Health Plan Benefits and Coverage Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	**CCHP Bronze60 HMO 6000/70 w/ Child Dental**
Overall deductible	$6,000 (Individual)/ $12,000 (Family)
Other deductibles for specific services	
Medical	$0
Pharmacy	$500 (Individual)/ $1,000 (Family)
Dental	$0
Out–of–pocket limit on expenses	$6,500 (Individual) / $13,000 (Family) Medical. Up to $500 (30-day-supply per script Tier 4 Rx) and up to $1,500 (90-day-supply per script Tier 4 Rx) Pharmacy.

Service Type	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic		
Preventive care/ screening/ immunization	No Cost Share	
Primary care visit or non-specialist practitioner visit to treat an injury or illness	$70 copay	After 1st 3 non-preventive visits
Specialist visit	$90 copay	X
Acupuncture	$90 copay	X
Allergy visit (testing and treatment)	$90 copay	X
Tests		
Laboratory Tests	$40 copay	
X-Rays and Diagnostic Imaging	100% coinsurance	X
Imaging (CT/PET scans, MRIs)	100% coinsurance	X
Drugs to treat illness or condition		
Tier 1 (30-Day Supply)	100% coinsurance (up to $500 per script after pharmacy deductible)	X
Tier 1 (90-Day Supply)	100% coinsurance (up to $1,500 per script after pharmacy deductible)	X
Tier 2 (30-Day Supply)	100% coinsurance (up to $500 per script after pharmacy deductible)	X
Tier 2 (90-Day Supply)	100% coinsurance (up to $1,500 per script after pharmacy deductible)	X
Tier 3 (30-Day Supply)	100% coinsurance (up to $500 per script after pharmacy deductible)	X
Tier 3 (90-Day Supply)	100% coinsurance (up to $1,500 per script after pharmacy deductible)	X
Tier 4 (30-Day Supply)	100% coinsurance (up to $500 per script after pharmacy deductible)	X
Tier 4 (90-Day Supply)	100% coinsurance (up to $1,500 per script after pharmacy deductible)	X
Outpatient services		
Facility fee (e.g., ambulatory surgery center)	100% coinsurance	X
Physician/surgeon fees	100% coinsurance	X

Outpatient visit	100% coinsurance	X
Need immediate attention		
Emergency room services (waived if admitted)	100% coinsurance	X
Emergency room physician fee (waived if admitted)	100% coinsurance	X
Emergency medical transportation	100% coinsurance	X
Urgent care	$120 copay	After 1st 3 non-preventive visits
Hospital stay		
Facility fee (e.g., hospital room)	100% coinsurance	X
Physician/surgeon fee	100% coinsurance	X
Mental health, behavioral health, or substance abuse needs		
Mental/Behavioral health outpatient office visits	$70 copay	After 1st 3 non-preventive visits
Mental/ Behavioral health other outpatient items and services	$0 copay	After 1st 3 non-preventive visits
Mental health partial hospital program treatment	$0 copay	After 1st 3 non-preventive visits
Mental health monitoring of drug therapy	$70 copay	X
Mental health psychological testing	100% coinsurance	X
Psychiatric observation	100% coinsurance	X
Mental/Behavioral health inpatient services (Facility fees)	100% coinsurance	X
Mental/ Behavioral health inpatient services (Physician fees)	100% coinsurance	X
Mental health crisis residential treatment	100% coinsurance	X
Mental health and Substance use disorder group evaluation and treatment	$70 copay	X
Substance use disorder intensive outpatient treatment program	$0 copay	After 1st 3 non-preventive visits
Substance use disorder day treatment program	$0 copay	After 1st 3 non-preventive visits
Substance use disorder medication treatment withdrawal	$70copay	After 1st 3 non-preventive visits
Substance use disorder drug testing	$40 copay	
Substance use disorder inpatient services (Facility fees)	100% coinsurance	X
Substance use disorder inpatient services (Physician fees)	100% coinsurance	X
Substance use disorder transitional residential	100% coinsurance	X

recovery services		
Pregnancy		
Family planning visit (consultation and contraceptive services)	$90 copay	X
Preconception/ prenatal/ postnatal care	$0 copay	
Delivery and all inpatient services (Hospital Services)	20% coinsurance	X
Delivery and all inpatient services (Professional Services)	100% coinsurance	X
PKU formulas and food products	100% coinsurance	X
Termination of pregnancy	100% coinsurance	X
Help recovering or other special health needs		
Home health care	100% coinsurance	X
Outpatient Rehabilitation services	$70 copay	
Outpatient Habilitation services	$70 copay	
Skilled nursing care	100% coinsurance	X
Durable medical equipment	100% coinsurance	X
Medical supplies	100% coinsurance	X
Contact lens to treat Aniridia and Aphakia	100% coinsurance	X
Diabetes Equipment and Supply Services	Lancets - Generic RX Copay Blood Testing Strips - Brand RX Copay Urine Testing Strips - Generic RX Copay	X
Hospice service	$0 copay	
Pediatric Vision and Dental (Included in Plan)		
Pediatric Vision (Ages 0-18) Administered by VSP		
Eye exam	No Cost Share	
1 pair of glasses per year (or contact lenses in lieu of glasses) calendar year	No Cost Share	
Pediatric Dental (Ages 0-18) Administered by Delta Dental		
Oral Exam	No Cost Share	
Preventive- Cleaning		
Preventive – X-ray		
Sealants per Tooth		
Topical fluoride Application		
Space Maintainers-Fixed		
Amalgam Fill- 1 Surface	$25	
Root Canal- Molar	$300	
Gingivectomy per Quad	$150	
Extraction- Single Tooth Exposed Root or	$65	
Extraction- Complete Bony	$160	
Porcelain with Metal Crown	$300	
Medically necessary orthodontics	$1000	
For More Information	See Delta Dental Evidence of Coverage (EOC) included as an addendum to this EOC	

Endnotes:

1. Co-payments may never exceed the cost of the service. For example, if laboratory tests cost less than the $45 copayment, the lesser amount is the applicable cost-sharing amount.

2. The deductible is waived after the 1st 3 non-preventive visits, which includes urgent care and outpatient Mental Health/ Substance Use Disorder visits.]
3. Member cost-share for oral anti-cancer drugs will not exceed $200 per month.
4. For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply.
5. Mental Health/ Substance Use Disorder Outpatient Items and Services include post-discharge ancillary care services, such as counseling and other outpatient support services, which may be provided as part of the offsite recovery component of a residential treatment plan.
6. Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as a substance use disorder inpatient services.
7. The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.
8. Drug tiers are defined as follows:

Tier	Definition
1	1) Most generic drugs and low cost preferred brands.
2	1) Non-preferred generic drugs or;
	2) Preferred brand name drugs or;
	3) Recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
3	1) Non-preferred brand name drugs or;
	2) Recommended by P&T committee based on drug safety, efficacy and cost or;
	3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	1) Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies or;
	2) Self administration requires training, clinical monitoring or;
	3) Drug was manufactured using biotechnology or;
	4) Plan cost (net of rebates) is >$600.