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Annual Maximum Benefit Individual $10,000 Family $20,000	**FMA Freedom Select Plan A** **Summary Plan of Coverage**
PPO Network (1)	**PHCS**
BASIC BENEFITS (Base Plan)	
Deductible - Individual / Family (2)	None
Healthcare2U's Direct Primary Care – Unlimited Virtual DPC / Telehealth (3) Unlimited In-Office Doctor Visits for Acute and Chronic Care (See Page 3) Unlimited Urgent Care Visits	Virtual Consults $0 Visit Fee (4) In-Office Visits $10 Visit Fee Urgent Care Visits $25 Visit Fee
Primary Care Office Visits (non-Healthcare2U Visits) Internal Medicine, Family Practice, Pediatrician, & OB/GYN - Office and Other Outpatient Services	Subject to Coinsurance
Specialist Care	Subject to Coinsurance (5)
Prescription Drugs (6) Generic / Brand	Subject to Coinsurance $500 Maximum on any Prescription/mo.
Inpatient & Outpatient Hospital (7)	Subject to Coinsurance
Behavioral Health Care Inpatient/Outpatient limited to 30 days/visits	Subject to Coinsurance
Chiropractic Care (Limited to Spinal Adjustments)	Subject to Coinsurance
Medical Imaging & X-Ray	Subject to Coinsurance
Emergency Room & Ambulance	Subject to Coinsurance
Urgent Care Facility	Subject to Coinsurance
Durable Medical Equipment	Subject to Coinsurance
Preventive Care Services and Minimum Essential Coverage (MEC) (8) **Adult, Women, Child - Immunization, Screenings, & Services** MEC not subject to Annual Maximum or Coinsurance Percentages	Preventive Care coverage paid at 100%
Careington Dental & Vision Discounted Benefits (9)	Fee Schedule
EXTRA ENHANCED BENEFITS	
Extra Inpatient Hospital & Outpatient Surgery and Professional Services (10) Excludes Outpatient Drugs, Kidney Dialysis, Chemo Therapy, & All Other Infusion Therapy	Applicable to Plan C Only
Annual Maximum Benefit Covered	Applicable to Plan C Only
Waiting Period	Applies to Plan C Extra Benefits Only
BASIC & EXTRA ENHANCED BENEFIT SUMMARY	
Coinsurance on Base Plan (Percentage of Covered Benefits by Plan)	50% of $10,000
Annual Out-of-Pocket Maximum (11)	$5,000 Individual $10,000 Family
Annual Maximum Benefit Covered (12)	$10,000 Individual $20,000 Family
Out of Network Coverage	See Provisions and Exclusions

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Annual Maximum Benefit Individual $20,000 Family $40,000	**FMA Freedom Select Plan B** **Summary Plan of Coverage**
PPO Network (1)	**PHCS**
BASIC BENEFITS (Base Plan)	
Deductible - Individual / Family (2)	None
Healthcare2U's Direct Primary Care – Unlimited Virtual DPC / Telehealth (3) Unlimited In-Office Doctor Visits for Acute and Chronic Care (See page 3) Unlimited Urgent Care Visits	Virtual Consults $0 Visit Fee (4) In-Office Visits $10 Visit Fee Urgent Care Visits $25 Visit Fee
Primary Care Office Visits (non-Healthcare2U Visits) Internal Medicine, Family Practice, Pediatrician, & OB/GYN - Office and Other Outpatient Services	Subject to Coinsurance
Specialist Care	Subject to Coinsurance (5)
Prescription Drugs (6) Generic / Brand	Subject to Coinsurance $500 Maximum on any Prescription/mo.
Inpatient & Outpatient Hospital (7)	Subject to Coinsurance
Behavioral Health Care Inpatient/Outpatient limited to 30 days/visits	Subject to Coinsurance
Chiropractic Care (Limited to Spinal Adjustments)	Subject to Coinsurance
Medical Imaging & X-Ray	Subject to Coinsurance
Emergency Room & Ambulance	Subject to Coinsurance
Urgent Care Facility	Subject to Coinsurance
Durable Medical Equipment	Subject to Coinsurance
Preventive Care Services and Minimum Essential Coverage (MEC) (8) **Adult, Women, Child - Immunization, Screenings, & Services** MEC not subject to Annual Maximum or Coinsurance Percentages	Preventive Care coverage paid at 100%
Careington Dental & Vision Discounted Benefits (9)	Fee Schedule
EXTRA ENHANCED BENEFITS	
Extra Inpatient Hospital & Outpatient Surgery and Professional Services (10) Excludes Outpatient Drugs, Kidney Dialysis, Chemo Therapy, & All Other Infusion Therapy	Applicable to Plan C Only
Annual Maximum Benefit Covered	Applicable to Plan C Only
Waiting Period	Applies to Plan C Extra Benefits Only
BASIC & EXTRA ENHANCED BENEFIT SUMMARY	
Coinsurance on Base Plan (Percentage of Covered Benefits by Plan)	50% of First $10,000 80% of Next $10,000
Annual Out-of-Pocket Maximum (11)	$7,000 Individual $14,000 Family
Annual Maximum Benefit Covered (12)	$20,000 Individual $40,000 Family
Out of Network Coverage	See Provisions and Exclusions

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Annual Maximum Benefit
Individual $20,000 + $25,000 Enhanced
Family $40,000 + $50,000 Enhanced

FMA Freedom Select Plan C

Summary Plan of Coverage

PPO Network (1)	**PHCS**
BASIC BENEFITS (Base Plan)	
Deductible - Individual / Family (2)	None
Healthcare2U's Direct Primary Care – Unlimited Virtual DPC / Telehealth (3) Unlimited In-Office Doctor Visits for Acute and Chronic Care (See page 3) Unlimited Urgent Care Visits	Virtual Consults $0 Visit Fee (4) In-Office Visits $10 Visit Fee Urgent Care Visits $25 Visit Fee
Primary Care Office Visits (non-Healthcare2U Visits) Internal Medicine, Family Practice, Pediatrician, & OB/GYN - Office and Other Outpatient Services	Subject to Coinsurance (5)
Specialist Care	Subject to Coinsurance
Prescription Drugs (6) Generic / Brand	Subject to Coinsurance $500 Maximum on any Prescription/mo.
Inpatient & Outpatient Hospital (7)	Subject to Coinsurance
Behavioral Health Care Inpatient/Outpatient limited to 30 days/visits	Subject to Coinsurance
Chiropractic Care (Limited to Spinal Adjustments)	Subject to Coinsurance
Medical Imaging & X-Ray	Subject to Coinsurance
Emergency Room & Ambulance	Subject to Coinsurance
Urgent Care Facility	Subject to Coinsurance
Durable Medical Equipment	Subject to Coinsurance
Preventive Care Services and Minimum Essential Coverage (MEC) (8) **Adult, Women, Child - Immunization, Screenings, & Services** MEC not subject to Annual Maximum or Coinsurance Percentages	Preventive Care coverage paid at 100%
Careington Dental & Vision Discounted Benefits (9)	Fee Schedule
EXTRA ENHANCED BENEFITS	
Extra Inpatient Hospital & Outpatient Surgery and Professional Services (10) Excludes Outpatient Drugs, Kidney Dialysis, Chemo Therapy, & All Other Infusion Therapy	Covered at 100%
Annual Maximum Benefit Covered	$25,000 Individual $50,000 Family
Waiting Period	See Provisions and Exclusions
BASIC & EXTRA ENHANCED BENEFIT SUMMARY	
Coinsurance on Base Plan (Percentage of Covered Benefits by Plan)	50% of First $10,000 80% of Next $10,000
Annual Out-of-Pocket Maximum (11)	$7,000 Individual $14,000 Family
Annual Maximum Benefit Covered (12)	Basic $20,000 Individual Basic $40,000 Family Enhanced $25,000 Individual Enhanced $50,000 Family
Out of Network Coverage	See Provisions and Exclusions