

	Gold 500 Direct [†]	Gold 1500 Direct [†]	
	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	\$500 / \$1,000	\$1,500 / \$3,000	\$10,000 / \$20,000
Out-of-Pocket Maximum Individual / Family	\$8,250 / \$16,500	\$7,500 / \$15,000	\$25,000 / \$50,000
Preventive Services	Covered in full		50% after deductible
Preventive Drug Coverage	Covered in full		90% after deductible
Accident Benefit	Covered in full up to \$500, within 90 days of accident		
Office Visits: Primary, Urgent Care, and Specialist	Primary/telehealth combined visits 1–3: \$5 no deductible, visits 4+ and Urgent Care: \$25 no deductible Specialist: \$50 no deductible		50% after deductible
Telehealth			
Inpatient Hospital	30% after deductible	20% after deductible	50% after deductible
Lab / X-ray	30% after deductible	20% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	30% after deductible	20% after deductible	50% after deductible
Outpatient Surgery	30% after deductible	20% after deductible	50% after deductible
Emergency Services	30% after deductible	20% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	\$25 no deductible		50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: \$25 no deductible Tier 2: \$50 no deductible Tier 3 & 4: 30% no deductible	Tier 1: \$25 no deductible Tier 2: \$50 no deductible Tier 3 & 4: 20% no deductible	90% after deductible
Pediatric Eye Exam	Covered in full		Covered in full up to \$40
Pediatric Vision Hardware	Covered in full up to \$150 then subject to in-network deductible and 30%	Covered in full up to \$150 then subject to in-network deductible and 20%	Same as in-network

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[†]Adult vision exam and hardware benefit included on this plan.

Out-of-network services are covered up to an allowed amount. After that amount is reached, members may be subject to balance billing.

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	Silver 3400 Direct	Silver 3900 Direct	Silver 5400 Direct	
	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	\$3,400 / \$6,800	\$3,900 / \$7,800	\$5,400 / \$10,800	\$10,000 / \$20,000
Out-of-Pocket Maximum Individual / Family	\$9,000 / \$18,000	\$8,500 / \$17,000	\$9,200 / \$18,400	\$25,000 / \$50,000
Preventive Services	Covered in full			50% after deductible
Preventive Drug Coverage	Covered in full			90% after deductible
Accident Benefit	Covered in full up to \$500, within 90 days of accident			
Office Visits: Primary, Urgent Care, and Specialist	Primary and Urgent Care: \$50 no deductible Specialist: \$100 no deductible	Primary and Urgent Care: \$30 no deductible Specialist: \$60 no deductible	Primary: \$40 no deductible Urgent Care: \$70 no deductible Specialist: \$80 no deductible	50% after deductible
Telehealth	\$50 no deductible	\$30 no deductible	\$40 no deductible	50% after deductible
Inpatient Hospital	50% after deductible	30% after deductible	30% after deductible	50% after deductible
Lab / X-ray	50% after deductible	30% after deductible	30% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	50% after deductible	30% after deductible	\$40 no deductible if provided in an office setting	50% after deductible
Outpatient Surgery	50% after deductible	30% after deductible	30% after deductible	50% after deductible
Emergency Services	50% after deductible	30% after deductible	30% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	\$50 no deductible	\$30 no deductible	\$40 no deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: \$20 no deductible Tier 2: \$50 no deductible Tier 3 & 4: 50% no deductible	30% after deductible	Tier 1: \$20 no deductible Tier 2: \$50 no deductible Tier 3 & 4: 50% no deductible	90% after deductible
Pediatric Eye Exam	Covered in full			Covered in full up to \$40
Pediatric Vision Hardware	Covered in full up to \$150 then subject to in-network deductible and 50%	Covered in full up to \$150 then subject to in-network deductible and 30%	Covered in full up to \$150 then subject to in-network deductible and 30%	Same as in-network

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	Bronze 7000 Direct	Bronze HSA 8050	
	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	\$7,000 / \$14,000	\$8,050 / \$16,100	\$10,000 / \$20,000
Out-of-Pocket Maximum Individual / Family	\$9,200 / \$18,400	\$8,050 / \$16,100	\$25,000 / \$50,000
Preventive Services	Covered in full		50% after deductible
Preventive Drug Coverage	Covered in full		90% after deductible
Accident Benefit	Covered in full up to \$500, within 90 days of accident		
Office Visits: Primary, Urgent Care, and Specialist	Primary/telehealth combined visits 1–3: \$5 no deductible, visits 4+ and Urgent Care: \$75 no deductible Specialist: \$125 no deductible	0% after deductible	50% after deductible
Telehealth			
Inpatient Hospital	40% after deductible	0% after deductible	50% after deductible
Lab / X-ray	40% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	40% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	40% after deductible	0% after deductible	50% after deductible
Emergency Services	40% after deductible	0% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	\$75 no deductible	0% after deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	40% after deductible	0% after deductible	90% after deductible
Pediatric Eye Exam	Covered in full		Covered in full up to \$40
Pediatric Vision Hardware	Covered in full up to \$150 then subject to in-network deductible and 40%	Covered in full up to \$150 then subject to in-network deductible	Same as in-network

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¹Adult vision exam and hardware benefit included on this plan.

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	Standard Gold	Standard Silver	Standard Bronze	
	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	\$1,500 / \$3,000	\$5,500 / \$11,000	\$9,200 / \$18,400	\$10,000 / \$20,000
Out-of-Pocket Maximum Individual / Family	\$7,000 / \$14,000	\$9,200 / \$18,400	\$9,200 / \$18,400	\$25,000 / \$50,000
Preventive Services	Covered in full			50% after deductible
Preventive Drug Coverage	Covered in full			90% after deductible
Accident Benefit	Not covered			
Office Visits: Primary, Urgent Care, and Specialist	Primary/telehealth combined visits 1–3: \$5 no deductible, visits 4+: \$20 no deductible Urgent Care: \$60 no deductible Specialist: \$40 no deductible	Primary/telehealth combined visits 1–3: \$5 no deductible, visits 4+: \$40 no deductible Urgent Care: \$70 no deductible Specialist: \$80 no deductible	Primary/telehealth combined visits 1–3: \$5 no deductible, visits 4+: \$50 no deductible Urgent Care: \$100 no deductible Specialist: \$150 no deductible	50% after deductible
Telehealth				
Inpatient Hospital	20% after deductible	30% after deductible	0% after deductible	50% after deductible
Lab / X-ray	20% after deductible	30% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	\$20 no deductible if provided in an office setting	\$40 no deductible if provided in an office setting	\$50 no deductible if provided in an office setting	50% after deductible
Outpatient Surgery	20% after deductible	30% after deductible	0% after deductible	50% after deductible
Emergency Services	20% after deductible	30% after deductible	0% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	\$20 no deductible	\$40 no deductible	\$50 no deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: \$10 no deductible Tier 2: \$30 no deductible Tier 3 & 4: 50% no deductible	Tier 1: \$15 no deductible Tier 2: \$60 no deductible Tier 3 & 4: 50% no deductible	Tier 1: \$25 no deductible Tier 2, 3, & 4: 0% after deductible	90% after deductible
Pediatric Eye Exam One exam per benefit period	Covered in full			Covered in full up to \$40
Pediatric Vision Hardware One item per benefit period	Covered in full up to \$150 then subject to in-network deductible and 20%	Covered in full up to \$150 then subject to in-network deductible and 30%	Covered in full up to \$150 then subject to in-network deductible	Same as in-network

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