Decent

Pathfinder 2020

BRONZE PLAN

BENEFIT	IN-NETWORK INSURED RESPONSIBILITY	OUT-OF-NETWORK INSURED RESPONSIBILITY
CALENDAR YEAR DEDUCTIBLE	$7,900 Individual $15,800 Family	
COINSURANCE	N/A	50% coinsurance after deductible
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	$7,900 Individual $15,800 Family	N/A N/A
OUTPATIENT SERVICES		
Direct Primary Care (DPC*) Office Visit	$0 copay	N/A
Non-Direct Primary Care (PCP*)	Covered at 100% after deductible	50% coinsurance after deductible
Specialist Office Visit	Covered at 100% after deductible	50% coinsurance after deductible
Laboratory/X-Ray Services	$100 copay	50% coinsurance after deductible
CT/PET/MRI/MRA/ Nuclear Medicine	Covered at 100% after deductible	Not covered
Surgical Procedures in selected DPC* Office	$0 copay	N/A
Surgical Procedures in other Physician's office	Covered at 100% after deductible	50% coinsurance after deductible
Outpatient Facility (e.g. ambulatory surgery center)	Covered at 100% after deductible	Not covered
Pre-Natal & Post-Natal Obstetrical Care	$25 copay	Not covered
Outpatient Mental Health Treatment	Covered at 100% after deductible	Not covered
Rehabilitation Services, Speech, Occupational & Physical Therapy	Covered at 100% after deductible	Not covered
INPATIENT SERVICES		
Hospital Confinement	Covered at 100% after deductible	50% coinsurance after deductible
PRESCRIPTION DRUGS (30-DAY SUPPLY)		
Preventive Meds	$15 copay not subject to deductible	Not covered
Generic	Covered at 100% after deductible	Not covered
Preferred Brand	Covered at 100% after deductible	Not covered
Non-Preferred Brand	Covered at 100% after deductible	Not covered
Specialty	Covered at 100% after deductible	Not covered
EMERGENCY CARE SERVICES		
Emergency Room Visit	Covered at 100% after deductible	50% coinsurance after deductible
Emergency Medical Transportation	Covered at 100% after deductible	50% coinsurance after deductible
Urgent Care Visit	Covered at 100% after deductible	50% coinsurance after deductible

PCP: Primary Care Physician **DPC:** Direct Primary Care

Got questions: 1-866-432-7887

AGE	TOBACCO FREE	TOBACCO USERS
14 & under	$187.78	N/A
15	$204.47	N/A
16	$210.85	N/A
17	$217.24	N/A
18	$224.11	$336.17
19	$230.12	$345.18
20	$236.34	$354.51
21	$242.75	$364.13
22	$243.61	$365.42
23	$244.49	$366.74
24	$245.37	$368.06
25	$247.49	$371.24
26	$252.61	$378.92
27	$258.50	$387.75
28	$267.20	$400.80
29	$274.65	$411.98
30	$275.00	$412.50
31	$284.50	$426.75
32	$289.85	$434.78
33	$293.55	$440.33
34	$297.45	$446.18
35	$299.88	$449.82
36	$302.31	$453.47
37	$304.76	$457.14
38	$307.22	$460.83
39	$311.18	$466.77
40	$315.15	$472.73
41	$322.33	$483.50
42	$329.44	$494.16
43	$338.30	$507.45
44	$348.75	$523.13
45	$360.60	$540.90
46	$374.70	$562.05
47	$390.25	$585.38
48	$407.61	$611.42
49	$424.96	$637.44
50	$444.13	$666.20
51	$463.30	$694.95
52	$484.14	$726.21
53	$505.34	$758.01
54	$528.03	$792.05
55	$550.94	$826.41
56	$575.53	$863.30
57	$600.53	$900.80
58	$627.06	$940.59
59	$643.45	$965.18
60	$670.46	$1,005.69
61	$693.27	$1,039.91
62	$710.13	$1,065.20
63	$730.09	$1,095.14
64	$744.48	$1,116.72

Decent

Virtual Pathfinder 2020

BRONZE PLAN

BENEFIT	IN-NETWORK INSURED RESPONSIBILITY	OUT-OF-NETWORK INSURED RESPONSIBILITY
CALENDAR YEAR DEDUCTIBLE	$7,900 Individual	
	$15,800 Family	
COINSURANCE	N/A	50% coinsurance after deductible
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	$7,900 Individual	N/A
	$15,800 Family	N/A
OUTPATIENT SERVICES		
Virtual direct primary care (VDPC*) visit	$0 copay	N/A
Preventative care / screening / immunization	$0 copay	Not covered
Non-direct primary care (PCP*)	Covered at 100% after deductible	50% coinsurance after deductible
Specialist office visit	Covered at 100% after deductible	50% coinsurance after deductible
Laboratory/X-Ray services	$100 copay	50% coinsurance after deductible
CT/PET/MRI/MRA/Nuclear medicine	Covered at 100% after deductible	Not covered
Surgical Procedures in PCP office	Covered at 100% after deductible	50% coinsurance after deductible
Outpatient Facility (e.g. ambulatory surgery center)	Covered at 100% after deductible	Not covered
Pre-Natal & Post-Natal Obstetrical Care	$25 copay	Not covered
Outpatient Mental Health Treatment	Covered at 100% after deductible	Not covered
Rehabilitation Services, Speech, Occupational & Physical Therapy	Covered at 100% after deductible	Not covered
INPATIENT SERVICES		
Hospital Confinement	Covered at 100% after deductible	50% coinsurance after deductible
PRESCRIPTION DRUGS (30-DAY SUPPLY)		
Preventive Meds	$15 copay not subject to deductible	Not covered
Generic	Covered at 100% after deductible	Not covered
Preferred Brand	Covered at 100% after deductible	Not covered
Non-Preferred Brand	Covered at 100% after deductible	Not covered
Specialty	Covered at 100% after deductible	Not covered
EMERGENCY CARE SERVICES		
Emergency Room Visit	Covered at 100% after deductible	50% coinsurance after deductible
Emergency Medical Transportation	Covered at 100% after deductible	50% coinsurance after deductible
Urgent Care Visit	Covered at 100% after deductible	50% coinsurance after deductible

PCP: Primary Care Physician

VDPC: Virtual Direct Primary Care

Got questions: 1-866-432-7887

AGE	TOBACCO FREE	TOBACCO USERS
14 & under	$163.25	N/A
15	$177.77	N/A
16	$183.31	N/A
17	$188.86	N/A
18	$194.84	$292.26
19	$200.41	$300.62
20	$206.18	$309.27
21	$212.14	$318.21
22	$212.55	$318.83
23	$212.95	$319.43
24	$213.37	$320.06
25	$214.75	$322.13
26	$219.11	$328.67
27	$224.23	$336.35
28	$232.15	$348.23
29	$238.79	$358.19
30	$238.31	$357.47
31	$247.34	$371.01
32	$252.21	$378.32
33	$255.42	$383.13
34	$258.82	$388.23
35	$260.74	$391.11
36	$262.67	$394.01
37	$264.60	$396.90
38	$266.54	$399.81
39	$269.97	$404.96
40	$273.40	$410.10
41	$279.13	$418.70
42	$284.72	$427.08
43	$292.02	$438.03
44	$300.85	$451.28
45	$311.02	$466.53
46	$323.14	$484.71
47	$336.62	$504.93
48	$351.84	$527.76
49	$366.96	$550.44
50	$383.81	$575.72
51	$400.57	$600.86
52	$418.89	$628.34
53	$437.49	$656.24
54	$457.47	$686.21
55	$477.55	$716.33
56	$499.21	$748.82
57	$521.15	$781.73
58	$544.51	$816.77
59	$557.59	$836.39
60	$581.17	$871.76
61	$601.31	$901.97
62	$615.40	$1,065.11
63	$632.52	$1,097.07
64	$643.99	$1,129.98