

# Silver 70 Value PPO 1700/50

**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>  | \$1,700 / \$3,400   | \$3,400 / \$6,800             |
| Out-of-pocket maximum (single / family) <sup>6</sup>   | \$8,000 / \$16,000  | \$16,000 / \$32,000           |
| <b>Professional services</b>   |   |                               |
| Office visit <sup>7</sup>  | \$50 (ded. waived)  | 50%                           |
| Specialist visit   | \$75  | 50%                           |
| Telehealth services through Babylon <sup>8</sup>   | \$0 (ded. waived)   | Not covered                   |
| Rehabilitation and habilitation therapy  | \$50 (ded. waived)  | 50%                           |
| X-ray/Laboratory procedures  | \$50 / \$40   | 50% / 50%                     |
| <b>Complex radiology services</b><br>(MRI, CT, PET)  | 40%   | 50%                           |
| <b>Outpatient services</b>   |   |                               |
| Outpatient surgery (ambulatory surgery center / hospital)  | 40% / 40%   | 50% / 50%                     |
| <b>Hospital services</b>   |   |                               |
| Inpatient hospital   | 40%   | 50%                           |
| Skilled nursing facility   | 40%   | 50%                           |
| <b>Emergency services</b>  |   |                               |
| Emergency room (copay waived if admitted)  | 40%   | 40%                           |
| Urgent care  | \$75  | 50%                           |
| <b>Mental/Behavioral health / Substance use disorder services<sup>9</sup></b>  |   |                               |
| Mental/Behavioral health / Substance use disorder (inpatient)  | 40%   | 50%                           |
| Mental/Behavioral health / Substance use disorder (outpatient office visit)  | \$50 (ded. waived)  | 50%                           |
| <b>Other services</b>  |   |                               |
| Durable medical equipment  | 40%   | 50%                           |
| Acupuncture (medically necessary) <sup>11</sup>  | \$50 (ded. waived)  | 50%                           |
| Chiropractic care  | \$25 (ded. waived)<br>12 visits max per year                  | 50%                           |
| <b>Prescription drug coverage<sup>13,14</sup></b>  |   |                               |
| Prescription drug deductible (single / family)   | \$1,700 / \$3,400 Integrated med/Rx ded. Applies to tiers 2-4 | Not covered                   |
| Prescription drugs Tier 1 / Tier 2 / Tier 3 <sup>12</sup><br>(up to a 30-day supply obtained through a participating pharmacy) | \$19 (ded. waived) / \$65 / \$100                             | Not covered                   |
| Tier 4 Specialty drugs <sup>15</sup>   | 40%   | Not covered                   |
| <b>Pediatric dental<sup>16</sup></b>   |   |                               |
| Diagnostic and preventive services   | \$0 (ded. waived)   | 10% (ded. waived)             |
| <b>Pediatric vision<sup>17</sup></b>   |   |                               |
| Routine eye exam   | \$0 (ded. waived)   | Not covered                   |
| Glasses (limitations apply)  | \$0 (ded. waived)   | Not covered                   |

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