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	**Silver 70 HMO 2000/45 + Child Dental INF**	
Overall deductible	$2,000 (Individual)/ $4,000 (Family)	
Other deductibles for specific services		
Medical	$0	
Pharmacy	$250 Individual)/ $500 (Family)	
Dental	$0	
Out–of–pocket limit on expenses	$6,800 (Individual) / $13,600 (Family) Medical.	
Service Type	**Member Cost Share**	**Deductible Applies**
Visit to a health care provider's office or clinic		
Primary care visit or non-specialist practitioner visit to treat an injury or illness	$45 copay	
Specialist visit	$75 copay	
Preventive care/ screening/ immunization	$0 copay	
Tests		
Laboratory Tests	$40 copay	
X-Rays and Diagnostic Imaging	$70 copay	
Imaging (CT/PET scans, MRIs)	$300 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)	$55 copay	X
Tier 2 (90-Day Supply)	$110 copay	X
Tier 3 (30-Day Supply)	$85 copay	X
Tier 3 (90-Day Supply)	$170 copay	X
Tier 4 (30-Day Supply)	20% coinsurance up to $500 per script	X
Outpatient services		
Facility fee (e.g., ambulatory surgery center)	20% coinsurance	
Physician/surgeon fees		
Office visit	20% coinsurance	
Need immediate attention		
Emergency room services (waived if admitted)	$350 copay	X
Emergency room physician fee (waived if admitted)	No Charge	X
Emergency medical transportation	$250 copay	X
Urgent care	$45 copay	
Hospital stay		
Facility fee (e.g., hospital room)	20% coinsurance	X
Physician/surgeon fee	20% coinsurance	X
Mental health, behavioral health, or substance abuse needs		
Mental/Behavioral health outpatient office visits	$45 copay	
Mental/ Behavioral health other outpatient items and services	No Charge	
Mental/Behavioral health inpatient services	20% coinsurance	X

Substance use disorder outpatient office visits	$45 copay	
Substance use disorder other outpatient items and services	No Charge	
Substance use disorder inpatient services	20% coinsurance	X
Pregnancy		
Prenatal care and preconception visits	No Charge	
Delivery and all inpatient services (Hospital Services)	20% coinsurance	X
Delivery and all inpatient services (Professional Services)	20% coinsurance	X
Help recovering or other special health needs		
Home health care	$45 copay	
Outpatient Rehabilitation services	$45 copay	
Outpatient Habilitation services	$45 copay	
Skilled nursing care	20% Coinsurance	
Durable medical equipment	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	No Charge	
Pediatric Vision and Dental (Included in Plan)		
Pediatric Vision (Ages 0-18) Administered by VSP		
Eye exam	No Charge	
1 pair of glasses per year (or contact lenses in lieu of glasses) calendar year	No Charge	
Pediatric Dental (Ages 0-18) Administered by Delta Dental		
Oral Exam	No Charge	
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	$50 - $150	
Extraction- Single Tooth Exposed Root or	$65	
Extraction- Complete Bony	$40	
Porcelain with Metal Crown	$335	
Medically necessary orthodontics	$1,000	
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. Member cost-share for oral anti-cancer drugs will not exceed $200 per month.
3. There is no cost-share for Diabetes Self-Management, which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member

to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.

4. For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes CCHP from offering mail order prescriptions at a reduced cost-share.
5. Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
6. Mental Health/ Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
7. Behavioral health treatment for autism and pervasive developmental disorder is covered under Mental/Behavioral health outpatient services.
8. 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.
9. 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.
10. The inpatient physician cost share may apply for any physician who bills separately from the facility (e.g. surgeon). A member's primary care physician or specialist may apply the office visit cost share when conducting a visit to the member in a hospital or skilled nursing facility.
11. 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.