[COMPANY NAME]
Small Business Health Options Programs (SHOP) MARKET
Standard Bronze HSA Plan – 60%
SCHEDULE OF BENEFITS

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible *Individual* *Family*	$6,000 per member $12,000 per family	$9,200 per member $18,400 per family
Out-of-Pocket Maximum *Individual* *Family* (Includes deductible, copayments and coinsurance)	$6,550 per member $13,100 per family	$12,900 per member $25,800 per family

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult Preventive Visit	No Cost	50% coinsurance
Infant / Pediatric Preventive Visit	No Cost	50% coinsurance
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	10% coinsurance after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Specialist Office Visits	10% coinsurance after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Mental Health and Substance Abuse Office Visit	10% coinsurance after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	10% coinsurance after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
Laboratory Services	10% coinsurance after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology (X-ray, Diagnostic)	10% coinsurance after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
Prescription Drugs – Retail Pharmacy ***(30 day supply per prescription)***		
Tier 1	10% coinsurance after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Tier 2	15% coinsurance after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Tier 3	25% coinsurance after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Tier 4	30% coinsurance up to a maximum of $500 per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per plan 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.)	10% coinsurance after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Physical and Occupational Therapy (40 visits per plan 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.)	10% coinsurance after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Other Services		
Chiropractic Services (up to 20 visits per plan year)	10% coinsurance after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Diabetic Equipment and Supplies	10% coinsurance after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Durable Medical Equipment (DME)	10% coinsurance after INET plan deductible is met	50% coinsurance after OON plan deductible is met
Home Health Care Services	10% coinsurance after INET plan deductible is met	25% coinsurance after OON plan deductible is met

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
(up to 100 visits per plan year)		
Outpatient Services **(**in a hospital or ambulatory facility**)**	10% coinsurance after INET plan deductible is met	50% coinsurance 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 plan year)	10% coinsurance after INET plan deductible is met	50% coinsurance after OON plan deductible is met
Emergency and Urgent Care		
Ambulance Services	10% coinsurance after INET plan deductible is met	10% coinsurance after INET plan deductible is met
Emergency Room	10% coinsurance after INET plan deductible is met	10% coinsurance after INET plan deductible is met
Urgent Care Centers	10% coinsurance after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	50% coinsurance after OON plan deductible is met
Basic Services	40% coinsurance after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Major Services	50% coinsurance after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Orthodontia Services (medically necessary only)	50% coinsurance after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Pediatric Vision Care		
Prescription Eye Glasses (one pair of frames and lenses or contact lens per plan year)	Lenses: $0 copayment after INET plan deductible is met; Collection frame: $0 copayment after INET plan deductible is met; 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

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Routine Eye Exam by Specialist (one exam per plan year)	10% coinsurance after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met