

# PrimeCare Silver

PPO

**Thank you for considering CHA Health.** Our Prime Network offers you one of the largest choices of participating providers in Kentucky. The PrimeCare Silver plan, our PPO option, gives you even more choices with out-of-network benefits and has no referral requirements for specialty care. For provider information go to [www.cha-health.com](http://www.cha-health.com) or our Prime Network Directory. Questions? Call CHA Health Member Services at 859-232-8686 or 800-457-5683.

**In-network benefits** apply to covered services received from participating providers. **Out-of-network benefits** apply if you receive covered services from non-participating providers. Out-of-network benefits require you to pay substantially more, including deductible, coinsurance and any amount above the eligible expense.

*This is a summary of benefits. Refer to the Certificate of Coverage for complete information. Prior Plan Approval requirements apply to certain services from both participating and non-participating providers.*



Option: PPO-10

	IN-NETWORK	OUT-OF-NETWORK
Deductible	Single: \$250 Family: \$500	Single: \$500 Family: \$1,000
Out-of-Pocket Limit	Single: \$1,500 Family: \$3,000	Single: \$3,000 Family: \$6,000
Maximum Lifetime Limit	Unlimited	
SERVICE	IN-NETWORK BENEFIT AFTER DEDUCTIBLE*	OUT-OF-NETWORK BENEFIT AFTER DEDUCTIBLE*
<b>Inpatient Hospital Care</b>		
Inpatient	20% Coinsurance*	40% Coinsurance*
Transplants	20% Coinsurance*	Not Covered
<b>Outpatient Services</b>		
Outpatient Surgery / Ambulatory Hospital	20% Coinsurance*	40% Coinsurance*
Physician Office Visits, including diagnostic and early detection tests, allergy testing, allergy serum and injections, diabetes education services, well child care through age 17, immunizations, injections	\$15 Copay per visit	40% Coinsurance*
Adult Preventive Care - Annual physical and gynecological exam office visits for persons over age 17 (the Testing benefit applies to early detection tests)	\$15 Copay per visit	40% Coinsurance*
Testing - laboratory, x-ray and other radiology/imaging services	\$15 Copay per visit	40% Coinsurance*
<b>Urgent Care</b>	\$15 Copay per visit	40% Coinsurance*
<b>Emergency Services</b>		
Hospital Emergency Room	20% Coinsurance*, waived if admitted	40% Coinsurance*, waived if admitted
Emergency Room Physician	20% Coinsurance*	40% Coinsurance*
Ambulance	20% Coinsurance*	20% Coinsurance*
<b>Maternity Care</b>		
Physician prenatal, labor, delivery and postpartum care	Covered in full after initial \$15 office visit Copay	40% Coinsurance*
Inpatient maternity services	20% Coinsurance*	40% Coinsurance*
<b>Mental Health &amp; Chemical Dependency</b>		
Inpatient - limit of 30 days per Plan Year	20% Coinsurance*	40% Coinsurance*
Outpatient - limit of 30 visits per Plan Year	\$15 Copay per visit	40% Coinsurance*
Autism: \$500 total monthly benefit for children ages 2-21 for therapeutic, respite and rehabilitative care	Copayment/Coinsurance applicable to service provided; 50% coinsurance for respite services.	

\* The Coinsurance applies after you meet the Deductible. For Out-of-Network services, after you meet the Deductible, you are responsible for the Coinsurance and any amount above the Plan's Eligible Expense up to the Provider's billed charges.

SERVICE and BENEFIT LIMIT	IN-NETWORK BENEFIT AFTER DEDUCTIBLE*	OUT-OF-NETWORK BENEFIT AFTER DEDUCTIBLE*
<b>Other Services</b>		
Outpatient Physical, Occupational, Chiropractic and/or Cardiac Rehabilitation Therapy - Limit of 30 visits per Plan Year for all therapies combined.	20% Coinsurance*	40% Coinsurance*
Speech Therapy - Limit of 30 visits per Plan Year	20% Coinsurance*	40% Coinsurance*
Skilled Nursing / Subacute Rehabilitation Facility - Limit of 30 days per Plan Year	20% Coinsurance*	40% Coinsurance*
Home Health - Limit of 60 visits per Plan Year	20% Coinsurance*	40% Coinsurance*
Hospice	Medicare Hospice Benefit	
Durable Medical Equipment, Prosthetics, Orthotics	20% Coinsurance*	40% Coinsurance*
<b>Prescription Drugs</b>		
Copay/coinsurance applies to each 30-day supply. Mail Order: a three month supply of maintenance drugs 2 copays/coinsurances.	Generic: \$5 Copay Preferred Brand: \$20 Copay Non-Preferred Brand: \$60 Copay \$200 Prescription Drug Deductible	Not Covered
<b>Supplemental Benefit Rider(s)</b>		
Basic Vision Rider adds coverage for one routine vision exam every 12 months up to age 18, every 24 months thereafter. \$10 Copay per visit.		

\* The Coinsurance applies after you meet the Deductible. For Out-of-Network services, after you meet the Deductible, you are responsible for the Coinsurance and any amount above the Plan's Eligible Expense up to the Provider's billed charges.

**PRIOR PLAN APPROVAL:** Certain services require Prior Plan Approval to be covered. Refer to the Certificate of Coverage or our web site for a complete list of services that require Prior Plan Approval before the service is rendered.

**DEDUCTIBLE:** The dollar amount that the Member pays for Covered Services before the Plan will provide benefits. The Deductible applies to all services except prescription drugs, autism, and services to which a Copay applies. Expenses that do not accumulate toward meeting the Deductible include charges for non-covered services, prescription drugs, autism, and services to which a Copay applies. Expenses accumulate separately toward the In-Network Deductible and Out-of-Network Deductible.

**PRESCRIPTION DRUG DEDUCTIBLE:** The dollar amount that the Member pays for covered prescription drugs before the Plan will provide benefits.

**OUT-OF-POCKET LIMIT:** When the Out-of-Pocket Limit is reached in a Plan Year, the Plan pays 100% of Eligible Expenses for Covered Services. The Deductible is included in the Out-of-Pocket Limit. These expenses do not apply toward the Out-of-Pocket Limit: prescription drugs, autism services, non-covered services and services rendered after a benefit limit is reached.

**PLAN YEAR:** Each successive twelve-month period starting on the Group Effective Date.

**DEPENDENT COVERAGE:** Unmarried dependent children to age 19, unmarried full-time students to age 25.

**EXCLUSIONS:** This is a partial list. Refer to your Certificate of Coverage for details on exclusions to your plan.

- Services which are not Medically Necessary, including cosmetic surgery
- Experimental or investigational services and drugs
- Routine vision services, unless covered by a Rider
- Dental services, except accidental dental, unless covered by a Rider
- Maternity care for dependent children
- Infertility services & infertility drug treatment
- Physical examinations or tests required by a third party, such as for employment or travel
- Illness or injury covered by Workers' Compensation
- Pre-existing Conditions for up to 12-months for persons without sufficient prior Creditable Coverage

**CHA Health Member Services (800) 457-5683 or (859) 232-8686**  
Visit our web site at [www.cha-health.com](http://www.cha-health.com)