	A	C	F	HDHP
Individual/Family DEDUCTIBLE	$100 / $300	$500 / $1,500	$1,500 / $3,000	$1,500 / $3,000
COINSURANCE %	Preferred 80% to $5,000; Non-Preferred Facility and Providers Payable amount up to 125% of the Medicare equivalent rate	Preferred 80% to $10,000; Non-Preferred Facility and Providers Payable amount up to 125% of the Medicare equivalent rate	Preferred 80% to $15,000; Non-Preferred Facility and Providers Payable amount up to 125% of the Medicare equivalent rate	Preferred 80% to $17,500; Non-Preferred Facility and Providers Payable amount up to 125% of the Medicare equivalent rate
OUT-OF-POCKET LIMIT* Individual/ Family	$1,000 plus deductible/ $3,000 plus deductible	$2,000 plus deductible/ $6,000 plus deductible	$3,000 plus deductible/ $6,000 plus deductible	$3,500 plus deductible/ $7,000 plus deductible
OUT-OF-POCKET (Non Preferred)	No Limit	No Limit	No Limit	No Limit
CHIROPRACTIC	Subject to deductible and coinsurance; up to 20 visits each per calendar year	Subject to deductible and coinsurance; up to 20 visits each per calendar year	Subject to PCP OVC or deductible/coinsurance; up to 20 visits each per calendar year	Subject to deductible and coinsurance; up to 20 visits each per calendar year
PHYSICIAN OFFICE VISIT CO-PAY	N/A	N/A	$25 (1st 6 visits per calendar year)	N/A
PRESCRIPTIONS - Retail (Generic medications required when available)	$12 / $25 / $50 (30-day supply)	$17 / $30 / $60 (30-day supply)	$17 / $30 / $60 (30-day supply)	Prescriptions are subject to deductible and coinsurance
PRESCRIPTIONS - Mail Order (Generic medications required when available)	$24 / $50 / $100 (90-day supply)	$34 / $60 / $120 (90-day supply)	$34 / $60 / $120 (90-day supply)	Prescriptions are subject to deductible and coinsurance
SPECIALTY MEDICATION PROGRAM (Not including oncology medications)	50% co-payment per prescription with a per prescription maximum of $100 Value $400 Formulary $600 Non-Formulary	50% co-payment per prescription with a per prescription maximum of $100 Value $400 Formulary $600 Non-Formulary	50% co-payment per prescription with a per prescription maximum of $100 Value $400 Formulary $600 Non-Formulary	50% co-payment per prescription with a per prescription maximum of $100 Value $400 Formulary $600 Non-Formulary
PREVENTIVE CARE (Well baby and routine cancer screenings)	Paid at 100%	Paid at 100%	Paid at 100%	Paid at 100%
EMERGENCY ROOM DEDUCTIBLE (waived if admitted)	$500	$500	$500	$500
INPATIENT HOSPITAL CO-PAY	$500 per admission; capped two times per individual per year.	$500 per admission; capped two times per individual per year.	$500 per admission; capped two times per individual per year.	$200 per admission; capped two times per individual per year; applies to out-of-pocket
BridgeHealth Surgery Benefit	100% no deductible	100% no deductible	100% no deductible	100% no deductible
Teladoc	100% no deductible	100% no deductible	100% no deductible	