

Small Business Health Options Programs (SHOP) MARKET  
Standard Silver Plan – 70%  
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, 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.</p>		
<p><b>Plan Deductible</b> <i>Individual</i></p> <p><i>Family</i></p>	<p>\$3,400 per member</p> <p>\$6,800 per family</p>	<p>\$6,000 per member</p> <p>\$12,000 per family</p>
<p><b>Separate Prescription Drug Deductible</b> <i>Individual</i></p> <p><i>Family</i></p>	<p>\$150 per member</p> <p>\$300 per family</p>	<p>\$350 per member</p> <p>\$700 per family</p>
<p><b>Out-of-Pocket Maximum</b> <i>Individual</i></p> <p><i>Family</i></p> <p>(Includes deductible, copayments and coinsurance)</p>	<p>\$6,850 per member</p> <p>\$13,700 per family</p>	<p>\$12,500 per member</p> <p>\$25,000 per family</p>
<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	40% coinsurance
Infant / Pediatric Preventive Visit	No Cost	40% coinsurance
Primary Care Provider Office Visits (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
<b>Outpatient Diagnostic Services</b>		

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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	\$40 copayment per service	40% coinsurance per service after OON plan deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	\$50 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
<b>Prescription Drugs – Retail Pharmacy (30 day supply per prescription)</b>		
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 \$200 per prescription after INET prescription drug deductible is met	40% coinsurance per prescription after OON prescription drug deductible is met
<b>Outpatient Rehabilitative and Habilitative Services</b>		
Speech Therapy (40 visits per plan 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 (40 visits per plan year limit combined for physical, speech, and occupational therapy)	\$30 copayment per visit	40% coinsurance per visit after OON plan deductible is met
<b>Other Services</b>		
Chiropractic Services (up to 20 visits per plan year)	\$50 copayment per visit	40% coinsurance per visit after OON plan deductible is met
Diabetic Equipment and Supplies	40% coinsurance per equipment/supply	40% coinsurance per visit after OON plan deductible is met

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		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 (up to 100 visits per plan 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
<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 plan 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
<b>Emergency and Urgent Care</b>		
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
<b>Pediatric Dental Care (for children under age 19)</b>		
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 (medically necessary only)	50% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
<b>Pediatric Vision Care</b>		

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Prescription Eye Glasses (one pair of frames and lenses or contact lens per plan 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 (one exam per plan year)	\$50 copayment per visit	40% coinsurance per visit after OON plan deductible is met