

Pathfinder 2020

BRONZE PLAN

	IN-NETWORK	OUT-OF-NETWORK	AGE	TOBACCO	TOBACCO
BENEFIT	INSURED RESPONSIBILITY	INSURED RESPONSIBILITY	14 & under	FREE \$187.78	N/A
		Individual	15	\$204.47	N/A
CALENDAR YEAR DEDUCTIBLE		O Family	16	\$210.85	N/A
	· · ·	·	17	\$217.24	N/A
COINSURANCE	N/A	50% coinsurance after deductible	18	\$224.11	\$336.17
641 ENDAR VIII	\$7,900 Individual	N/A	19	\$230.12	\$345.18
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	\$15.800 Family	N/A	20	\$236.34	\$354.51
	\$15,000 Tulliny	14/7	21	\$242.75	\$364.13
OUTPATIENT SERVICES			22	\$243.61	\$365.42
Direct Primary Care (DPC*)	\$0 copay	N/A	23	\$244.49	\$366.74
Office Visit			24	\$245.37	\$368.06
Non-Direct Primary Care (PCP*)	Covered at 100% after	50% coinsurance after deductible	25	\$247.49	\$371.24
	deductible		26	\$252.61	\$378.92
Specialist Office Visit	Covered at 100% after deductible	50% coinsurance after deductible 50% coinsurance after deductible	27	\$258.50	\$387.75
			28	\$267.20	\$400.80
Laboratory/X-Ray Services	\$100 copay		29	\$274.65	\$411.98
CT/PET/MRI/MRA/	Covered at 100%	Not covered	30	\$275.00	\$412.50
Nuclear Medicine	after deductible	Not covered	31	\$284.50	\$426.75
Surgical Procedures in selected	\$0 copay	N/A	32	\$289.85	\$434.78
DPC* Office	\$0 copay	IN/A	33	\$293.55	\$440.33
Surgical Procedures in	Covered at 100%	50% coinsurance	34	\$297.45	\$446.18
other Physician's office	after deductible	after deductible	35	\$299.88	\$449.82
Outpatient Facility (e.g.	Covered at 100%	Not covered	36	\$302.31	\$453.47
ambulatory surgery center)	after deductible	TWOL COVERED	37	\$304.76	\$457.14
Pre-Natal & Post-Natal Obstetrical Care	¢25	Not covered	38	\$307.22	\$460.83
	\$25 copay		39	\$311.18	\$466.77
Outpatient Mental Health Treatment	Covered at 100% after deductible	Not covered	40	\$315.15	\$472.73
			41	\$322.33	\$483.50
			42	\$329.44	\$494.16
Rehabilitation Services, Speech, Occupational & Physical Therapy	Covered at 100% after deductible	Not covered	43	\$338.30	\$507.45
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INPATIENT SERVICES			45	\$360.60	\$540.90
Hospital Confinement	Covered at 100% after deductible	50% coinsurance after deductible	46	\$374.70	\$562.05
			47	\$390.25	\$585.38
			48	\$407.61	\$611.42
PRESCRIPTION DRUGS (30-DAY SUPPLY)			49	\$424.96	\$637.44
Preventive Meds	\$15 copay not subject	Not covered	50	\$444.13	\$666.20
	to deductible	AL .	51	\$463.30	\$694.95
Generic	Covered at 100% after deductible	Not covered	52	\$484.14	\$726.21
Preferred Brand	Covered at 100%	Not covered	53	\$505.34	\$758.01
	after deductible		54	\$528.03	\$792.05
Non-Preferred Brand	Covered at 100% after deductible	Not covered	55	\$550.94	\$826.41
Specialty	Covered at 100% after deductible	Not covered	56	\$575.53	\$863.30
			57	\$600.53	\$900.80
EMERGENCY CARE SERVICES			58	\$627.06	\$940.59
Emergency Room Visit	Covered at 100% after deductible	50% coinsurance after deductible	59	\$643.45	\$965.18
			60	\$670.46	\$1,005.69
Emergency Medical Transportation	Covered at 100% after deductible	50% coinsurance after deductible	61	\$693.27	\$1,039.91
			62	\$710.13	\$1,065.20
Urgent Care Visit	Covered at 100% after deductible	50% coinsurance after deductible	63	\$730.09	\$1,095.14
3			64	\$744.48	\$1,116.72

PCP: Primary Care Physician

Got questions: 1-866-432-7887

DPC: Direct Primary Care



Virtual Pathfinder

2020

BRONZE PLAN

	IN-NETWORK	OUT-OF-NETWORK	AGE	TOBACCO	TOBACCO
BENEFIT	INSURED	INSURED		FREE	USERS
	RESPONSIBILITY	RESPONSIBILITY	14 & under	\$163.25	N/A
CALENDAR YEAR	\$7,900	Individual	15	\$177.77	N/A
DEDUCTIBLE	\$15,80	0 Family	16	\$183.31	N/A
COINSURANCE	N/A	50% coinsurance	17	\$188.86	N/A
		after deductible	18	\$194.84	\$292.26
CALENDAR YEAR	\$7,900 Individual	N/A	19	\$200.41	\$300.62
OUT-OF-POCKET MAXIMUM	\$15,800 Family	N/A	20	\$206.18	\$309.27
OUTPATIENT SERVICES			21	\$212.14	\$318.21
	\$0 copay	N/A	22	\$212.55	\$318.83
Virtual direct primary care (VDPC*) visit			23	\$212.95	\$319.43
Preventative care / screening /	\$0 copay	Not covered	24	\$213.37	\$320.06
immunization	φο σοραγ	TVOL COVETCO	25	\$214.75	\$322.13
Non-direct primary	Covered at 100%	50% coinsurance	26	\$219.11	\$328.67
care (PCP*)	after deductible	after deductible	27	\$224.23	\$336.35
Specialist office visit	Covered at 100%	50% coinsurance after deductible	28	\$232.15	\$348.23
	after deductible		29	\$238.79	\$358.19
Laboratory/X-Ray	\$100 copay	50% coinsurance	30	\$238.31	\$357.47
services		after deductible	31	\$247.34	\$371.01
CT/PET/MRI/MRA/Nuclear	Covered at 100%	Not covered	32	\$252.21	\$378.32
medicine	after deductible		33	\$255.42	\$383.13
Surgical Procedures in	Covered at 100%	50% coinsurance	34	\$258.82	\$388.23
PCP office	after deductible	after deductible	35	\$260.74	\$391.11
Outpatient Facility (e.g.	Covered at 100%	Not covered	36	\$262.67	\$394.01
ambulatory surgery center)	after deductible		37	\$264.60	\$396.90
Pre-Natal & Post-Natal	\$25 copay	Not covered	38	\$266.54	\$399.81
Obstetrical Care			39	\$269.97	\$404.96
Outpatient Mental Health	Covered at 100% after deductible	Not covered	40	\$273.40	\$410.10
Treatment			41	\$279.13	\$418.70
Rehabilitation Services, Speech, Occupational & Physical Therapy	Covered at 100% after deductible	Not covered	42	\$284.72	\$427.08
		Not covered	43	\$292.02	\$438.03
				\$300.85	\$451.28
INPATIENT SERVICES			45	\$311.02	\$466.53
Hospital Confinement	Covered at 100% after deductible	50% coinsurance after deductible	46	\$323.14	\$484.71
			47	\$336.62	\$504.93
PRESCRIPTION DRUGS (30-DAY SUPPLY)			48	\$351.84	\$527.76
	\$15 copay not subject to deductible	Not covered	49	\$366.96	\$550.44
Preventive Meds		Not covered	50	\$383.81	\$575.72
Generic	Covered at 100%	Not covered	51	\$400.57	\$600.86
	after deductible		52	\$418.89	\$628.34
Preferred Brand	Covered at 100% after deductible	Not covered	53	\$437.49	\$656.24
Non-Preferred Brand	Covered at 100%	Not covered	54	\$457.47	\$686.21
Specialty	after deductible Covered at 100% after deductible	Not covered	55	\$477.55	\$716.33
			56	\$499.21	\$748.82
			57	\$521.15	\$781.73
EMERGENCY CARE SERVICES			58	\$544.51	\$816.77
Emergency Room Visit	Covered at 100% after deductible	50% coinsurance after deductible	59	\$557.59	\$836.39
			60	\$581.17	\$871.76
Emergency Medical Transportation	Covered at 100% after deductible	50% coinsurance after deductible	61	\$601.31	\$901.97
			62	\$615.40	\$1,065.11
Urgent Care Visit	Covered at 100% after deductible	50% coinsurance after deductible	63	\$632.52	\$1,097.07
			64	\$643.99	\$1,129.98

PCP: Primary Care Physician VDPC: Virtual Direct Primary Care

Got questions: 1-866-432-7887