Curbell, Inc. PPO 7200 $3,000/$6,000

Benefit	In Network	Out of Network
General Provisions		
Effective Date	April 1	
Benefit Period (1)	Contract Year	
Deductible (per benefit period) Individual Family	 $3,000 $6,000	
Deductible Accumulation (2)	Non-Embedded	
Coinsurance - payment based on the plan allowance	0% after deductible	30% after deductible
Out-of-Pocket Maximum (Includes coinsurance, copays, deductible and prescription drug cost sharing and other qualified medical expenses). Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $6,000 $12,000	 $10,000 $20,000
Out-of-Pocket Accumulation (2)	Embedded	Embedded
Office/Urgent Care Visits		
Primary Care Provider Office Visits & Virtual Visits	$25 copay after deductible	30% after deductible
Specialist Office Visits & Virtual Visits	$25 copay after deductible	30% after deductible
Virtual Visit Provider Originating Site Fee	0% after deductible	30% after deductible
Urgent Care Center Visits	$35 copay after deductible	$35 copay after in-network deductible
Telemedicine Services (3)	$25 copay after deductible	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 covered in full	 not covered
Adult Immunizations	covered in full	30% after deductible
Routine Gynecological Exams, including a Pap Test	covered in full	30% after deductible
Mammograms, Annual Routine	covered in full	30% after deductible
Diagnostic Services and Procedures	covered in full	30% after deductible
Routine Pediatric Physical Exams	 covered in full	 30% after deductible
Pediatric Immunizations	covered in full	30% after deductible
Diagnostic Services and Procedures	covered in full	30% after deductible
Emergency Services		
Emergency Room Services	$50 copay after deductible (waived if admitted); $35 copay for freestanding urgent care facility after deductible	$50 copay after in-network deductible (waived if admitted); $35 copay for freestanding urgent care facility after in-network deductible
Ambulance - Emergency and Non-Emergency	$50 copay after deductible	$50 copay after in-network deductible
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	$250 inpatient copay/admission after deductible	30% after deductible
Outpatient Surgery	$75 copay after deductible	30% after deductible
Maternity (non-preventive professional services) including dependent daughters	$25 copay after deductible	30% after deductible
Medical Care (including inpatient visits and consultations)	0% after deductible	30% after deductible

Therapy and Rehabilitation Services		
Physical Therapy	$25 copay after deductible	30% after deductible
	limit: 30 visits/benefit period aggregate with occupational therapy and speech therapy	
Speech Therapy	$25 copay after deductible	30% after deductible
	limit: 30 visits/benefit period aggregate with occupational therapy and physical medicine	
Occupational Therapy	$25 copay after deductible	30% after deductible
	limit: 30 visits/benefit period aggregate with speech therapy and physical medicine	
Respiratory Therapy	$25 copay after deductible	30% after deductible
Spinal Manipulations	$25 copay after deductible	30% after deductible
Cardiac Rehabilitation Therapy	$25 copay after deductible	30% after deductible
	limit: 24 visits/benefit period	
Infusion Therapy	$25 copay after deductible; 0% after deductible for home imfusion	30% after deductible
Chemotherapy	$25 copay after deductible	30% after deductible
Radiation Therapy	$25 copay after deductible	30% after deductible
Dialysis	$25 copay after deductible; 0% after deductible for home dialysis	30% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	$250 inpatient copay/admission after deductible	30% after deductible
Inpatient Detoxification / Rehabilitation	$250 inpatient copay/admission after deductible	30% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	$25 copay after deductible	30% after deductible
Outpatient Substance Abuse Services	$25 copay after deductible	30% after deductible
Other Services		
Allergy Extracts	0% after deductible	30% after deductible
Allergy Injections	$25 copay after deductible	30% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder	$25 copay after deductible	30% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	$25 copay after deductible	30% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	$25 copay after deductible	30% after deductible
Mammograms, Medically Necessary	$25 copay after deductible	30% after deductible
Durable Medical Equipment and Supplies	50% after deductible; $25 copay for diabetic supplies after deductible ; $25 copay for diabetic equipment after deductible	50% after deductible; 30% after deductible for diabetic equipment and supplies
Orthotics	50% after deductible	50% after deductible
Prosthetic Devices	0% after deductible; 50% after deductible for external prosthetics	30% after deductible; 50% after deductible for external prosthetics
Home Health Care	$25 copay after deductible	30% after deductible
	limit: 40 visits/benefit period aggregate with visiting nurse	
Hospice	$250 inpatient copay/admission after deductible; $25 copay for outpatient services after deductible	30% after deductible
Infertility Counseling, Testing and Treatment	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)
Skilled Nursing Facility Care	$250 inpatient copay/admission after deductible	30% after deductible
	limit: 60 days/benefit period	
Transplant Services	$250 inpatient copay/admission after deductible	30% after deductible

Prescription Drugs	
Prescription Drug Deductible Individual Family	 Integrated with medical deductible Integrated with medical deductible
Prescription Drug Program (5) Defined by the National Plus NY Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (30/60/90-day Supply)** $5 / $10 / $15 Formulary generic copay after in-network deductible $50 / $100 / $150 Non-Formulary generic copay after in-network deductible $30 / $60 / $90 Formulary brand copay after in-network deductible $50 / $100 / $150 Non-Formulary brand copay after in-network deductible Cost-sharing for prescription insulin drugs will not exceed $100 for a 30-day supply **Select Specialty Drugs (31-day Supply)** $50 Non-Formulary copay after in-network deductible $5 Formulary generic copay after in-network deductible $30 Formulary brand copay after in-network deductible **Maintenance Drugs through Mail Order (30/60/90-day Supply)** $5 / $10 / $10 Formulary generic copay after in-network deductible $50 / $100 / $100 Non-Formulary generic copay after in-network deductible $30 / $60 / $60 Formulary brand copay after in-network deductible $50 / $100 / $100 Non-Formulary brand copay after in-network deductible Cost-sharing for prescription insulin drugs will not exceed $100 for a 30-day supply