

Standard Silver Cost Sharing Reduction Plan - 94%

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>	\$0 \$0	\$6,000 \$12,000
Out-of-Pocket Maximum <i>Individual</i> <i>Family</i>	\$2,000 \$4,000	\$12,500 \$25,000
Physician Office Visits		
Preventive Care/Screenings/Immunizations	\$0	40% coinsurance
Primary Care (injury or illness)	\$5 copay	40% coinsurance*
Specialist	\$15 copay	40% coinsurance*
Emergency/Urgent Care		
Urgent Care Center or Facility	\$50 copay	40% coinsurance*
Emergency Room	\$75 copay	\$75 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	\$5 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)	\$50 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)	\$15 copay	40% coinsurance*

*After out-of-network deductible is met

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Outpatient Services		
Laboratory Services	\$5 copay	40% coinsurance*
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) <i>combined 40 visit calendar year maximum</i>	\$5 copay	40% coinsurance*
Chiropractic Care <i>20 visit calendar maximum</i>	\$15 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	\$5 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 out-of-network deductible is met