

# 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 <sup>1,2</sup>	OUT-OF-NETWORK <sup>1,3</sup>
Unlimited lifetime maximum.	✓	✓
<b>Plan maximums</b>		
Calendar year deductible <sup>4</sup>	\$0	\$2,000 / \$4,000
Out-of-pocket maximum (single / family) <sup>6</sup>	\$7,600 / \$15,200	\$15,200 / \$30,400
<b>Professional services</b>		
Office visit <sup>7</sup>	\$30	50%
Specialist visit	\$50	50%
Telehealth services through Babylon <sup>8</sup>	\$0	Not covered
Rehabilitation and habilitation therapy	\$30	50%
X-ray/Laboratory procedures	\$40 / \$30	50% / 50%
<b>Complex radiology services</b> (MRI, CT, PET)	30%	50%
<b>Outpatient services</b>		
Outpatient surgery (ambulatory surgery center / hospital)	30% / 30%	50% / 50%
<b>Hospital services</b>		
Inpatient hospital	30%	50%
Skilled nursing facility	30%	50%
<b>Emergency services</b>		
Emergency room (copay waived if admitted)	30%	30% (ded. waived)
Urgent care	\$50	50%
<b>Mental/Behavioral health / Substance use disorder services<sup>9</sup></b>		
Mental/Behavioral health / Substance use disorder (inpatient)	30%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	\$30	50%
<b>Other services</b>		
Durable medical equipment	30%	50%
Acupuncture (medically necessary) <sup>11</sup>	\$30	50%
Chiropractic care	\$25 12 visits max per year	50%
<b>Prescription drug coverage<sup>13,14</sup></b>		
Prescription drug deductible (single / family)	N/A	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3 <sup>12</sup> (up to a 30-day supply obtained through a participating pharmacy)	\$15 / \$40 / \$70	Not covered
Tier 4 Specialty drugs <sup>15</sup>	30%	Not covered
<b>Pediatric dental<sup>16</sup></b>		
Diagnostic and preventive services	\$0	10% (ded. waived)
<b>Pediatric vision<sup>17</sup></b>		
Routine eye exam	\$0	Not covered
Glasses (limitations apply)	\$0	Not covered