SCOPE OF SERVICES

Bronze.

HEALTH PLANS

	Bronze 5000 HDHP		Bronze 5000		Bronze 6000	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Deductible Individual/Family	**$5,000 $12,700**	**$6,000 $18,700**	**$5,000 $12,700**	**$6,000 $18,700**	**$6,000 $9,000**	**$6,000 $18,000**
Max OOP Individual/Family	**$6,000 $12,700**	**None**	**$6,000 $12,700**	**None**	**$8,150 $12,000**	**None**
Coinsurance After Deductible	**70%**	**50%**	**70%**	**50%**	**60%**	**50%**
Primary Specialist Urgent Care	**70%**	**50%**	**$10 $80 $100**	**50%**	**$10 $80 $100**	**50%**
Other Services*	**70%**	**50%†**	**70%**	**50%†**	**60%**	**50%†**
Prescription Medications						
Generic	**70%**	**Not Covered**	**$1**	**Not Covered**	**$1**	**Not Covered**
Preferred	**70%**	**Not Covered**	**$35**	**Not Covered**	**$35**	**Not Covered**
Non-Preferred	**70%**	**Not Covered**	**$75**	**Not Covered**	**$75**	**Not Covered**
Specialty	**70%**	**Not Covered**	**$200**	**Not Covered**	**$200**	**Not Covered**

* This refers to **Imaging** (CT, PET, MRI, X-Ray, and Diagnostic), Labs, Hospice, and Emergency Room Services (including facility, physician, surgery, PT, or DME during the visit; MRIs will be a separate co-pay).
† Out-of-Network Ambulance Services are treated the same as In-Network. This is ONLY for Ambulance Services.
Not Listed is Organ Replacement, which is covered In-Network and not covered Out-of-Network for all plans.