

EnhancedCare Gold 80 PPO 1000/30

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	\$1,000 / \$2,000	\$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 (ded. waived)	50%
Specialist visit	\$50 (ded. waived)	50%
Telehealth services through Babylon ⁸	\$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	\$30 (ded. waived)	Not covered
X-ray/Laboratory procedures	\$40 (ded. waived) / \$30 (ded. waived)	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%
Urgent care	\$50 (ded. waived)	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 (ded. waived)	50%
Other services		
Durable medical equipment	30%	Not covered
Acupuncture (medically necessary) ¹⁰	\$30 (ded. waived)	Not covered
Chiropractic care	\$25 (ded. waived) 12 visits max per year	Not covered
Prescription drug coverage^{12,13}		
Prescription drug deductible (single / family)	\$250 / \$500 Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3 ¹¹ (up to a 30-day supply obtained through a participating pharmacy)	\$15 (ded. waived) / \$40 / \$70	Not covered
Tier 4 Specialty drugs ¹⁴	30%	Not covered
Pediatric dental¹⁵		
Diagnostic and preventive services	\$0 (ded. waived)	10% (ded. waived)
Pediatric vision¹⁶		
Routine eye exam	\$0 (ded. waived)	Not covered
Glasses (limitations apply)	\$0 (ded. waived)	Not covered

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