

EnhancedCare Silver 70 PPO 2250/55

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	\$2,250 / \$4,500	\$4,500 / \$9,000
Out-of-pocket maximum (single / family) ⁶	\$7,800 / \$15,600	\$15,600 / \$31,200
Professional services		
Office visit ⁷	\$55 (ded. waived)	50%
Specialist visit	\$80 (ded. waived)	50%
Telehealth services through Teladoc ⁸	\$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	\$55 (ded. waived)	Not covered
X-ray/Laboratory procedures	\$65 / \$40 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	40%	50%
Outpatient services		
Outpatient surgery (ambulatory surgery center / hospital)	40% / 40%	50% / 50%
Hospital services		
Inpatient hospital	40%	50%
Skilled nursing facility	40%	50%
Emergency services		
Emergency room (copay waived if admitted)	40%	40%
Urgent care	\$80 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services⁹		
Mental/Behavioral health / Substance use disorder (inpatient)	40%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	\$55 (ded. waived)	50%
Other services		
Durable medical equipment	40%	Not covered
Acupuncture (medically necessary) ¹⁰	\$55 (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)	\$300 / \$600 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)	\$19 (ded. waived) / \$65 / \$85	Not covered
Tier 4 Specialty drugs ¹⁴	40%	Not covered
Pediatric dental¹⁵		
Diagnostic and preventive services	\$0	10%
Pediatric vision¹⁶		
Routine eye exam	\$0	Not covered
Glasses (limitations apply)	\$0	Not covered

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