

SCOPE OF SERVICES

Silver.

HEALTH PLANS



Silver 2000



Silver 3000



Silver 3200 HDHP

	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Deductible Individual/Family	\$2,000 \$8,000	\$6,000 \$18,000	\$3,000 \$9,000	\$6,000 \$18,000	\$3,200 \$9,000	\$6,000 \$18,000
Max OOP Individual/Family	\$8,000 \$12,000	None	\$6,000 \$12,000	None	\$6,000 \$12,000	None
Coinsurance After Deductible	80%	50%	80%	50%	80%	50%
Primary Specialist Urgent Care	\$10 \$55 \$55	50%	\$10 \$55 \$55	50%	80%	50%
Other Services*	80%	50%	80%	50%	100%	50%
Prescription Medications						
Generic	\$1	Not Covered	\$1	Not Covered	80%	Not Covered
Preferred	\$35	Not Covered	\$35	Not Covered	80%	Not Covered
Non-Preferred	\$75	Not Covered	\$75	Not Covered	80%	Not Covered
Specialty	\$200	Not Covered	\$200	Not Covered	80%	Not Covered

* This refers to In-Patient Hospitalization, Out-Patient Surgery, X-rays, Labs, or Emergency Room.

