

A Healthy Smile

Keep your smile healthy with dental benefits from Delta Dental. Your smile is a good indicator of your health. Did you know that your dentist can detect up to 120 different diseases, including diabetes and heart disease? Early detection is one of the best ways to prevent further complications.

Questions?

If you have questions, please call our Customer Service team at 800-524-0149 (TTY users call 711) or look online at https://www.DeltaDentalMI.com.

Delta Dental of Michigan
Dental Benefits Highlights
High Pediatric Dental Plan

DELTA DENTAL

2023 ESSENTIAL HEALTH BENEFITS (EHB) for individuals age 18 and under Delta Dental PPO (Point-of-Service)	In-Network		Out-of-Network
	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	80%	60%	60%
Oral Surgery Services – extractions and dental surgery	80%	60%	60%
Endodontic Services – root canals	80%	60%	60%
Periodontic Services – to treat gum disease	80%	60%	60%
Relines and Repairs – prosthetic appliances	80%	60%	60%
Other Basic Services – misc. services	80%	60%	60%
Major Services			
Prosthodontic Services – bridges, dentures, and crowns over implants	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%

**When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.*

***Note:** Composite resin restorations are optional on posterior teeth. An allowance will be made for an amalgam (silver) filling.*

In-Network Annual Out-of-Pocket Maximum – An Out-of-Pocket Maximum is the maximum amount that an Eligible Person will pay for EHB Covered Services throughout a Benefit Year. The In-Network Annual Out-of-Pocket Maximum for EHB Covered Services shall be $375 per Benefit Year if this Certificate covers one Eligible Person age 18 and under, or $750 per Benefit Year if this Certificate covers two or more Eligible Persons age 18 and under. Any Copayments, Deductibles, or other out-of-pocket expenses paid by an Eligible Person for In-Network EHB Covered Services provided shall count toward that In-Network Annual Out-of-Pocket Maximum. The In-Network Annual Out-of-Pocket Maximum will not include any amounts paid for the following: (i) premiums; (ii) non-covered services; (iii) Out-of-Network Dentists; (iv) Copayments, Deductibles, or other out-of-pocket expenses for services other than EHB Covered Services; or (v) Copayments, Deductibles, or other out-of-pocket expenses paid for EHB Covered Services provided to individuals 19 years of age and older. Once the applicable In-Network Annual Out-of-Pocket Maximum is reached for the Benefit Year, all In-Network EHB Covered Services provided to an Eligible Person will be covered at 100% of the Maximum Approved Fee.

Out-of-Network Annual Out-of-Pocket Maximum – There is no annual Out-of-Pocket Maximum for Out-of-Network EHB Covered Services. Eligible Persons will be responsible for all Copayments, Deductibles, and other out-of-pocket expenses associated with all Out-of-Network EHB Covered Services provided to Eligible Persons throughout the Benefit Year.

Annual and Lifetime Maximum Payments – There are no annual or lifetime Maximum Payments for EHB Covered Services under this Certificate.

Deductibles for EHB Covered Services – None.

Waiting Period for EHB Covered Services – There are no waiting periods for Eligible Persons age 18 and under seeking EHB Covered Services.

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