



Active Choice - **Benefit Matrix**

CCHP Individual and Family Deductible Plan

This matrix is intended to be used as a summary only. The Evidence of Coverage (EOC) should be consulted for a detailed description of coverage benefits and limitations. Applicants who want to review the EOC prior to enrollment can call CCHP at 415-955-8800 x 3256 to request a copy.

Covered Services	Member Pay
<p>MEDICAL DEDUCTIBLE (per calendar year)</p> <p>Some services below are subject to deductible. Once the deductible has been met, a copayment or coinsurance may apply.</p>	<p>\$3,000 per Individual \$5,000 per Family</p>
<p>LIFETIME MAXIMUM</p>	<p>No Limit</p>
<p>ANNUAL OUT-OF-POCKET MAXIMUM (per calendar year)</p> <p>The annual limit to the total amount of deductibles, copayments and coinsurance that an individual or family may pay in a calendar year (see services listed below)</p>	<p>\$4,000 per Individual \$6,000 per Family</p>
<p>PROFESSIONAL PREVENTIVE CARE SERVICES</p> <ul style="list-style-type: none"> Annual Physical Maternity/prenatal care Well-child preventive care visits <ul style="list-style-type: none"> Birth to 23 months 24 months to 5 years Immunizations 	<p>Not Subject To Deductible</p> <ul style="list-style-type: none"> \$30 per visit Covered in Full \$10 per visit \$20 per visit Covered in Full
<p>PROFESSIONAL SERVICES – <i>Subject to Deductible:</i></p> <ul style="list-style-type: none"> Primary and specialty care visits Eye exams Hearing examinations 	<p>After Deductible</p> <ul style="list-style-type: none"> \$30 per visit \$30 per visit \$30 per visit
<p>OUTPATIENT SERVICES – <i>Subject to Deductible:</i></p> <ul style="list-style-type: none"> Allergy injection & serum Allergy diagnosis & testing Occupational, physical, and speech therapy Lab test, X-rays MRI/CT/PET Outpatient surgery (physician office) Outpatient surgery (medical facility) 	<p>After Deductible</p> <ul style="list-style-type: none"> 50% of cost (not applicable to OOP max) \$30 per visit \$30 per visit \$10 per visit \$50 per visit \$30 per visit \$250 per visit

Covered Services	Member Pay
<p>HOSPITAL SERVICES – Subject to Deductible: Inpatient Hospital services Skilled Nursing Facility (up to 30 days per calendar year)</p>	<p>After Deductible \$500/day \$50/day</p>
<p>EMERGENCY HEALTH COVERAGE – Subject to Deductible: Emergency Room Ambulance Services</p>	<p>After Deductible \$100 per visit (waived if admitted) \$100 per trip</p>
<p>MENTAL HEALTH SERVICES – Subject to Deductible: Outpatient (up to 20 visits per calendar year)* Inpatient (up to 30 days per calendar year)* <i>* for severe emotional disturbance of children, and severe mental illness, the number of visits and day limits do not apply as determined by the PCP</i></p>	<p>After Deductible \$30/\$15 per visit (individual/group session) \$500/day</p>
<p>CHEMICAL DEPENDENCY SERVICES – Subject to Deductible: Outpatient (up to 20 visits per calendar year) Inpatient (detoxification only)</p>	<p>After Deductible \$30/\$15 per visit (individual/group session) \$500/day</p>
<p>DURABLE MEDICAL EQUIPMENT Inpatient Outpatient (maximum annual benefit of \$500)</p>	<p>Not Subject To Deductible Covered in Full 50% of cost (not applicable to OOP max)</p>
<p>PROSTHETICS & ORTHOTICS Inpatient Outpatient</p>	<p>Not Subject To Deductible Covered in Full \$30 per item</p>
<p>HOME HEALTH SERVICES (up to 50 visits per calendar year)</p>	<p>Not Subject To Deductible Covered in Full</p>
<p>PRESCRIPTION DRUG COVERAGE Generic drugs (up to a 30 day supply) Mail-order Generic (up to a 90 days supply) Brand-name drugs ** (up to a 30 day supply) Mail-order Brand ** (up to a 90 days supply)</p>	<p>\$10 \$20 \$30 (after Rx deductible) \$60 (after Rx deductible)</p>

** Brand-name drugs have a \$250 calendar year deductible