

INDIVIDUAL MARKET  
Standard Bronze HSA Plan – 60%  
SCHEDULE OF BENEFITS

<b>Deductible and Out-of-Pocket Maximum</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-Network (OON) Member Pays</b>
<p><b>Deductible</b> - 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, the entire Family Annual Deductible must be met before any member of the family can receive benefits that are subject to the deductible.</p>		
<p><b>Plan Deductible</b> <i>Individual</i></p>	\$5,300 per member	\$9,200 per member
<p><i>Family</i></p>	\$10,600 per family	\$18,400 per family
<p><b>Out-of-Pocket Maximum</b> <i>Individual</i></p>	\$6,500 per member	\$12,900 per member
<p><i>Family</i>  (Includes deductible, copayments and coinsurance)</p>	\$13,000 per family	\$25,800 per family
<b>Benefits</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-Network (OON) Member Pays</b>
<b>Provider Office Visits</b>		
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
<b>Outpatient Diagnostic Services</b>		
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

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Non-Advanced Radiology (X-ray, Diagnostic)	10% coinsurance after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
<b>Prescription Drugs – Retail Pharmacy (30 day supply per prescription)</b>		
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
<b>Outpatient Rehabilitative and Habilitative Services</b>		
Speech Therapy (40 visits per calendar year limit combined for physical, speech, and occupational therapy)	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 calendar year limit combined for physical, speech, and occupational therapy)	10% coinsurance after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Other Services</b>		
Chiropractic Services (up to 20 visits per calendar 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 (up to 100 visits per calendar year)	10% coinsurance after INET plan deductible is met	25% coinsurance after INET plan deductible is met
Outpatient Services (in a hospital or ambulatory facility)	10% coinsurance after INET plan deductible is met	50% coinsurance after OON plan deductible is met

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<b>Inpatient Hospital Services</b>		
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)	10% coinsurance after INET plan deductible is met	50% coinsurance after OON plan deductible is met
<b>Emergency and Urgent Care</b>		
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
<b>Pediatric Dental Care (for children under age 19)</b>		
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
<b>Pediatric Vision Care</b>		
Prescription Eye Glasses (one pair of frames and lenses or contact lens per calendar 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
Routine Eye Exam by Specialist (one exam per calendar year)	10% coinsurance after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met