2021 Schedule of Benefits & Coverage Matrix: Bronze 60 HMO

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE (EOC) AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Accumulation Period
The Accumulation Period for this plan is 01/01/21 through 12/31/21 (Calendar year).

Calendar Year Out-of-Pocket Maximum	
You will not pay any more Cost Share during a calendar year if the Copayments and Coinsurance you pay add up to one of the following amounts:	
For Self-only enrollment (a Family of one Member)	$8,200 per calendar year
For an entire Family of two or more Members	$16,400 per calendar year

Plan Deductible	
You must meet your Plan Deductible before your Cost Share applies (except those services that have "No charge"):	
Medical Deductible	$6,300/person or $12,600/family
Pharmacy Deductible	$500/person or $1000/family

Lifetime Maximum	None

Professional Services (Plan Provider office visits)	Your Cost Share
Most Primary Care Visits for evaluations and treatment	$65 per visit*
Most Specialty Care Visits for consultations, evaluations and treatment	$95 per visit*
Other Practitioner Office Visits**	$65 per visit*
Routine physical maintenance exams, including well woman exams	No charge
Well-child preventative exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist for Members under age 19	No charge
Hearing exams	No charge
Most Physical, occupational, and speech therapy	$65 per visit
Urgent care consultations, evaluations, and treatment	$65 per visit*

Note:

1. Urgent care includes Mental/Behavioral health and Chemical dependency (Substance Use Disorder) crisis intervention services.
2. Telehealth are covered benefits. Your cost-share for telehealth services shall not exceed the cost-share charged for the same services delivered in-person.

Outpatient Services	Your Cost Share
Outpatient surgery facility fee	40% coinsurance per procedure+
Outpatient Physician/surgeon fee	40% coinsurance per visit+
Outpatient Visit***	40% coinsurance per visit+
Most Immunizations (including the vaccine)	No charge
Most X-rays	40% coinsurance per encounter+
Most Laboratory tests	$40 per encounter
MRI, most CT, and PET scans	40% coinsurance per procedure+
Rehabilitation/Habilitation services	$65 per visit
Covered individual health education counseling	No charge
Covered health education programs	No charge

Hospitalization Services	Your Cost Share
Inpatient stay (facility fee)	40% coinsurance per admission+
Physician/surgeon fee for surgery	40% coinsurance per admission+

Emergency Health Coverage	Your Cost Share
Emergency room facility fee	40% per visit+
Emergency room physician fee	No charge

Note: Emergency room fees do not apply if admitted directly to the hospital as an inpatient for Covered Services.

Ambulance Services	Your Cost Share
Ambulance Services	40% coinsurance per trip+

Prescription Drug Coverage		Your Cost Share
Covered outpatient items in accord with our drug formulary guidelines:		
Tier 1	At a Plan Pharmacy or our mail order service	$18 for up to a 30-day supply+
Tier 2	At a Plan Pharmacy or our mail order service	40% coinsurance up to $500 per script for up to a 30-day supply+
Tier 3	At a Plan Pharmacy or our mail order service	40% coinsurance up to $500 per script for up to a 30-day supply+
Tier 4	Items at a Plan Pharmacy	40% coinsurance up to $500 per script for up to a 30-day supply+

Drug Tiers	Categories
1	•Most generic drugs and •Low cost preferred brands
2	•Non-preferred generic drugs; •Preferred brand name drugs; and •Any other drugs recommended by plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
3	•Non-preferred brand name drugs or; •Drugs that are recommended by P&T committee based on drug safety, efficacy and cost or; •Generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	• Drugs that are biologics and drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies ; • Drugs that requires the enrollee to have special training or; clinical monitoring; • Drugs that cost the health plan (net of rebates) more than six hundred dollars ($600) net of rebates for a one-month supply.

Mental/Behavioral Health (MH) Services	Your Cost Share
Inpatient:	
MH psychiatric hospitalization fee	40% coinsurance per admission+
MH psychiatric physician/surgeon fee	40% coinsurance per admission+
MH psychiatric observation	Included in psychiatric hospitalization fee
MH psychological testing	Included in psychiatric hospitalization fee
MH individual and group treatment	Included in psychiatric hospitalization fee
MH individual and group evaluation	Included in psychiatric hospitalization fee
MH crisis residential program	40% coinsurance per admission+
Outpatient:	
MH office visits	$65 per visit*
MH monitoring of drug therapy	$65 per visit*
MH individual and group treatment	$65 per visit*
MH individual and group evaluation	$65 per visit*
Outpatient, Other Items and Services:	
Applied behavior analysis and behavioral health treatment	$65 per visit+
MH multidisciplinary treatment in an intensive outpatient psychiatric treatment program	$65 per visit+
Neuropsychological testing	$65 per visit+
MH partial hospitalization	$65 per visit+
MH psychological testing	$65 per visit+

Note: Telehealth are covered benefits. Your cost-share for telehealth services shall not exceed the cost-share charged for the same services delivered in-person.

Chemical Dependency (Substance Use Disorder) Services	Your Cost Share
Inpatient:	
Chemical dependency hospitalization fee	40% coinsurance per admission+
Chemical dependency physician/surgeon fee	40% coinsurance per admission+
Inpatient detoxification	Included in hospitalization fee
Individual and group treatment	Included in hospitalization fee
Individual and group chemical dependency counseling	Included in hospitalization fee
Individual and group evaluation	Included in hospitalization fee
Transitional residential recovery services	40% coinsurance per admission+
Outpatient:	
Chemical dependency office visits	$65 per visit*
Chemical dependency individual and group evaluation	$65 per visit*
Chemical dependency individual and group counseling	$65 per visit*
Methadone Maintenance	$65 per visit*
Outpatient, Other Items and Services:	
Chemical dependency intensive outpatient programs	$65 per visit+
Chemical dependency day treatment programs	$65 per visit+
Note: Telehealth are covered benefits. Your cost-share for telehealth services shall not exceed the cost-share charged for the same services delivered in-person.	

Durable Medical Equipment (DME)	Your Cost Share
DME items that are essential health benefits	40% coinsurance+

Home Health Services	Your Cost Share
Home health care (up to 100 visits per calendar year)	40% coinsurance per visit+

Other	Your Cost Share
Eyeglasses or contact lenses for Members under age 19:	
Eyeglass frame from selected styles per calendar year	No charge
Standard contact lenses per calendar	No charge
Regular eyeglasses lenses per calendar year	No charge
Note: Limited to one pair of glasses per year (contact lenses in lieu of glasses).	
Skilled Nursing Facility care (up to 100 days per benefit period)	40% coinsurance+
Hospice care	No charge
Dental Services	
For associated cost-sharing such as oral exam, preventive cleaning, medically necessary orthodontics, etc. please see Liberty Dentals schedule of benefits with the appropriate cost-amounts.	

Notes:

+ Deductible applies

*Deductible applies after 1st three non-preventive visits. Deductible is waived for the first three non-preventive visits combined, which may include office visits (primary, other practitioner, and specialist), urgent care visits, or OP Mental Health/Substance Use Disorder visits.

**Other Practitioner Office Visits include visits not provided by either Primary Care or Specialty Practitioners.

***Outpatient Visits includes but not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of- pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the "Benefits and Cost Share", "Limitations & Exclusions", and "Payment & Reimbursement Responsibility" sections in your EOC.