



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 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) Behavioral Health Care Inpatient/Outpatient limited to 30 days/visits	Subject to Coinsurance 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				





Annual Maximum Benefit Individual \$20,000 Family \$40,000

FMA Freedom Select Plan B

Summary Plan of Coverage

PPO Network ① BASIC BENEFITS (Base Plan)	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 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) 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 (1)	\$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		





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

FMA Freedom Select Plan C

Summary Plan of Coverage

Inpatient & Outpatient Hospital 7 Behavioral Health Care Inpatient/Outpatient limited to 30 days/visits Chiropractic Care (Limited to Spinal Adjustments) Medical Imaging & X-Ray Emergency Room & Ambulance Urgent Care Facility Durable Medical Equipment Subject to Coinsurance	Family \$40,000 + \$50,000 Enhanced	Summary Plan o	1 Coverage			
Deductible - Individual / Family ② None	PPO Network 1			PHCS		
Healthcare2U's Direct Primary Care - Unlimited Virtual DPC / Telehealth (a) Nirtual Consults \$0 Visit Fee (b) In-Office Doctor Visits for Acute and Chronic Care (See page 3) In-Office Visits \$10 Visit Fee (c) In-Office Visits \$25 Visit Fee (c) In-Office Visits \$10 Visit Fee (c) In-Office Visi	BASIC BENEFITS (Base Plan)					
Unlimited In-Office Doctor Visits for Acute and Chronic Care (See page 3) Unlimited Urgent Care Visits \$25 Visit Fee Ungent Care Visits \$25 Visit Fee Ungent Care Visits \$25 Visit Fee Ungent Care Visits \$25 Visit Fee Virgent Care Coinsurance Subject to Coinsurance Visits \$10 Visit Fee Virgent Care Coinsurance Visits \$10 Visit Fee Visits \$10 Visit \$10 Visit Fee Visits \$10 Visit \$1	Deductible - Individual / Family 2		None			
Primary Care Office Visits (non-Healthcare2U Visits) Internal Medicine, Family Practice, Pediatrician, & OB/GYN - Office and Other Outpatient Services Specialist Care Prescription Drugs (a) Subject to Coinsurance Inpatient & Outpatient Hospital (a) Subject to Coinsurance Subject to Coinsurance Inpatient A Outpatient limited to 30 days/visits Chiropractic Care (Limited to Spinal Adjustments) Subject to Coinsurance Inpatient A Outpatient limited to Spinal Adjustments) Subject to Coinsurance Medical Imaging & X-Ray Subject to Coinsurance Inpatient A Subject to Coinsurance In	Unlimited In-Office Doctor Visits for Acute and Chronic Car	\sim	In-Office Visits \$10 Visit Fee			
Internal Medicine, Family Practice, Pediatrician, & OB/GYN - Office and Other Outpatient Services Specialist Care Prescription Drugs (a) Subject to Coinsurance Generic / Brand Subject to Coinsurance Behavioral Health Care Inpatient & Outpatient Hospital (b) Subject to Coinsurance Inpatient (a) Inpatient & Outpatient Himited to 30 days/visits Chiropractic Care (Limited to Spinal Adjustments) Medical Imaging & X-Ray Subject to Coinsurance Wedical Imaging & X-Ray Subject to Coinsurance Urgent Care Facility						
Prescription Drugs	Internal Medicine, Family Practice, Pediatrician, & OB/GYN	l-	Subject to Coinsurance (5)			
Sepand	Specialist Care		Subject to Coinsurance			
Subject to Coinsurance			Subject to Coinsurance \$500 Maximum on any Prescription/mo			
Inpatient/Outpatient limited to 30 days/visits Chiropractic Care (Limited to Spinal Adjustments) Subject to Coinsurance Medical Imaging & X-Ray Subject to Coinsurance Emergency Room & Ambulance Urgent Care Facility Subject to Coinsurance Durable Medical Equipment Preventive Care Services and Minimum Essential Coverage (MEC) (a) Adult, Women, Child - Immunization, Screenings, & Services MEC not subject to Annual Maximum or Coinsurance Percentages Careington Dental & Vision Discounted Benefits (a) EXTRA ENHANCED BENEFITS Extra Inpatient Hospital & Outpatient Surgery and Professional Services (a) All Other Infusion Therapy 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 80% of Next \$10,000 annual Out-of-Pocket Maximum (1) \$7,000 Individual \$14,000 Family Annual Maximum Benefit Covered (12) Basic \$20,000 Individual \$14,000 Family Annual Maximum Benefit Covered (2) Basic \$20,000 Individual \$14,000 Family Annual Maximum Benefit Covered (2) Basic \$20,000 Individual \$14,000 Family Annual Maximum Benefit Covered (2) Basic \$20,000 Individual \$14,000 Family Annual Maximum Benefit Covered (2) Basic \$20,000 Individual \$14,000 Family Annual Maximum Benefit Covered (2) Basic \$20,000 Individual \$14,000 Family Annual Maximum Benefit Covered (2) Basic \$20,000 Individual \$14,000 Family Annual Maximum Benefit Covered (2) Basic \$20,000 Individual \$14,000 Family	Inpatient & Outpatient Hospital 7		Subject to Coinsurance			
Medical Imaging & X-Ray Emergency Room & Ambulance Urgent Care Facility Subject to Coinsurance Urgent Care Facility Subject to Coinsurance Durable Medical Equipment Preventive Care Services and Minimum Essential Coverage (MEC) (a) Adult, Women, Child - Immunization, Screenings, & Services MEC not subject to Annual Maximum or Coinsurance Percentages Careington Dental & Vision Discounted Benefits (a) EXTRA ENHANCED BENEFITS Extra Inpatient Hospital & Outpatient Surgery and Professional Services (a) All Other Infusion Therapy Annual Maximum Benefit Covered Assignment Covered See Provisions and Exclusions BASIC & EXTRA ENHANCED BENEFIT SUMMARY Coinsurance on Base Plan (Percentage of Covered Benefits by Plan) See Provisions and Exclusions BASIC & EXTRA ENHANCED BENEFIT SUMMARY Coinsurance on Base Plan (Percentage of Covered Benefits by Plan) Annual Out-of-Pocket Maximum (1) See Source (a) Sea Source (a) Sea Source (a) Sea			·			
Emergency Room & Ambulance Urgent Care Facility Subject to Coinsurance Durable Medical Equipment Preventive Care Services and Minimum Essential Coverage (MEC) (a) Adult, Women, Child - Immunization, Screenings, & Services MEC not subject to Annual Maximum or Coinsurance Percentages Careington Dental & Vision Discounted Benefits (a) EXTRA ENHANCED BENEFITS Extra Inpatient Hospital & Outpatient Surgery and Professional Services (b) & All Other Infusion Therapy Annual Maximum Benefit Covered \$25,000 Individual \$50,000 Family Waiting Period 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 (1) \$7,000 Individual \$14,000 Family Annual Maximum Benefit Covered (2) Basic \$20,000 Individual \$25,000 Individua	Chiropractic Care (Limited to Spinal Adjustments)		Subject to Coinsurance			
Urgent Care Facility Durable Medical Equipment Subject to Coinsurance Preventive Care Services and Minimum Essential Coverage (MEC) Adult, Women, Child - Immunization, Screenings, & Services MEC not subject to Annual Maximum or Coinsurance Percentages Careington Dental & Vision Discounted Benefits Extra Inpatient Hospital & Outpatient Surgery and Professional Services All Other Infusion Therapy 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 \$7,000 Individual \$14,000 Family Annual Maximum Benefit Covered Basic \$20,000 Individual \$14,000 Family Enhanced \$25,000 Individual \$25,000 Indiv	Medical Imaging & X-Ray		Subject to Coinsurance			
Durable Medical Equipment Preventive Care Services and Minimum Essential Coverage (MEC) (a) Adult, Women, Child - Immunization, Screenings, & Services MEC not subject to Annual Maximum or Coinsurance Percentages Careington Dental & Vision Discounted Benefits (a) Extra Inpatient Hospital & Outpatient Surgery and Professional Services (b) Excludes Outpatient Drugs, Kidney Dialysis, Chemo Therapy, & All Other Infusion Therapy Annual Maximum Benefit Covered \$25,000 Individual \$50,000 Family Waiting Period BASIC & EXTRA ENHANCED BENEFIT SUMMARY Coinsurance on Base Plan (Percentage of Covered Benefits by Plan) Annual Out-of-Pocket Maximum (1) Annual Maximum Benefit Covered (2) Basic \$20,000 Individual \$14,000 Family Annual Maximum Benefit Covered (2) Basic \$20,000 Individual Basic \$25,000 Individual \$14,000 Family Enhanced \$25,000 Individual Basic \$20,000 Individual Basic \$40,000 Family Enhanced \$25,000 Individual Basic \$20,000 Individual Basic \$25,000 Individual Basic	Emergency Room & Ambulance		Subject to Coinsurance			
Preventive Care Services and Minimum Essential Coverage (MEC) (a) Adult, Women, Child - Immunization, Screenings, & Services MEC not subject to Annual Maximum or Coinsurance Percentages Careington Dental & Vision Discounted Benefits (a) EXTRA ENHANCED BENEFITS Extra Inpatient Hospital & Outpatient Surgery and Professional Services (b) Excludes Outpatient Drugs, Kidney Dialysis, Chemo Therapy, & All Other Infusion Therapy 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 80% of Next \$10,000 Family Annual Maximum Benefit Covered Basic \$20,000 Individual \$14,000 Family Annual Maximum Benefit Covered (2) Basic \$20,000 Individual Basic \$40,000 Family Enhanced \$55,000 Individual Basic \$40,000 Family Enhanced \$55,000 Individual Basic \$40,000 Family Enhanced \$55,000 Individual Enhanced \$50,000 Family	Urgent Care Facility		Subject to Coinsurance			
Adult, Women, Child - Immunization, Screenings, & Services MEC not subject to Annual Maximum or Coinsurance Percentages Careington Dental & Vision Discounted Benefits EXTRA ENHANCED BENEFITS Extra Inpatient Hospital & Outpatient Surgery and Professional Services Extra Inpatient Drugs, Kidney Dialysis, Chemo Therapy, & All Other Infusion Therapy 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) \$000 of First \$10,000 800 of Next \$10,000 Annual Out-of-Pocket Maximum \$14,000 Family Annual Maximum Benefit Covered Basic \$20,000 Individual \$14,000 Family Enhanced \$25,000 Individual Basic \$40,000 Family Enhanced \$25,000 Individual Enhanced \$50,000 Family	Durable Medical Equipment		Subject to Coinsurance			
Extra Inpatient Hospital & Outpatient Surgery and Professional Services 10 Excludes Outpatient Drugs, Kidney Dialysis, Chemo Therapy, & All Other Infusion Therapy 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 10 \$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	Adult, Women, Child - Immunization, Screenings, & Ser	vices	Preventive Care coverage paid at 100%			
Extra Inpatient Hospital & Outpatient Surgery and Professional Services ① Excludes Outpatient Drugs, Kidney Dialysis, Chemo Therapy, & All Other Infusion Therapy 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 ① \$7,000 Individual \$14,000 Family Annual Maximum Benefit Covered ② Basic \$20,000 Individual Basic \$40,000 Family Enhanced \$25,000 Individual Enhanced \$50,000 Family	Careington Dental & Vision Discounted Benefits 9		Fee Schedule			
Excludes Outpatient Drugs, Kidney Dialysis, Chemo Therapy, & All Other Infusion Therapy 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 Basic \$20,000 Individual Basic \$40,000 Family Enhanced \$25,000 Individual Enhanced \$50,000 Family	EXTRA ENHANCED BENEFITS					
Waiting Period See Provisions and Exclusions BASIC & EXTRA ENHANCED BENEFIT SUMMARY Coinsurance on Base Plan (Percentage of Covered Benefits by Plan) Annual Out-of-Pocket Maximum 11 Annual Maximum Benefit Covered (12) Basic \$20,000 Individual \$14,000 Family Basic \$40,000 Family Enhanced \$25,000 Individual Enhanced \$50,000 Family	Excludes Outpatient Drugs, Kidney Dialysis, Chemo Therap	_	Covered at 100%			
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 1 \$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	Annual Maximum Benefit Covered					
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	Waiting Period		See Provisions and Exclusions			
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	BASIC & EXTRA ENHANCED BENEFIT SU	MMARY				
Annual Maximum Benefit Covered 12 Basic \$20,000 Individual Basic \$40,000 Family Enhanced \$25,000 Individual Enhanced \$50,000 Family	Coinsurance on Base Plan (Percentage of Covered Benef	fits by Plan)				
Basic \$40,000 Family Enhanced \$25,000 Individual Enhanced \$50,000 Family	Annual Out-of-Pocket Maximum (1)		. ,			
Out of Network Coverage See Provisions and Exclusions	Annual Maximum Benefit Covered (12)		Basic Enhanced	\$40,000 \$25,000	Family Individual	
	Out of Network Coverage		See Provisions and Exclusions			