

CommunityCare Silver \$50

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The Evidence of Coverage (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	CommunityCare Silver \$50
Unlimited lifetime maximum	✓
Plan maximums	
Calendar year deductible (single / family)	\$1,750 / \$3,500
Out-of-pocket maximum (single / family)	\$7,800 / \$15,600
Professional services¹	
Office visit copay	\$50 (ded. waived)
Teladoc consultation telehealth services ²	\$0 (ded. waived)
Specialist visit	\$70 (ded. waived)
Rehabilitation and habilitation therapy	\$50 (ded. waived)
MinuteClinic ³	\$30 (ded. waived)
X-ray / Laboratory procedures	\$50 / \$40
Complex radiology services (MRI, CT, PET)	\$300
Outpatient services	
Outpatient surgery (ambulatory surgery center / hospital)	30% / 40%
Hospital services	
Inpatient hospital	40%
Skilled nursing facility	\$25 per day (ded. waived)
Emergency services	
Emergency room (copay waived if admitted)	40%
Urgent care	\$70 (ded. waived)
Mental/Behavioral health / Substance use disorder services⁴	
Mental/Behavioral health / Substance use disorder (inpatient)	40%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	\$50 (ded. waived)
Other services	
Durable medical equipment	40%
Acupuncture (medically necessary) ⁵	\$10 (ded. waived)
Prescription drug coverage^{7,8}	
Brand-name calendar year deductible (single / family)	\$250 / \$500
Prescription drugs Tier 1 / Tier 2 / Tier 3 ⁶ (up to a 30-day supply obtained through a participating pharmacy)	\$15 (ded. waived) / 40% / 40%
Tier 4 Specialty drugs ⁹	40%
Pediatric dental¹⁰	
Diagnostic and preventive services	\$0 (ded. waived)
Pediatric vision¹¹	
Routine eye exam	\$0 (ded. waived)
Glasses (limitations apply)	\$0 (ded. waived)

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