

Standard Bronze Plan 2 - 60%

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>	\$6,250 \$12,500	\$6,500 \$13,000
Out-of-Pocket Maximum <i>Individual</i> <i>Family</i>	\$6,250 \$12,500	\$12,500 \$25,000
Physician Office Visits		
Preventive Care/Screenings/Immunizations	\$0	50% coinsurance
Primary Care (injury or illness)	\$30 copay for the first 3 visits (deductible waived); thereafter deductible applies***	50% coinsurance**
Specialist	\$0*	50% coinsurance**
Emergency/Urgent Care		
Urgent Care Center or Facility	\$0*	50% coinsurance**
Emergency Room	\$0*	\$0*
Ambulance	\$0*	\$0*
Hospital Services		
Inpatient	\$0*	50% coinsurance**
Outpatient (performed at hospital or ambulatory facility)	\$0*	50% coinsurance**
Skilled Nursing Facility <i>90 day calendar year maximum</i>	\$0*	50% coinsurance**
Mental Health, Substance Abuse & Behavioral Health Services		
Inpatient	\$0*	50% coinsurance**
Outpatient	\$30 copay for the first 3 visits (deductible waived); thereafter deductible applies***	50% coinsurance**
Hospice Care		
Hospice Services	\$0*	50% coinsurance**
Outpatient Services		
Home Health Care <i>100 visit calendar year maximum</i>	25% coinsurance subject to a \$50 deductible	25% coinsurance subject to a \$50 deductible
Advanced Radiology (CT/PET Scan, MRI)	\$0*	50% coinsurance**
Non-Advanced Radiology (X-ray, Diagnostic)	\$0*	50% coinsurance**

*After in-network deductible is met

**After out-of-network deductible is met

***3 visit copay limit is combined for mental health visits and primary care visits

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	In-Network Member Pays	Out-of-Network Member Pays
Outpatient Services		
Laboratory Services	\$0*	50% coinsurance**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) <i>combined 40 visit calendar year maximum</i>	\$0*	50% coinsurance**
Chiropractic Care <i>20 visit calendar maximum</i>	\$0*	50% coinsurance**
Other Services		
Durable Medical Equipment	\$0*	50% coinsurance**
Prosthetics	\$0*	50% coinsurance**
Diabetic Supplies & Equipment	\$0*	50% coinsurance**
Prescription Drugs		
Generic Drugs	\$0*	50% coinsurance**
Preferred Brand Drugs	\$0*	50% coinsurance**
Non-Preferred Brand Drugs	\$0*	50% coinsurance**
Specialty Drugs	\$0*	50% coinsurance**

Pediatric-Only Services (for children under age 19)

Pediatric Dental Care		
Diagnostic & Preventive	\$0*	50% coinsurance**
Basic Restorative	\$0*	50% coinsurance**
Major Restorative	\$0*	50% coinsurance**
Orthodontia Services <i>medically necessary only</i>	\$0*	50% coinsurance**
Pediatric Vision Care		
Routine Eye Exam	\$0*	50% 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