Bronze 6550

Individual Plan Benefit Summary



	Network sponsible for:	
Per Centre Person	Unlimited	
Per Covered Person \$6,550 \$13,100 \$26,200 Per Family \$13,100 \$26,200 Annual Maximum Out-of-Pocket (including deductible and co-pay) Per Covered Person \$6,550 \$20,000 Per Family \$6,550 \$20,000 Physician Services Physician (PCP) \$0%**** \$30%**** USC** Physician (PCP) \$0%**** \$30%***** \$30%*** USC** Physician Telehedilh Visit \$45 \$30%***** \$30%****** Physician Telehedilh Visit \$45 \$30%********* \$30%********** Physician Telehedilh Visit \$45 \$30%**************** Physician Telehedilh Visit \$45 \$30%*********************** Physician Telehedilh Visit \$45 \$30%******************************** Physician Telehedilh Visit \$45 \$30%************************************		
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20 visits per Benefit Year (not including Autism/Applied Behavioral An		

Speech Therapy	0%**	30%** U&C*	
	Unlin	nited	
Cardiac Rehabilitation	0%**	30%** U&C*	
	36 visits per	Benefit Year	
Pulmonary Rehabilitation	0%**	30%** U&C*	
	20 visits per	Benefit Year	
Chiropractic Services	0%**	30%** U&C*	
	26 visits per Benefit Year	r without prior approval	
Diagnostic Laboratory, Imaging and Radiology	0%**	30%** U&C*	
Home Health Care	0%**	30%** U&C*	
	100 visits per	Benefit Year	
Private Duty Nursing	0%**	30%** U&C*	
	82 visits per Benefit Year, 16	54 visits Lifetime Maximum	
Ambulance Services	0%**	0%**	
Educational Services	0%**	30%** U&C*	
Durable Medical Equipment	0%**	30%** U&C*	
Orthotics	0%**	30%** U&C*	
Disposable Medical Supplies	0%**	30%** U&C*	
Prosthetics	0%**	30%** U&C*	
Mental Health Services			
Mental Health Office Visit	0%**	30%** U&C*	
Mental Health Services not received in an office setting	0%**	30%** U&C*	
Hospital Inpatient / Residential Treatment	0%**	30%** U&C*	
Substance Abuse			
Outpatient Annual Maximum Benefit (unlimited)	0%**	30%** U&C*	
Inpatient/Residential Annual Maximum (unlimited)	0%**	30%** U&C*	
Medical or Social Setting Detox Annual Max (unlimited)	0%**	30%** U&C*	
Dental Services (only related to accidental injury or for certain members	00/**	200/** 110.5*	
requiring general anesthesia)	0%**	30%** U&C*	
Pediatric Dental (dependent children through age 18)			
Dental Exam	0%	* *	
Basic Dental Care	0%	* *	
Major Dental Care	0%	5 **	
Orthodontia (requires prior authorization)	0%	5 **	
Pediatric Vision (dependent children through age 18)			
Routine Eye Exam (1 visit per Benefit Year)	0%	ó**	
Eye Glasses (1 pair of glasses (lenses and frames) per Benefit Year)	0%	0%**	
Autism Services	Benefits are based on the setting in which Covered Services are received****		
Applied Behavior Analysis (ABA) (dependent children through age 18) Requires prior authorization	0%**	30%** U&C*	
Pharmacy Services			
Deductible	Subject to Medical Dedu	Subject to Medical Deductible and Co-insurance	
Generic (most), Tier 1 (30 day supply)	0%**	30%** U&C*	
Preferred Brand, Tier 2 (30 day supply)	0%**	30%** U&C*	
Other Brand / Non-Formulary, Tier 3 (30 day supply)	0%**	30%** U&C*	
Specialty Formulary Brand / Non-Formulary, Tier 4 (30 day supply)	0%**	N/A	
Mail Order (90 day supply)	2.5×	N/A	

 $^{{}^{*}}U\&C$ is used as an abbreviation for Usual and Customary.

This is only a brief summary of benefits, which is not intended to be comprehensive. Your Individual Health Plan Policy is the governing document for benefit information.

All Plans Are Qualified Health Plans

(Plans Available Beginning: 1/1/2017)

^{**}Co-insurance applies after Deductible is met.

^{***}Co-pays/Co-insurance for Physical Therapy will not exceed the physician office visit once the deductible is met.

^{****}Coverage for the diagnosis and treatment of Autism Spectrum Disorders will not be subject to any greater Deductible/Co-pay/Co-insurance than is applicable to other physical health care services covered by this Plan.