

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	\$7,600 / \$15,200	\$15,200 / \$30,400
Professional services		
Office visit ⁷	\$30	50%
Specialist visit	\$50	50%
Telehealth services through Babylon 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 services⁹		
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 dental¹⁵		
Diagnostic and preventive services	\$0	10% (ded. waived)
Pediatric vision¹⁶		
Routine eye exam	\$0	Not covered
Glasses (limitations apply)	\$0	Not covered