Balance by CCHP

Benefit Chart	Bronze 60 HDHP HMO
Covered Services	**2023**
DEDUCTIBLES	
Annual Deductible	Individual $7,000/ Family $14,000 (Combined Medical/Drug Deductible)
Out–of–Pocket Limit On Expenses	Individual $7,000/ Family $14,000
PROFESSIONAL SERVICES	**Member Cost Share**
Visit to a Health Care Provider's Office or Clinic	
Preventive Care/ Screening/ Immunization	$0 Copay
Family Planning (Consultation and Contraceptive Services	$0 Copay
Prenatal Care and Preconception Visits	$0 Copay
Diabetes Care Management	$0 Copay
Diabetes Education	$0 Copay
Primary Care Visit to Treat an Injury or Illness	Full cost until out-of-pocket is met
Specialist Visit	Full cost until out-of-pocket is met
Acupuncture	Full cost until out-of-pocket is met
Allergy Visit (Testing and Treatment)	Full cost until out-of-pocket is met
Other Practitioner Office Visit	Full cost until out-of-pocket is met
Outpatient Services	**Member Cost Share**
Tests	
Laboratory Tests	Full cost until out-of-pocket is met
X-Rays	Full cost until out-of-pocket is met
Imaging (CT/PET scans, MRIs)	Full cost until out-of-pocket is met
Outpatient Surgery	
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	Full cost until out-of-pocket is met
Physician/Surgeon Fees	Full cost until out-of-pocket is met
Outpatient Visit	Full cost until out-of-pocket is met
Hospitalization Services	
Facility Fee (e.g., Hospital Room)	Full cost until out-of-pocket is met
Physician/Surgeon Fees	Full cost until out-of-pocket is met
Delivery and All Inpatient Services (Hospital Services)	Full cost until out-of-pocket is met
Delivery and All Inpatient Services (Professional Services)	Full cost until out-of-pocket is met
Emergency Health Coverage	
Emergency Room Services	Full cost until out-of-pocket is met
Emergency Room Physician Fee	Full cost until out-of-pocket is met
Urgent Care	Full cost until out-of-pocket is met
Ambulance Services	
Medical Transportation (Including Emergency and Non-Emergency)	Full cost until out-of-pocket is met
Prescription Drug Coverage	
Tier 1: Generic Drugs (30-Day Supply)	Full cost until out-of-pocket is met
Tier 1: Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	Full cost until out-of-pocket is met
Tier 2: Preferred Brand Drugs (30-Day Supply)	Full cost until out-of-pocket is met
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	Full cost until out-of-pocket is met
Tier 3: Non-Preferred Brand Drugs (30-Day Supply)	Full cost until out-of-pocket is met

Benefit Chart	Bronze 60 HDHP HMO
Covered Services	**2023**
Tier 3: Non-Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	Full cost until out-of-pocket is met
Tier 4: Specialty Drugs (30-Day Supply)	Full cost until out-of-pocket is met
Medical Supplies/ Durable Medical Equipment	
Medical Supplies	Full cost until out-of-pocket is met
Prosthetic Devices	Full cost until out-of-pocket is met
Durable Medical Equipment (Outpatient)	Full cost until out-of-pocket is met
Mental Health Services	
Mental/Behavioral Health Outpatient Office Visits	Full cost until out-of-pocket is met
Mental/ Behavioral Health Other Outpatient Items and Services	Full cost until out-of-pocket is met
Mental/Behavioral Health Inpatient Facility Fee	Full cost until out-of-pocket is met
Mental/Behavioral Health Inpatient Professional Fee	Full cost until out-of-pocket is met
Chemical Dependency Services	
Substance Use Disorder Outpatient Office Visits	Full cost until out-of-pocket is met
Substance Use Disorder Other Outpatient Items and Services	Full cost until out-of-pocket is met
Substance Use Disorder Inpatient Facility Services	Full cost until out-of-pocket is met
Substance Use Disorder Inpatient Professional Fee	Full cost until out-of-pocket is met
Home Health Services	
Home Health Care	Full cost until out-of-pocket is met
Rehabilitation Services	Full cost until out-of-pocket is met
Habilitation Services	Full cost until out-of-pocket is met
Skilled Nursing Care	Full cost until out-of-pocket is met
Hospice Services	Full cost until out-of-pocket is met
Pediatric Vision and Dental (Included in Plan)	
Pediatric Vision (Ages 0-18) Administered by VSP	
Eye Exam Including Refraction and Dilation Per Year	$0 Copay
1 Pair of Glasses Per Year (or Contact Lenses in Lieu of Glasses) Calendar Year	$0 Copay
Pediatric Dental (Ages 0-18) Administered by Delta Dental	
Child Dental Diagnostic and Preventive Services	See Delta Dental EOC

Footnotes: *Preventive care services are not subject to the deductible.

Medical / RX cost-sharing contributes toward annual deductible.

You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use, unless the service is not subject to the deductible. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st).