INDIVIDUAL MARKET
Standard Silver Plan – 73%
SCHEDULE OF BENEFITS

| Deductible and Out-of-Pocket Maximum | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|---|---|---|
| **Deductible -** The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible. | | |
| **Plan Deductible**<br>*Individual*<br>*Family* | $2,200 per member<br>$4,400 per family | $6,000 per member<br>$12,000 per family |
| **Separate Prescription Drug Deductible**<br>*Individual*<br>*Family* | $100 per member<br>$200 per family | $350 per member<br>$700 per family |
| **Out-of-Pocket Maximum**<br>*Individual*<br>*Family*<br>(Includes deductible, copayments and coinsurance) | $5,200 per member<br>$10,400 per family | $12,500 per member<br>$25,000 per family |
| **Benefits** | **In-Network (INET) Member Pays** | **Out-of-Network (OON) Member Pays** |
| **Provider Office Visits** | | |
| Adult Preventive Visit | No Cost | 40% coinsurance |
| Infant / Pediatric Preventive Visit | No Cost | 40% coinsurance |
| Primary Care Provider Office Visits<br>(includes services for illness, injury, follow-up care and consultations) | $30 copayment per visit | 40% coinsurance per visit after OON plan deductible is met |
| Specialist Office Visits | $50 copayment per visit | 40% coinsurance per visit after OON plan deductible is met |
| Mental Health and Substance Abuse Office Visit | $30 copayment per visit | 40% coinsurance per visit after OON plan deductible is met |
| **Outpatient Diagnostic Services** | | |



AVC 73.83%

| Deductible and Out-of-Pocket Maximum | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|---|---|---|
| Advanced Radiology (CT/PET Scan, MRI) | $75 copayment per service up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans | 40% coinsurance per service after OON plan deductible is met |
| Laboratory Services | $35 copayment per service | 40% coinsurance per service after OON plan deductible is met |
| Non-Advanced Radiology (X-ray, Diagnostic) | $45 copayment per service | 40% coinsurance per service after OON plan deductible is met |
| Mammography Ultrasound | $20 copayment per service | 40% coinsurance per service after OON plan deductible is met |
| **Prescription Drugs – Retail Pharmacy** ***(30 day supply per prescription)*** | | |
| Tier 1 | $5 copayment per prescription | 40% coinsurance per prescription after OON prescription drug deductible is met |
| Tier 2 | $35 copayment per prescription | 40% coinsurance per prescription after OON prescription drug deductible is met |
| Tier 3 | $55 copayment per prescription | 40% coinsurance per prescription after OON prescription drug deductible is met |
| Tier 4 | 20% coinsurance up to a maximum of $100 per prescription after INET prescription drug deductible is met | 40% coinsurance per prescription after OON prescription drug deductible is met |
| **Outpatient Rehabilitative and Habilitative Services** | | |
| Speech Therapy<br>(40 visits per calendar year limit combined for physical, speech, and occupational therapy) | $30 copayment per visit | 40% coinsurance per visit after OON plan deductible is met |
| Physical and Occupational Therapy<br>(40 visits per calendar year limit combined for physical, speech, and occupational therapy) | $30 copayment per visit | 40% coinsurance per visit after OON plan deductible is met |
| **Other Services** | | |
| Chiropractic Services<br>(up to 20 visits per calendar year) | $50 copayment per visit | 40% coinsurance per visit after OON plan deductible is met |

| Deductible and Out-of-Pocket Maximum | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|---|---|---|
| Diabetic Equipment and Supplies | 40% coinsurance per equipment/supply | 40% coinsurance per visit after OON plan deductible is met |
| Durable Medical Equipment (DME) | 40% coinsurance per equipment/supply | 40% coinsurance per visit after OON plan deductible is met |
| Home Health Care Services<br>(up to 100 visits per calendar year) | No Cost | 25% coinsurance per visit after $50 deductible is met |
| Outpatient Services (in a hospital or ambulatory facility) | $500 copayment per visit after INET plan deductible is met | 40% coinsurance per visit after OON plan deductible is met |
| **Inpatient Hospital Services** | | |
| Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*)<br>*(skilled nursing facility stay is limited to 90 days per calendar year) | $500 copayment per day to a maximum of $2,000 per admission after INET plan deductible is met | 40% coinsurance per visit after OON plan deductible is met |
| **Emergency and Urgent Care** | | |
| Ambulance Services | No Cost | No Cost |
| Emergency Room | $150 copayment per visit | $150 copayment per visit |
| Urgent Care Centers | $75 copayment per visit | 40% coinsurance per visit after OON plan deductible is met |
| **Pediatric Dental Care (for children under age 19)** | | |
| Diagnostic & Preventive | No Cost | 50% coinsurance per visit after OON plan deductible is met |
| Basic Services | 40% coinsurance per visit | 50% coinsurance per visit after OON plan deductible is met |
| Major Services | 50% coinsurance per visit | 50% coinsurance per visit after OON plan deductible is met |
| Orthodontia Services<br>(medically necessary only) | 50% coinsurance per visit | 50% coinsurance per visit after OON plan deductible is met |
| **Pediatric Vision Care** | | |

| Deductible and Out-of-Pocket Maximum | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|---|---|---|
| Prescription Eye Glasses<br>(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. | Not Covered |
| Routine Eye Exam by Specialist<br>(one exam per calendar year) | $50 copayment per visit | 40% coinsurance per visit after OON plan deductible is met |