Decent

Virtual Trailblazer 2020

SILVER PLAN

BENEFIT	IN-NETWORK INSURED RESPONSIBILITY	OUT-OF-NETWORK INSURED RESPONSIBILITY
CALENDAR YEAR DEDUCTIBLE	$4,500 Individual	
	$9,000 Family	
COINSURANCE	N/A	50% coinsurance after deductible
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	$7,150 Individual	N/A
	$14,300 Family	N/A
OUTPATIENT SERVICES		
Virtual primary care (VDPC*) visit	$0 copay	N/A
Non-direct primary care (PCP*)	$50 copay (with referral)	50% coinsurance after deductible
Prevantitive care / Screening / Immunization	$0 copay	Not covered
Specialist office visit	$50 copay	50% coinsurance after deductible
Laboratory/X-Ray services	$100 copay	50% coinsurance after deductible
CT/PET/MRI/MRA/Nuclear Medicine	$100 copay after deductible	Not covered
Surgical Procedures in PCP* Office	$50 copay	50% coinsurance after deductible
Outpatient Facility (e.g. ambulatory surgery center)	$500 copay after deductible	Not covered
Pre-Natal & Post-Natal Obstetrical Care	$25 copay	50% coinsurance after deductible
Outpatient Mental Health Treatment	$50 copay	Not covered
Rehabilitation Services, Speech, Occupational & Physical Therapy	$50 copay	Not covered
INPATIENT SERVICES		
Hospital Confinement	$300 copay per day after deductible	50% coinsurance after deductible
Obstetrical services (delivery & all patient services)	$1,500 copay	50% coinsurance after deductible
PRESCRIPTION DRUGS (30-DAY SUPPLY)		
Generic	Up to $15 copay	Not covered
Preferred Brand	Up to $35 copay	Not covered
Non-Preferred Brand	Up to $100 copay	Not covered
Specialty	Up to $150 copay	Not covered
EMERGENCY CARE SERVICES		
Emergency Room Visit	$500 copay	50% coinsurance after deductible
Emergency Medical Transportation	$500 copay	50% coinsurance after deductible
Urgent Care Visit	$150 copay	50% coinsurance after deductible

PCP: Primary Care Physician **VDPC:** Virtual Direct Primary Care

AGE	TOBACCO FREE	TOBACCO USERS
14	$204.22	N/A
15	$222.38	N/A
16	$229.32	N/A
17	$236.26	N/A
18	$243.74	$365.61
19	$250.62	$375.93
20	$257.75	$386.63
21	$265.11	$397.67
22	$265.70	$398.55
23	$266.30	$399.45
24	$266.90	$400.35
25	$268.74	$403.11
26	$274.22	$411.33
27	$280.63	$420.95
28	$290.45	$435.68
29	$298.71	$448.07
30	$298.31	$447.47
31	$309.41	$464.12
32	$315.45	$473.18
33	$319.46	$479.19
34	$323.72	$485.58
35	$326.17	$489.26
36	$328.63	$492.95
37	$331.09	$496.64
38	$333.58	$500.37
39	$337.86	$506.79
40	$342.16	$513.24
41	$349.46	$524.19
42	$356.60	$534.90
43	$365.83	$548.75
44	$376.94	$565.41
45	$389.70	$584.55
46	$404.90	$607.35
47	$421.77	$632.66
48	$440.78	$661.17
49	$459.68	$689.52
50	$480.71	$721.07
51	$501.65	$752.48
52	$524.52	$786.78
53	$547.75	$821.63
54	$572.68	$859.02
55	$597.75	$896.63
56	$624.78	$937.17
57	$652.18	$978.27
58	$681.32	$1,021.98
59	$697.98	$1,046.97
60	$727.45	$1,091.18
61	$752.57	$1,128.86
62	$770.34	$1,155.51
63	$791.82	$1,187.73
64	$806.42	$1,209.63

Got questions: 1-866-432-7887

Decent

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CALENDAR YEAR DEDUCTIBLE	$4,500 Individual	
	$9,000 Family	
COINSURANCE	N/A	50% coinsurance after deductible
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	$7,150 Individual	N/A
	$14,300 Family	N/A
OUTPATIENT SERVICES		
Direct primary care (DPC*) office visit	$0 copay	N/A
Non direct primary care (PCP*)	$50 copay (with referral)	50% coinsurance after deductible
Specialist office visit	$50 copay	50% coinsurance after deductible
Laboratory/X-Ray services	$50 copay	50% coinsurance after deductible
CT/PET/MRI/MRA/ Nuclear Medicine	$100 copay after deductible	Not covered
Surgical Procedures in DPC* Office	$0 copay	N/A
Surgical Procedures in other Physician's office	$50 copay	50% coinsurance after deductible
Outpatient Facility (e.g. ambulatory surgery center)	$500 copay after deductible	Not covered
Pre-Natal & Post-Natal Obstetrical Care	$25 copay	50% coinsurance after deductible
Outpatient Mental Health Treatment	$50 copay	Not covered
Rehabilitation Services, Speech, Occupational & Physical Therapy	$50 copay	Not covered
INPATIENT SERVICES		
Hospital Confinement	$300 copay per day after deductible	50% coinsurance after deductible
Obstetrical services (delivery & all patient services)	$1,500 copay	50% coinsurance after deductible
PRESCRIPTION DRUGS (30-DAY SUPPLY)		
Generic	Up to $15 copay	Not covered
Preferred Brand	Up to $35 copay	Not covered
Non-Preferred Brand	Up to $100 copay	Not covered
Specialty	Up to $150 copay	Not covered
EMERGENCY CARE SERVICES		
Emergency Room Visit	$500 copay	50% coinsurance after deductible
Emergency Medical Transportation	$500 copay	50% coinsurance after deductible
Urgent Care Visit	$150 copay	50% coinsurance after deductible

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

AGE	TOBACCO FREE	TOBACCO USERS
14	$228.75	N/A
15	$249.08	N/A
16	$256.86	N/A
17	$264.64	N/A
18	$273.01	$409.52
19	$280.33	$420.50
20	$287.90	$431.85
21	$295.72	$443.58
22	$296.77	$445.16
23	$297.83	$446.75
24	$298.91	$448.37
25	$301.49	$452.24
26	$307.72	$461.58
27	$314.90	$472.35
28	$325.50	$488.25
29	$334.58	$501.87
30	$335.00	$502.50
31	$346.57	$519.86
32	$353.10	$529.65
33	$357.60	$536.40
34	$362.35	$543.53
35	$365.31	$547.97
36	$368.27	$552.41
37	$371.25	$556.88
38	$374.25	$561.38
39	$379.07	$568.61
40	$383.91	$575.87
41	$392.66	$588.99
42	$401.31	$601.97
43	$412.11	$618.17
44	$424.84	$637.26
45	$439.28	$658.92
46	$456.46	$684.69
47	$475.39	$713.09
48	$496.55	$744.83
49	$517.68	$776.52
50	$541.03	$811.55
51	$564.38	$846.57
52	$589.77	$884.66
53	$615.60	$923.40
54	$643.24	$964.86
55	$671.14	$1,006.71
56	$701.10	$1,051.65
57	$731.55	$1,097.33
58	$763.88	$1,145.82
59	$783.84	$1,175.76
60	$816.74	$1,225.11
61	$844.53	$1,266.80
62	$865.07	$1,297.61
63	$889.39	$1,334.09
64	$906.91	$1,360.37

Got questions: 1-866-432-7887