



BRONZE PLAN

BENEFIT	IN-NETWORK	OUT-OF-NETWORK	AGE	TOBACCO FREE	TOBACCO USERS
	INSURED RESPONSIBILITY	INSURED RESPONSIBILITY			
CALENDAR YEAR DEDUCTIBLE	\$7,900 Individual \$15,800 Family		14 & under	\$163.25	N/A
COINSURANCE	N/A	50% coinsurance after deductible	15	\$177.77	N/A
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	\$7,900 Individual \$15,800 Family	N/A	16	\$183.31	N/A
OUTPATIENT SERVICES			17	\$188.86	N/A
Virtual direct primary care (VDPC*) visit	\$0 copay	N/A	18	\$194.84	\$292.26
Preventative care / screening / immunization	\$0 copay	Not covered	19	\$200.41	\$300.62
Non-direct primary care (PCP*)	Covered at 100% after deductible	50% coinsurance after deductible	20	\$206.18	\$309.27
Specialist office visit	Covered at 100% after deductible	50% coinsurance after deductible	21	\$212.14	\$318.21
Laboratory/X-Ray services	\$100 copay	50% coinsurance after deductible	22	\$212.55	\$318.83
CT/PET/MRI/MRA/Nuclear medicine	Covered at 100% after deductible	Not covered	23	\$212.95	\$319.43
Surgical Procedures in PCP office	Covered at 100% after deductible	50% coinsurance after deductible	24	\$213.37	\$320.06
Outpatient Facility (e.g. ambulatory surgery center)	Covered at 100% after deductible	Not covered	25	\$214.75	\$322.13
Pre-Natal & Post-Natal Obstetrical Care	\$25 copay	Not covered	26	\$219.11	\$328.67
Outpatient Mental Health Treatment	Covered at 100% after deductible	Not covered	27	\$224.23	\$336.35
Rehabilitation Services, Speech, Occupational & Physical Therapy	Covered at 100% after deductible	Not covered	28	\$232.15	\$348.23
INPATIENT SERVICES			29	\$238.79	\$358.19
Hospital Confinement	Covered at 100% after deductible	50% coinsurance after deductible	30	\$238.31	\$357.47
PRESCRIPTION DRUGS (30-DAY SUPPLY)			31	\$247.34	\$371.01
Preventive Meds	\$15 copay not subject to deductible	Not covered	32	\$252.21	\$378.32
Generic	Covered at 100% after deductible	Not covered	33	\$255.42	\$383.13
Preferred Brand	Covered at 100% after deductible	Not covered	34	\$258.82	\$388.23
Non-Preferred Brand	Covered at 100% after deductible	Not covered	35	\$260.74	\$391.11
Specialty	Covered at 100% after deductible	Not covered	36	\$262.67	\$394.01
EMERGENCY CARE SERVICES			37	\$264.60	\$396.90
Emergency Room Visit	Covered at 100% after deductible	50% coinsurance after deductible	38	\$266.54	\$399.81
Emergency Medical Transportation	Covered at 100% after deductible	50% coinsurance after deductible	39	\$269.97	\$404.96
Urgent Care Visit	Covered at 100% after deductible	50% coinsurance after deductible	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

PCP: Primary Care Physician

VDPC: Virtual Direct Primary Care

Got questions: 1-866-432-7887

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	INSURED RESPONSIBILITY	INSURED RESPONSIBILITY			
CALENDAR YEAR DEDUCTIBLE	\$7,900 Individual \$15,800 Family		14 & under	\$187.78	N/A
COINSURANCE	N/A	50% coinsurance after deductible	15	\$204.47	N/A
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	\$7,900 Individual \$15,800 Family	N/A	16	\$210.85	N/A
OUTPATIENT SERVICES			17	\$217.24	N/A
Direct Primary Care (DPC*) Office Visit	\$0 copay	N/A	18	\$224.11	\$336.17
Non-Direct Primary Care (PCP*)	Covered at 100% after deductible	50% coinsurance after deductible	19	\$230.12	\$345.18
Specialist Office Visit	Covered at 100% after deductible	50% coinsurance after deductible	20	\$236.34	\$354.51
Laboratory/X-Ray Services	\$100 copay	50% coinsurance after deductible	21	\$242.75	\$364.13
CT/PET/MRI/MRA/Nuclear Medicine	Covered at 100% after deductible	Not covered	22	\$243.61	\$365.42
Surgical Procedures in selected DPC* Office	\$0 copay	N/A	23	\$244.49	\$366.74
Surgical Procedures in other Physician's office	Covered at 100% after deductible	50% coinsurance after deductible	24	\$245.37	\$368.06
Outpatient Facility (e.g. ambulatory surgery center)	Covered at 100% after deductible	Not covered	25	\$247.49	\$371.24
Pre-Natal & Post-Natal Obstetrical Care	\$25 copay	Not covered	26	\$252.61	\$378.92
Outpatient Mental Health Treatment	Covered at 100% after deductible	Not covered	27	\$258.50	\$387.75
Rehabilitation Services, Speech, Occupational & Physical Therapy	Covered at 100% after deductible	Not covered	28	\$267.20	\$400.80
INPATIENT SERVICES			29	\$274.65	\$411.98
Hospital Confinement	Covered at 100% after deductible	50% coinsurance after deductible	30	\$275.00	\$412.50
PRESCRIPTION DRUGS (30-DAY SUPPLY)			31	\$284.50	\$426.75
Preventive Meds	\$15 copay not subject to deductible	Not covered	32	\$289.85	\$434.78
Generic	Covered at 100% after deductible	Not covered	33	\$293.55	\$440.33
Preferred Brand	Covered at 100% after deductible	Not covered	34	\$297.45	\$446.18
Non-Preferred Brand	Covered at 100% after deductible	Not covered	35	\$299.88	\$449.82
Specialty	Covered at 100% after deductible	Not covered	36	\$302.31	\$453.47
EMERGENCY CARE SERVICES			37	\$304.76	\$457.14
Emergency Room Visit	Covered at 100% after deductible	50% coinsurance after deductible	38	\$307.22	\$460.83
Emergency Medical Transportation	Covered at 100% after deductible	50% coinsurance after deductible	39	\$311.18	\$466.77
Urgent Care Visit	Covered at 100% after deductible	50% coinsurance after deductible	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

PCP: Primary Care Physician

DPC: Direct Primary Care

Got questions: 1-866-432-7887