EnhancedCare Gold 80 PPO 500/20

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]	$500 / $1,000	$2,000 / $4,000
Out-of-pocket maximum (single / family)[6]	$7,600 / $15,200	$15,200 / $30,400
Professional services Office visit[7]	$20 (ded. waived)	50%
Specialist visit	$40 (ded. waived)	50%
Telehealth services through Babylon[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$20 (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	$40 (ded. waived)	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)	$20 (ded. waived)	50%
Other services Durable medical equipment	30%	Not covered
Acupuncture (medically necessary)[10]	$20 (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 dental[15] Diagnostic and preventive services	$0 (ded. waived)	10% (ded. waived)
Pediatric vision[16] Routine eye exam	$0 (ded. waived)	Not covered
Glasses (limitations apply)	$0 (ded. waived)	Not covered

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