

Standard Silver Plan - 70%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Medical Deductible <i>Individual</i> <i>Family</i> <i>(copays are not applied to deductible)</i>	\$3,000 \$6,000	\$6,000 \$12,000 deductibles are combined
Prescription Drug Deductible <i>Individual</i> <i>Family</i> <i>(copays are not applied to deductible)</i>	\$400 \$800	
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	40% coinsurance
Primary Care (injury or illness)	\$30 copay	40% coinsurance**
Specialist	\$45 copay	40% coinsurance**
Emergency/Urgent Care		
Urgent Care Center or Facility	\$75 copay	40% coinsurance**
Emergency Room	\$150 copay	\$150 copay
Ambulance	\$0	\$0
Hospital Services		
Inpatient	\$500 copay per day to a maximum of \$2,000 per admission*	40% coinsurance**
Outpatient (performed at hospital or ambulatory facility)	\$500 copay*	40% coinsurance**
Skilled Nursing Facility <i>90 day calendar year maximum</i>	\$500 copay per day to a maximum of \$2,000 per admission*	40% coinsurance**
Mental Health, Substance Abuse & Behavioral Health Care		
Mental Health, Substance Abuse & Behavioral Health Services	Covered same as any other illness	Covered same as any other illness
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**

*After in-network medical deductible is met

**After out-of-network deductible is met

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Outpatient Services		
Non-Advanced Radiology (X-ray, Diagnostic)	\$45 copay	40% coinsurance**
Laboratory Services	\$30 copay	40% coinsurance**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) <i>combined 40 visit calendar year maximum</i>	\$30 copay	40% coinsurance**
Chiropractic Care <i>20 visit calendar maximum</i>	\$45 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	\$10 copay	40% coinsurance**
Preferred Brand Drugs	\$25 copay***	40% coinsurance**
Non-Preferred Brand Drugs	\$40 copay***	40% coinsurance**
Specialty Drugs	40% coinsurance***	40% coinsurance**

Pediatric-Only Services (for children under age 19)

Pediatric Dental Care		
Diagnostic & Preventive (Oral Exam, Cleaning, X-ray)	\$0	50% coinsurance**
Basic Restorative (Filling, Simple Extraction)	40% coinsurance	50% coinsurance**
Major Restorative (Endodontic, Crown)	50% coinsurance	50% coinsurance**
Orthodontia Services <i>medically necessary only</i>	50% coinsurance	50% coinsurance**
Pediatric Vision Care		
Routine Eye Exam	\$30 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 medical deductible is met

**After out-of-network deductible is met

***After in-network prescription drug deductible is met