

Standard Silver Cost Sharing Reduction Plan - 87%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Deductible <i>Individual</i> <i>Family</i> <i>(copays are not applied to deductible)</i>	\$500 \$1,000	\$6,000 \$12,000
Out-of-Pocket Maximum <i>Individual</i> <i>Family</i>	\$2,250 \$4,500	\$12,500 \$25,000
Physician Office Visits		
Preventive Care/Screenings/Immunizations	\$0	40% coinsurance
Primary Care (injury or illness)	\$10 copay	40% coinsurance**
Specialist	\$30 copay	40% coinsurance**
Emergency/Urgent Care		
Urgent Care Center or Facility	\$50 copay	40% coinsurance**
Emergency Room	\$100 copay	\$100 copay
Ambulance	\$0	\$0
Hospital Services		
Inpatient	\$250 copay per day to a maximum of \$500 per admission*	40% coinsurance**
Outpatient (performed at hospital or ambulatory facility)	\$250 copay*	40% coinsurance**
Skilled Nursing Facility <i>90 day calendar year maximum</i>	\$250 copay per day to a maximum of \$500 per admission*	40% coinsurance**
Mental Health, Substance Abuse & Behavioral Health Services		
Inpatient	\$250 copay per day to a maximum of \$500 per admission*	40% coinsurance**
Outpatient	\$10 copay	40% coinsurance**
Hospice Care		
Hospice Services	\$0	40% coinsurance**
Outpatient Services		
Home Health Care <i>100 visit calendar year maximum</i>	\$0	25% coinsurance subject to a \$50 deductible
Advanced Radiology (CT/PET Scan, MRI)	\$75 copay per service up to a combined calendar year maximum of \$375 for MRI and CT scans; \$400 for PET scans	40% coinsurance**
Non-Advanced Radiology (X-ray, Diagnostic)	\$30 copay	40% coinsurance**

*After in-network deductible is met

**After out-of-network deductible is met

Standard Silver Cost Sharing Reduction Plan - 87%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Outpatient Services		
Laboratory Services	\$10 copay	40% coinsurance**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) <i>combined 40 visit calendar year maximum</i>	\$10 copay	40% coinsurance**
Chiropractic Care <i>20 visit calendar maximum</i>	\$30 copay	40% coinsurance**
Other Services		
Durable Medical Equipment	40% coinsurance	40% coinsurance**
Prosthetics	40% coinsurance	40% coinsurance**
Diabetic Supplies & Equipment	40% coinsurance	40% coinsurance**
Prescription Drugs		
Generic Drugs	\$5 copay	40% coinsurance**
Preferred Brand Drugs	\$15 copay	40% coinsurance**
Non-Preferred Brand Drugs	\$30 copay	40% coinsurance**
Specialty Drugs	\$40 copay	40% coinsurance**

Pediatric-Only Services (for children under age 19)

Pediatric Dental Care		
Diagnostic & Preventive	\$0	50% coinsurance**
Basic Restorative	20% coinsurance	50% coinsurance**
Major Restorative	40% coinsurance	50% coinsurance**
Orthodontia Services <i>medically necessary only</i>	50% coinsurance	50% coinsurance**
Pediatric Vision Care		
Routine Eye Exam	\$10 copay	40% coinsurance
Prescription Eye Glasses <i>one pair of frames & lenses per calendar year</i>	lenses: \$0 collection frames: \$0 non-collection frames: \$0 up to a \$150 allowance; any amount over the \$150 allowance is payable by the member minus a 20% discount	lenses: \$0 frames: \$0 up to a \$30 allowance; any amount over the allowance is payable by the member

*After in-network deductible is met

**After out-of-network deductible is met