

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 Gold80 HMO 0/35 w/ Child Dental	
Overall deductible		\$0	
Other deductibles for specific services			
Medical		\$0	
Pharmacy		\$0	
Dental		\$0	
Out-of-pocket limit on expenses		\$6,200 (Individual) / \$12,400 (Family) Medical. Up to \$250 (30-day-supply per script Tier 4 Rx) and up to \$750 (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	\$35 copay		
Specialist visit	\$55 copay		
Acupuncture	\$55 copay		
Allergy visit (testing and treatment)	\$55 copay		
Tests			
Laboratory Tests	\$35 copay		
X-Rays and Diagnostic Imaging	\$50 copay		
Imaging (CT/PET scans, MRIs)	\$250 copay		
Drugs to treat illness or condition			
Tier 1 (30-Day Supply)	\$15 copay		
Tier 1 (90-Day Supply)	\$30 copay		
Tier 2 (30-Day Supply)	\$50 copay		
Tier 2 (90-Day Supply)	\$100 copay		
Tier 3 (30-Day Supply)	\$70 copay		
Tier 3 (90-Day Supply)	\$140 copay		
Tier 4 (30-Day Supply)	20% coinsurance (up to \$250 per script out-of-pocket maximum)		
Tier 4 (90-Day Supply)	20% coinsurance (up to \$750 per script out-of-pocket maximum)		
Outpatient services			
Facility fee (e.g., ambulatory surgery center)	\$600 copay		
Physician/surgeon fees	\$55 copay		
Outpatient visit	20% coinsurance		
Need immediate attention			
Emergency room services (waived if admitted)	\$250 copay		
Emergency room physician fee (waived if admitted)	\$0 copay		
Emergency medical transportation	\$250 copay		
Urgent care	\$60 copay		
Hospital stay			

Facility fee (e.g., hospital room)	\$600 per day (up to first 5 days)	
Physician/surgeon fee	\$55 copay	
Mental health, behavioral health, or substance abuse needs		
Mental/Behavioral health outpatient office visits	\$35 copay	
Mental/ Behavioral health other outpatient items and services	\$0 copay	
Mental health partial hospital program treatment	\$0 copay	
Mental health monitoring of drug therapy	\$35 copay	
Mental health psychological testing	\$600 copay	
Psychiatric observation	\$600 copay per day (up to first 5 Days)	
Mental/Behavioral health inpatient services (Facility fees)	\$600 copay per day (up to first 5 Days)	
Mental/ Behavioral health inpatient services (Physician fees)	\$55 copay	
Mental health crisis residential treatment	\$600 copay per day (up to first 5 Days)	
Mental health and Substance use disorder group evaluation and treatment	\$35 copay	
Substance use disorder intensive outpatient treatment program	\$0 copay	
Substance use disorder day treatment program	\$0 copay	
Substance use disorder medication treatment withdrawal	\$35 copay	
Substance use disorder drug testing	\$35 copay	
Substance use disorder inpatient services (Facility fees)	\$600 copay per day (up to first 5 Days)	
Substance use disorder inpatient services (Physician fees)	\$55 copay	
Substance use disorder transitional residential recovery services	\$600 copay per day (up to first 5 Days)	
Pregnancy		
Family planning visit (consultation and contraceptive services)	\$55 copay	
Preconception/ prenatal/ postnatal care	\$0 copay	
Delivery and all inpatient services (Hospital Services)	\$600 per day (up to first 5 Days)	
Delivery and all inpatient services (Professional Services)	\$55 copay	
PKU formulas and food products	\$600 copay	
Termination of pregnancy	\$600 copay	
Help recovering or other special health needs		
Home health care	\$30 copay	
Outpatient Rehabilitation services	\$35 copay	
Outpatient Habilitation services	\$35 copay	
Skilled nursing care	\$300 per day (up to first 5 Days)	
Durable medical equipment	20% coinsurance	
Medical supplies	20% coinsurance	
Contact lens to treat Aniridia and Aphakia	20% coinsurance	
Diabetes Equipment and Supply Services	Lancets - Generic RX Copay Blood Testing Strips - Brand RX Copay Urine Testing Strips - Generic RX Copay	
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. Inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of continuous stay.
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.