

Employer Group Benefit 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.

BENEFITS	PLAN A	PLAN B	PLAN C	PLAN D	PLAN E	Active Choice
ANNUAL DEDUCTIBLE (PER CALENDAR YEAR)	No Deductible	No Deductible	No Deductible	No Deductible	No Deductible	\$3,000 / \$5,000
ANNUAL OUT OF POCKET-MAXIMUM						
Individual/Family	\$2,000 / \$4,000	\$2,000 / \$4,000	\$2,500 / \$5,000	\$3,000 / \$6,000	\$3,500 / \$7,000	\$4,000 / \$6,000
LIFETIME MAXIMUM	No Limit	No Limit	No Limit	No Limit	No Limit	No Limit
PROFESSIONAL SERVICES						After Deductible
Primary and specialty care visits	\$5 per visit	\$10 per visit	\$15 per visit	\$20 per visit	\$45 per visit	\$30 per visit
Maternity / Prenatal Care	\$5 per visit	\$10 per visit	\$10 per visit	\$10 per visit	\$10 per visit	No Charge
Eye examinations	\$5 per visit	\$10 per visit	\$15 per visit	\$20 per visit	\$45 per visit	\$30 per visit
Hearing examinations	\$5 per visit	\$10 per visit	\$15 per visit	\$20 per visit	\$45 per visit	\$30 per visit
Physical Examinations:						Not Subject To Deductible
Preventive Services - Children	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Preventive Services - Women	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Preventive Services - All Adults	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Immunizations	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
OUTPATIENT SERVICES						After Deductible
Lab test, X-rays	No Charge	No Charge	No Charge	No Charge	No Charge	\$10 per visit
MRI/CT/PET	No Charge	No Charge	No Charge	No Charge	No Charge	\$50 per visit
Allergy testing and serum	50% of cost	50% of cost	50% of cost	50% of cost	50% of cost	50% of cost
Allergy diagnosis and injection	50% of cost	50% of cost	50% of cost	50% of cost	50% of cost	\$30 per visit
Infertility Services	50% of cost	50% of cost	50% of cost	50% of cost	50% of cost	50% of cost
Physical, speech, & occupational therapy	\$5 per visit	\$10 per visit	\$15 per visit	\$20 per visit	\$45 per visit	\$30 per visit
Outpatient surgery (Facility Charge)	No Charge	\$100 per visit	\$100 per visit	\$200 per visit	\$200 per visit	\$250 per visit
HOSPITALIZATION SERVICES						After Deductible
Inpatient hospital services	No Charge	\$200 per admission	\$500 per admission	\$250 per day; limit of \$1000	\$500 per day	\$500 per day
Skilled nursing facility care	No Charge	No Charge	No Charge	\$100 per day	\$100 per day	\$50 per day
EMERGENCY ROOM						After Deductible
(waived if admitted to the hospital)	\$50 per visit	\$50 per visit	\$50 per visit	\$100 per visit	\$100 per visit	\$100 per visit
AMBULANCE	\$100 per trip	\$100 per trip	\$100 per trip	\$100 per trip	\$100 per trip	\$100 per trip
DURABLE MEDICAL EQUIPMENT						Not Subject To Deductible
Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient	50% of cost (Maximum annual benefit of \$2000)	50% of cost (Maximum annual benefit of \$2000)	50% of cost (Maximum annual benefit of \$2000)	50% of cost (Maximum annual benefit of \$2000)	50% of cost (Maximum annual benefit of \$2000)	50% of cost (not applicable to OOP Max) (Maximum annual benefit of \$500)
PROSTHETICS						Not Subject To Deductible
Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient	\$5 per item	\$10 per item	\$15 per item	\$20 per item	\$45 per item	\$30 per item
MENTAL HEALTH & CHEMICAL DEPENDENCY						After Deductible
Outpatient Care	\$5 per visit	\$10 per visit	\$15 per visit	\$20 per visit	\$45 per visit	\$30 copay per visit
Inpatient Mental Health Services	No Charge	\$200 per admission	\$500 per admission	\$250 per day; limit of \$1000	\$500 per day	\$500 per day
Inpatient Chemical Dependency - Detox Only	No Charge	\$200 per admission	\$500 per admission	\$250 per day; limit of \$1000	\$500 per day	\$500 per day
HOME HEALTH SERVICES	No Charge	No Charge	No Charge	No Charge	No Charge	Not Subject To Deductible No Charge
PRESCRIPTION DRUG COVERAGE (on CCHP formulary)						
Generic Drugs Up to 30 Days Supply	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay
Brand-name Drugs* Up to 30 Days Supply (*\$250 Calendar Year Brand Name Drug Deductible)	\$30 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay