[COMPANY NAME]
Individual
[PLAN NAME]
SCHEDULE OF BENEFITS

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible *Individual Coverage* *Family Coverage*	$ $ [[No benefits are payable to any family member until the family deductible is met] Or [No benefits will be payable for an individual family member until the earlier of when that member's claims reach $[Current fed. MOOP] or the family deductible is met]]	
Out-of-Pocket Maximum *Individual [Coverage]* *Family[Coverage]* (Includes deductible, copayments and coinsurance)	$ $ [No family member satisfies the OOP limit until the family OOP is reached.]	

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult Preventive Visit		
Infant / Pediatric Preventive Visit		
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)		
Specialist Office Visits		
Mental Health and Substance Abuse Office Visit		

[COMPANY NAME]
Individual
[PLAN NAME]
SCHEDULE OF BENEFITS

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)		
Laboratory Services		
Non-Advanced Radiology (X-ray, Diagnostic)		
Prescription Drugs - Retail Pharmacy ***up to 30 day supply per prescription***		
Tier 1		
Tier 2		
Tier 3		
Tier 4		
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per calendar year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per calendar year limit combined for Habilitative speech, physical and occupational therapies.)		
Physical and Occupational Therapy (40 visits per calendar year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per calendar year limit combined for Habilitative physical, occupational and speech therapies.)		
Other Services		
Chiropractic Services (up to 20 visits per calendar year)		
Diabetic Equipment and Supplies		
Durable Medical Equipment (DME)		
Home Health Care Services (up to 100 visits per calendar year)		
Outpatient Services (in a hospital or ambulatory facility)		
Inpatient Services		
Inpatient Hospital Services (including		

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
mental health, substance abuse, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year)		
Emergency and Urgent Care		
Ambulance Services		
Emergency Room		
Urgent Care Centers		
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive		
Basic Services		
Major Services		
Orthodontia Services (medically necessary only)		
Pediatric Vision Care (for children under age 19)		
Prescription Eye Glasses (one pair of frames and lenses or contact lens per calendar year)	Lenses: $0; Collection frame: $0; Non–collection frame: members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	

[COMPANY NAME]
Individual
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Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Routine Eye Exam by Specialist (one exam per calendar year)		