EnhancedCare Gold 80 PPO 0/30

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]	$0	$2,000 / $4,000
Out-of-pocket maximum (single / family)[6]	$7,400 / $14,800	$14,800 / $29,600
Professional services Office visit[7]	$30	50%
Specialist visit	$50	50%
Telehealth services through Teladoc[8]	$0	Not covered
Rehabilitation and habilitation therapy	$30	Not covered
X-ray/Laboratory procedures	$40 / $30	50% / 50%
Complex radiology services (MRI, CT, PET)	30%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 30%	50% / 50%
Hospital services Inpatient hospital	30%	50%
Skilled nursing facility	30%	50%
Emergency services Emergency room (copay waived if admitted)	30%	30% (ded. waived)
Urgent care	$50	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	30%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$30	50%
Other services Durable medical equipment	30%	Not covered
Acupuncture (medically necessary)[10]	$30	Not covered
Chiropractic care	$25 12 visits max per year	Not covered
Prescription drug coverage[12,13] Prescription drug deductible (single / family)	N/A	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[11] (up to a 30-day supply obtained through a participating pharmacy)	$15 / $40 / $70	Not covered
Tier 4 Specialty drugs[14]	30%	Not covered
Pediatric dental[15] Diagnostic and preventive services	$0	10%
Pediatric vision[16] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)