

PureCare Gold 80 HSP 250/25

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The Evidence of Coverage (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Gold 80 HSP 250/25
Unlimited lifetime maximum	✓
Plan maximums	
Calendar year deductible (single / family)	\$250 / \$500
Out-of-pocket maximum (single / family)	\$7,800 / \$15,600
Professional services¹	
Office visit	\$25 (ded. waived)
Specialist visit	\$50 (ded. waived)
Telehealth services through Teladoc ²	\$0 (ded. waived)
Rehabilitation and habilitation therapy	\$25 (ded. waived)
X-ray / Laboratory procedures	\$65 (ded. waived) / \$25 (ded. waived)
Complex radiology services (MRI, CT, PET)	20% (ded. waived)
Outpatient services	
Outpatient surgery (ambulatory surgery center / hospital)	20% (ded. waived)/ 20% (ded. waived)
Hospital services	
Inpatient hospital	20%
Skilled nursing facility	20%
Emergency services	
Emergency room (copay waived if admitted)	\$250
Urgent care	\$25 (ded. waived)
Mental/Behavioral health / Substance use disorder services⁴	
Mental/Behavioral health / Substance use disorder (inpatient)	20%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	\$25 (ded. waived)
Other services	
Durable medical equipment	20% (ded. waived)
Acupuncture (medically necessary) ⁵	\$25 (ded. waived)
Prescription drug coverage^{7,8}	
Brand-name calendar year deductible (single / family)	N/A
Prescription drugs Tier 1 / Tier 2 / Tier 3 ⁶ (up to a 30-day supply obtained through a participating pharmacy)	\$15 / \$50 / \$80
Tier 4 Specialty drugs ⁹	20%
Pediatric dental¹⁰	
Diagnostic and preventive services	\$0
Pediatric vision¹¹	
Routine eye exam	\$0
Glasses (limitations apply)	\$0