2023 BRONZE PLAN

	In-Network	Out-of-Network
Deductible (per calendar year)	$2,000 Individual	$4,000 Individual
	$4,000 Family	$8,000 Family
Coinsurance	20%	40%
Out-Of-Pocket Maximum (includes deductible: excludes all copays and penalty amounts)	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family
Preventive Care Services		
Adult Routine Physical Exam (every 24 months), Annual Routine Mammogram, GYN Exam and PSA.	Covered 100%; no deductible, no copay	Not covered
Routine Eye and Hearing Screening (one exam every 24 months)	Not covered	Not covered
Physician Services		
Primary Doctor Office Visit	20% co-insurance after deductible	40% copay, after deductible
Specialist Office Visits	20% co-insurance after deductible	40% copay, after deductible
X-ray and Lab Services (during office visit)	20% co-insurance after deductible	40% copay, after deductible
Emergency Services		
Emergency Room (copay waived if admitted)	20% co-insurance after deductible	20% co-insurance after deductible
Urgent Care		
Immediate Medical Attention	20% co-insurance after deductible	40% copay, after deductible
Hospital Services		
Hospital Admission	20% co-insurance after deductible	40% copay, after deductible
Outpatient Hospital	20% co-insurance after deductible	40% copay, after deductible
Alternatives to Hospital Care		
Skilled Nursing (max. 120 days), this is facility benefit and covered	20% co-insurance after deductible	20% co-insurance after deductible
Home Health (max. 120 days) and Urgent Care	20% co-insurance after deductible	20% co-insurance after deductible
Other Services		
Outpatient Short-Term Rehabilitation (includes speech, physical, occupational and spinal manipulation therapy), in office setting.	20% after deductible	40% copay, after deductible

HCTC-Eligible and Non-HCTC Plan Options

Prescription Drug Plan—Retail Pharmacy		
Generic	After deductible, $15 co-pay for retail	After deductible, $30 co-pay for retail
Preferred Brand-Name Drugs	After deductible/$50 copay for retail or mail order	After deductible, $100 co-pay f or retail or mail order
Non-Preferred Brand-Name Drugs	After deductible/$70 copay or 50% co-insurance of approved amount (whichever is greater) no more than $100 copay	After deductible/$70 copay additional 20% approved amount
Prescription Drug Plan—Mail Order (90 Day Supply)		
Generic	After deductible/$30 co-pay for 30 day supply	After deductible, co-pay plus additional 20% of approved amount
Preferred Brand	$100 co-pay for mail order 90- day supply	After deductible, co-pay plus an additional 20% of approved amount
Non-Preferred Brand	$140 or 50% whichever is greater, max of $200 after deductible	After deductible, co-pay plus an additional 20% of approved amount

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