[COMPANY NAME]
INDIVIDUAL MARKET
[Standard Silver Coinsurance Plan – 94%]
SCHEDULE OF BENEFITS

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible *Individual* *Family*	$0 per member $0 per family	$7,400 per member $14,800 per family
Separate Prescription Drug Deductible *Individual* *Family*	$0 per member $0 per family	$500 per member $1,000 per family
Out-of-Pocket Maximum *Individual* *Family* (Includes deductible, copayments and coinsurance)	$750 per member $1,500 per family	$15,800 per member $31,600 per family

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult Preventive Visit	No Cost	40% coinsurance per visit
Infant / Pediatric Preventive Visit	No Cost	40% coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	20% coinsurance per visit	40% coinsurance per visit after OON plan deductible is met
Specialist Office Visits	20% coinsurance per visit	40% coinsurance per visit after OON plan deductible is met
Mental Health and Substance Abuse Office Visit	20% coinsurance per visit	40% coinsurance per visit after OON plan deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	20% coinsurance per service	40% coinsurance per service after OON plan deductible is met

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Laboratory Services	20% coinsurance per service	40% coinsurance per service after OON plan deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	20% coinsurance per service	40% coinsurance per service after OON plan deductible is met
Mammography Ultrasound	20% coinsurance 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	20% coinsurance per prescription	40% coinsurance per prescription after OON prescription drug deductible is met
Tier 3	20% coinsurance per prescription	40% coinsurance per prescription after OON prescription drug deductible is met
Tier 4	20% coinsurance up to a maximum of $60 per prescription	40% coinsurance per prescription after OON prescription drug deductible is met
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.)	20% coinsurance per visit	40% coinsurance per visit after OON plan deductible is met
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.)	20% coinsurance per visit	40% coinsurance per visit after OON plan deductible is met
Other Services		

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Chiropractic Services (up to 20 visits per calendar year)	20% coinsurance per visit	40% coinsurance per visit after OON plan deductible is met
Diabetic Equipment and Supplies	20% coinsurance per equipment/supply	40% coinsurance per equipment/supply after OON plan deductible is met
Durable Medical Equipment (DME)	20% coinsurance per equipment/supply	40% coinsurance per equipment/supply after OON plan deductible is met
Home Health Care Services (up to 100 visits per calendar year)	25% coinsurance per visit after separate $50 deductible is met	25% coinsurance per visit after separate $50 deductible is met
Outpatient Services **(**in a hospital or ambulatory facility**)**	20% coinsurance per visit	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*) *(skilled nursing facility stay is limited to 90 days per calendar year)	20% coinsurance per admission	40% coinsurance per admission after OON plan deductible is met
Emergency and Urgent Care		
Ambulance Services	20% coinsurance per service	20% coinsurance per service
Emergency Room	20% coinsurance per visit	20% coinsurance per visit
Urgent Care Centers	20% coinsurance 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	30% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Major Services	40% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Orthodontia Services (medically necessary only)	50% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Pediatric Vision Care		

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Prescription Eye Glasses (one pair of frames and lenses or contact lens per calendar year)	20% coinsurance	Not Covered
Routine Eye Exam by Specialist (one exam per calendar year)	20% coinsurance per visit	40% coinsurance per visit after OON plan deductible is met