

Bronze 60 HDHP PPO 5600/20%

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance (COI)* should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK ^{1,2}	OUT-OF-NETWORK ^{1,3}
Unlimited lifetime maximum.	✓	✓
Plan maximums		
Calendar year deductible ⁴	\$5,600 / \$11,200	\$11,200 / \$22,400
Out-of-pocket maximum (single / family) ⁶	\$6,850 / \$13,700	\$13,700 / \$27,400
Professional services		
Office visit ⁷	20%	50%
Specialist visit	20%	50%
Telehealth services through Teladoc ⁸	\$0	Not covered
Rehabilitation and habilitation therapy	20%	50%
X-ray/Laboratory procedures	20% / 20%	50% / 50%
Complex radiology services (MRI, CT, PET)	20%	50%
Outpatient services		
Outpatient surgery (ambulatory surgery center / hospital)	20% / 20%	50% / 50%
Hospital services		
Inpatient hospital	20%	50%
Skilled nursing facility	20%	50%
Emergency services		
Emergency room (copay waived if admitted)	20%	20%
Urgent care	20%	50%
Mental/Behavioral health / Substance use disorder services⁹		
Mental/Behavioral health / Substance use disorder (inpatient)	20%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	20%	50%
Other services		
Durable medical equipment	20%	50%
Acupuncture (medically necessary) ¹¹	20%	50%
Chiropractic care	\$25 (unlimited visits)	50%
Prescription drug coverage^{13,14}		
Prescription drug deductible (single / family)	\$5,600 / \$11,200 Integrated med/Rx ded. Applies to all tiers	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3 ¹² (up to a 30-day supply obtained through a participating pharmacy)	\$5 / \$15 / \$40	Not covered
Tier 4 Specialty drugs ¹⁵	20%	Not covered
Pediatric dental¹⁶		
Diagnostic and preventive services	\$0	10%
Pediatric vision¹⁷		
Routine eye exam	\$0	Not covered
Glasses (limitations apply)	\$0	Not covered

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