

	Gold 500 Exchange <sup>†</sup>		Gold 1500 Exchange <sup>†</sup>		
	IN-NETWORK		IN-NETWORK		OUT-OF-NETWORK
<b>Deductible</b> Individual / Family	\$500 / \$1,000		\$1,500 / \$3,000		\$10,000 / \$20,000
<b>Out-of-Pocket Maximum</b> Individual / Family	\$8,250 / \$16,500		\$7,500 / \$15,000		\$25,000 / \$50,000
<b>Preventive Services</b>	Covered in full				50% after deductible
<b>Preventive Drug Coverage</b>	Covered in full				90% after deductible
<b>Accident Benefit</b>	Covered in full up to \$500, within 90 days of accident				
<b>Office Visits: Primary, Urgent Care, and Specialist</b>	Primary and Urgent Care: \$25 no deductible Specialist: \$50 no deductible				50% after deductible
<b>Telehealth</b>	\$25 no deductible				50% after deductible
<b>Inpatient Hospital</b>	30% after deductible		20% after deductible		50% after deductible
<b>Lab / X-ray</b>	30% after deductible		20% after deductible		50% after deductible
<b>Physical, Occupational, and Speech Therapy</b> Combined 30 visits per year	30% after deductible		20% after deductible		50% after deductible
<b>Outpatient Surgery</b>	30% after deductible		20% after deductible		50% after deductible
<b>Emergency Services</b>	30% after deductible		20% after deductible		Same as in-network
<b>Chiropractic / Acupuncture</b> Visits per benefit period: Chiro: 20 / Acu: 12	\$25 no deductible				50% after deductible
<b>Prescription (Rx) Drug Coverage</b> 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
<b>Pediatric Eye Exam</b>	Covered in full				Covered in full up to \$40
<b>Pediatric Vision Hardware</b>	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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<sup>†</sup>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 3500 Exchange	Silver 4000 Exchange	
	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
<b>Deductible</b> Individual / Family	<b>\$3,500 / \$7,000</b>	<b>\$4,000 / \$8,000</b>	<b>\$10,000 / \$20,000</b>
<b>Out-of-Pocket Maximum</b> Individual / Family	<b>\$9,000 / \$18,000</b>	<b>\$8,500 / \$17,000</b>	<b>\$25,000 / \$50,000</b>
<b>Preventive Services</b>	Covered in full		50% after deductible
<b>Preventive Drug Coverage</b>	Covered in full		90% after deductible
<b>Accident Benefit</b>	Covered in full up to \$500, within 90 days of accident		
<b>Office Visits: Primary, Urgent Care, and Specialist</b>	Primary and Urgent Care: \$50 no deductible Specialist: \$100 no deductible	Primary and Urgent Care: \$30 no deductible Specialist: \$60 no deductible	50% after deductible
<b>Telehealth</b>	\$50 no deductible	\$30 no deductible	50% after deductible
<b>Inpatient Hospital</b>	50% after deductible	30% after deductible	50% after deductible
<b>Lab / X-ray</b>	50% after deductible	30% after deductible	50% after deductible
<b>Physical, Occupational, and Speech Therapy</b> Combined 30 visits per year	50% after deductible	30% after deductible	50% after deductible
<b>Outpatient Surgery</b>	50% after deductible	30% after deductible	50% after deductible
<b>Emergency Services</b>	50% after deductible	30% after deductible	Same as in-network
<b>Chiropractic / Acupuncture</b> Visits per benefit period: Chiro: 20 / Acu: 12	\$50 no deductible	\$30 no deductible	50% after deductible
<b>Prescription (Rx) Drug Coverage</b> 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	90% after deductible
<b>Pediatric Eye Exam</b>	Covered in full		Covered in full up to \$40
<b>Pediatric Vision Hardware</b>	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%	Same as in-network

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	Bronze 7000 Exchange	Bronze HSA 8050	
	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
<b>Deductible</b> Individual / Family	<b>\$7,000 / \$14,000</b>	<b>\$8,050 / \$16,100</b>	<b>\$10,000 / \$20,000</b>
<b>Out-of-Pocket Maximum</b> Individual / Family	<b>\$9,200 / \$18,400</b>	<b>\$8,050 / \$16,100</b>	<b>\$25,000 / \$50,000</b>
<b>Preventive Services</b>	Covered in full		50% after deductible
<b>Preventive Drug Coverage</b>	Covered in full		90% after deductible
<b>Accident Benefit</b>	Covered in full up to \$500, within 90 days of accident		
<b>Office Visits: Primary, Urgent Care, and Specialist</b>	Primary and Urgent Care: \$75 no deductible Specialist: \$125 no deductible	0% after deductible	50% after deductible
<b>Telehealth</b>	\$75 no deductible	0% after deductible	50% after deductible
<b>Inpatient Hospital</b>	40% after deductible	0% after deductible	50% after deductible
<b>Lab / X-ray</b>	40% after deductible	0% after deductible	50% after deductible
<b>Physical, Occupational, and Speech Therapy</b> Combined 30 visits per year	40% after deductible	0% after deductible	50% after deductible
<b>Outpatient Surgery</b>	40% after deductible	0% after deductible	50% after deductible
<b>Emergency Services</b>	40% after deductible	0% after deductible	Same as in-network
<b>Chiropractic / Acupuncture</b> Visits per benefit period: Chiro: 20 / Acu: 12	\$75 no deductible	0% after deductible	50% after deductible
<b>Prescription (Rx) Drug Coverage</b> Out-of-network: 30-day max fill, no more than 3 per year	40% after deductible	0% after deductible	90% after deductible
<b>Pediatric Eye Exam</b>	Covered in full		Covered in full up to \$40
<b>Pediatric Vision Hardware</b>	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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	Standard Gold	Standard Silver	Standard Bronze	
	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
<b>Deductible</b> Individual / Family	<b>\$1,500 / \$3,000</b>	<b>\$5,500 / \$11,000</b>	<b>\$9,200 / \$18,400</b>	<b>\$10,000 / \$20,000</b>
<b>Out-of-Pocket Maximum</b> Individual / Family	<b>\$7,000 / \$14,000</b>	<b>\$9,200 / \$18,400</b>	<b>\$9,200 / \$18,400</b>	<b>\$25,000 / \$50,000</b>
<b>Preventive Services</b>	Covered in full			50% after deductible
<b>Preventive Drug Coverage</b>	Covered in full			90% after deductible
<b>Accident Benefit</b>	Not covered			
<b>Office Visits: Primary, Urgent Care, and Specialist</b>	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
<b>Telehealth</b>				
<b>Inpatient Hospital</b>	20% after deductible	30% after deductible	0% after deductible	50% after deductible
<b>Lab / X-ray</b>	20% after deductible	30% after deductible	0% after deductible	50% after deductible
<b>Physical, Occupational, and Speech Therapy</b> 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
<b>Outpatient Surgery</b>	20% after deductible	30% after deductible	0% after deductible	50% after deductible
<b>Emergency Services</b>	20% after deductible	30% after deductible	0% after deductible	Same as in-network
<b>Chiropractic / Acupuncture</b> Visits per benefit period: Chiro: 20 / Acu: 12	\$20 no deductible	\$40 no deductible	\$50 no deductible	50% after deductible
<b>Prescription (Rx) Drug Coverage</b> 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: 50% no deductible Tier 4: 50% no deductible \$500 max/script	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
<b>Pediatric Eye Exam</b> One exam per benefit period	Covered in full			Covered in full up to \$40
<b>Pediatric Vision Hardware</b> 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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