DELTA HEALTH SYSTEMS

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

The Edcare Group
Modern Care Plan

Network in California is Anthem Blue Cross
Network out of California is Anthem Blue Card
Benefits described below are effective October 1, 2020 – September 30, 2021

Calendar Year Medical Deductible Limit
The deductible applies to all services unless noted

Network Provider	Non-Network Provider
$400-individual **see below-family	$5,000–individual

An individual within a family shall not have a deductible that is more than the individual deductible limit. **To satisfy the family deductible, three family members must each meet their individual deductible. Network Provider deductible is not applied toward the Non-Network Provider deductible.

Calendar Year Medical Out of Pocket Maximums

Network Provider	Non-Network Provider
$3,000-individual **see below-family	$10,000–individual *see below

For family coverage, an individual within a family shall not have a maximum out of pocket limit that is greater than the maximum out of pocket limit for an individual. ***For participants with Family coverage, the Out of Pocket will be considered satisfied when 3 individuals each satisfy their individual maximum* The out of pocket amount includes *medical* copays, deductible and coinsurance amounts for 'essential health benefits' as defined under the Affordable Care Act. *Prescription expenses are not included in the Medical Out-of-Pocket maximum.* For the 2019 plan year, the combined Medical and Prescription annual Out of Pocket maximum for covered services received In-Network will not exceed limits of $8,150 per Individual or $16,300 for Family coverage.

Calendar Year Prescription Out of Pocket Maximum - $3,000–individual / $7,500 (2.5x) – family (Network participating pharmacies only) ***Please see prescription information on page 4. *Only copays will count toward the prescription Out of Pocket Maximum.***

LIFETIME BENEFIT MAXIMUM **Unlimited**

PROFESSIONAL SERVICES	Network Provider	Non-Network Provider
Professional (Physician) Benefits		
Physician Office * ADHD – Office visit for diagnosis and Medical Management for RX only	PCP: $30 Copay Specialist: $60 Copay (deductible waived)	50%
Inpatient Hospital Visits	10%	50%
Allergy: Injection/Serum/Testing	10%	50%
Pregnancy-Delivery Charge	10%	50%
Surgeon, Assistant Surgeon, Anesthesiologist	10%	50%
Urgent Care	$50 Copay / 10%	$50 Copay / 50%
Counseling (Mental Health and Substance Abuse– must be approved by Halcyon or not covered)	PCP: $30 Copay (deductible waived)	50%
Testing (Mental Health)	10%	50%

Benefit Descriptions, continued	Network Provider	Non-Network Provider
Preventive Health Benefits		
Colonoscopy (starting at age 50 and above, in accordance with ACA requirements)	$0 (deductible waived)	Not Covered
Immunizations (in accordance with ACA requirements)	$0 (deductible waived)	Not Covered
Mammogram (starting at age 39 in accordance with ACA requirements – unless medically necessary)	$0 (deductible waived)	Not Covered
Preventive Exam (in accordance with ACA requirements)	$0 (deductible waived)	Not Covered
Pre-Natal Care/Dependent Women (all ages in accordance with ACA requirements)	$0 (deductible waived)	Not Covered
Women's Health Care (gynecological exam, screening, breast-feeding equipment, tubal ligation and birth control services)	$0 (deductible waived)	Not Covered
Outpatient Services		
CT scans, MRIs, MRAs, PET Scans, and Cardiac Diagnostic (Complex Services)	$75 Copay /10%	$75 Copay /50%
Laboratory and Pathology	$30 Copay /10%	$30 Copay /50%
X-ray, EKG, Diagnostic Medicine Services	$30 Copay /10%	$30 Copay /50%
Hospital Services		
Outpatient Surgery	Facility - $200 Copay /10% Ambulatory (applicable for same-day or overnight stay) $150 Copay/10%	Facility - $200 Copay/50% Ambulatory (applicable for same-day or oversight stay) $150 Copay /50% ($750 copay applies to Summit Surgical)
Emergency Room/Facility Charge	$300 Copay /10%	$300 Copay /10% Non-emergency use of ER = $300Copay/50%
Emergency Room/Physician Charge	10%	10% Non-emergency use of ER =50%
Inpatient Room and Board (including mental health and substance abuse)	$250 Copay per day (up to $750 per admission) /10%	$250 Copay per day (up to $750 per admission) /50%
Skilled Nursing Facility (100 days per calendar year)	10%	50%
Day Treatment and Residential Treatment (mental health/substance abuse)	$250 Copay per day (up to $750 per admission) /10%	$250 Copay per day (up to $750 per admission) /50%

Benefit Descriptions, continued	Network Provider	Non-Network Provider
Additional Covered Services		
Ambulance Services (emergency or authorized transport)	10%	10% Non-emergency use of ambulance 50%
Bariatric Surgery (must use Santé services for coverage – see last page)	10%	50%
Dialysis	10%	50%
Chemotherapy / Radiation Therapy	10%	50%
Durable Medical Equipment/Orthotics/Devices/Oxygen &Supplies	10%	50%
Home Health Services		
Home Care Agency Services (aide and private duty nurse is covered / 2 visits per day maximum)	10%	50%
Hospice	10%	50%
Rehabilitation Services		
Cardiac Rehabilitation	10%	50%
Chiropractic ($500 per calendar year maximum) ***Network is PhysMetrics**	$30 Copay (Deductible waived) Spinal Manipulation 10% and subject to deductible	Limited to $15 maximum reimbursement after deductible
Occupational/Physical/Speech Therapy (physical therapy requires a MD referral) ***Network is PhysMetrics**	10%	50%
Pulmonary/Respiratory Therapy	10%	50%
Prescription Services		
Generic drugs (on Basic Formulary)	$10/retail prescription $20/mail-order prescription	
Preferred Brand name drugs (on Basic Formulary)	$45/retail prescription $90/mail-order prescription	
Non-Preferred Brand name drugs	$80/retail prescription $160/mail-order prescription	
Specialty drugs	$250/retail prescription	

Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription). Step therapy and Pre-authorization requirements may apply for certain drug categories.

ADDITIONALINFORMATION

Prescription Benefits are administered by: **IPM…….. (877) 860-8846**

- **Specialty Drugs and all other prescribed medication**
- **Mandatory Generic required. Patient responsible for the cost difference between generic and brand when generic is available. Only the co-pay will count toward Out of Pocket Maximum.**

Dental Claims administered by: **Ameritas…… (800) 487-5553**

Vision Claims administered by: **Vision Service Plan…….. (800) 877-7195**

Medical: Non-Covered Services, please refer to the summary plan document for details on any service limitation before service(s) are incurred.

Non-Network Provider allowance is based on Anthem contracted pricing.

Utilization Review is required for the items listed below - Anthem Blue Cross should be notified in advance for non-emergency services (800) 274-7767 and within 48 hours of any emergency service listed below:

- All inpatient facility services (acute care, surgical, mental health and substance abuse)
- Skilled Nursing facility
- Home health
- Home infusion therapy
- Transplants
- Outpatient surgery (for specific procedures only, contact Anthem to confirm if surgery requires pre-authorization)
- Case Management
- Air Ambulance (non-emergency use)
- Durable Medical Equipment

For Mental Health and Substance Abuse services, inpatient or outpatient, requires a pre-service authorization you must call Halcyon Behavioral at (800) 425-4800

For Weight Management services, including bariatric surgery, you must contact Santé at (559) 228-5405.

For your Chiropractic, Physical Therapy, Occupational Therapy, Speech Therapy needs, call PhysMetrics at (877) 519-8839 to locate a network provider.