

# Bronze 60 PPO 6300/65

**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 <sup>1,2</sup>	OUT-OF-NETWORK <sup>1,3</sup>
Unlimited lifetime maximum.	✓	✓
<b>Plan maximums</b>		
Calendar year deductible <sup>4</sup>	\$6,300 / \$12,600	\$12,600 / \$25,200
Out-of-pocket maximum (single / family) <sup>6</sup>	\$7,800 / \$15,600	\$15,600 / \$31,200
<b>Professional services</b>		
Office visit <sup>7</sup>	Visits 1-3 \$65 (ded. waived) / Visits 4+ \$65 <sup>10</sup>	50%
Specialist visit	Visits 1-3 \$95 (ded. waived) / Visits 4+ \$95 <sup>10</sup>	50%
Telehealth services through Teladoc <sup>8</sup>	\$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	\$65 (ded. waived)	50%
X-ray/Laboratory procedures	40% / \$40 (ded. waived)	50% / 50%
<b>Complex radiology services</b> (MRI, CT, PET)	40%	50%
<b>Outpatient services</b>		
Outpatient surgery (ambulatory surgery center / hospital)	40% / 40%	50% / 50%
<b>Hospital services</b>		
Inpatient hospital	40%	50%
Skilled nursing facility	40%	50%
<b>Emergency services</b>		
Emergency room (copay waived if admitted)	40%	40%
Urgent care	Visits 1-3 \$65 (ded. waived) / Visits 4+ \$65 <sup>10</sup>	50%
<b>Mental/Behavioral health / Substance use disorder services<sup>9</sup></b>		
Mental/Behavioral health / Substance use disorder (inpatient)	40%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	\$65 (ded. waived)	50%
<b>Other services</b>		
Durable medical equipment	40%	50%
Acupuncture (medically necessary) <sup>11</sup>	Visits 1-3 \$65 (ded. waived) / Visits 4+ \$65 <sup>10</sup>	50%
Chiropractic care	Not covered	Not covered
<b>Prescription drug coverage<sup>13,14</sup></b>		
Prescription drug deductible (single / family)	\$500 / \$1,000 Applies to all tiers	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3 <sup>12</sup> (up to a 30-day supply obtained through a participating pharmacy)	\$18 / 40% / 40%	Not covered
Tier 4 Specialty drugs <sup>15</sup>	40%	Not covered
<b>Pediatric dental<sup>16</sup></b>		
Diagnostic and preventive services	\$0	10%
<b>Pediatric vision<sup>17</sup></b>		
Routine eye exam	\$0	Not covered
Glasses (limitations apply)	\$0	Not covered

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