BENEFITS

Commonwealth Essential

Covered Services	Commonwealth Essential	
	In-network	Out-of-Network
Annual Deductible	Single - $750 Family - $1,500	Single - $1,500 Family - $3,000
Out-of-pocket maximum (excludes prescription drug expenses and emergency room co-payments)	Single - $3,500 Family - $7,000	Single - $7,000 Family - $14,000
Lifetime maximum	Unlimited	
In-hospital care – provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas, or mental health and chemical dependency services	25%*	50%*
Outpatient services – physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy; injections, lab fees, X-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site).	25%*	50%*
Diagnostic testing – laboratory tests, X-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	25%*	50%*
Ambulatory hospital and outpatient surgery services – outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	25%*	50%*

Covered Benefits	In-Network		Out-of-Network
Preventive care – annual gynecological exam, well child care, and routine physical early detection tests, subject to age and periodicity limits.	Plan pays 100% up to a maximum of $200 per covered individual. Plan pays 100% of eligible immunizations.		
Emergency services			
Emergency room treatment (Emergency room co-pay waived if admitted).	$50 co-pay plus 25%*		$50 co-pay plus 50%*
Emergency room physician charges	25%*		50%*
Urgent care center treatment	25%*		50%*
Ambulance services	25%*		50%*
Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval.	25%*		50%*
Prescription drugs – Retail (30 day supply)	25%		
	Min	Max	
1st Tier	$10	$25	
2nd Tier	$20	$50	
3rd Tier	$35	$100	
Prescription drugs – Mail Order (90 day supply)	25%		
	Min	Max	
Generic	$20	$50	
Preferred Brand	$40	$100	
Non-preferred Brand	$70	$200	
Audiometric services in conjunction with a disease, illness or injury	25%*		50%*
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	25%*		50%*
Autism Service			
Rehabilitative and therapeutic care services	25%*		50%*
Respite care for children ages two through 21 ($500 maximum per month)	25%*		50%*
Hospice care – subject to precertification by the plan	Covered the same as under the federal Medicare program		
Durable Medical Equipment	25%*		50%*
Prosthetic devices	25%*		50%*
Home health – limited to 60 visits per year	25%*		50%*

Covered Services	In-Network	Out-of-Network
Physical therapy – limited to 30 visits per year	25%*	50%*
Occupational therapy – limited to 30 visits per year	25%*	50%*
Cardiac rehabilitation therapy – limited to 30 visits per year	25%*	50%*
Speech therapy – limited to 30 visits per year	25%*	50%*
Skilled nursing facility services – limited to 30 days per year	25%*	50%*
Hearing aids – individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	25%*	50%*

*Services subject to deductible

Commonwealth Enhanced and Commonwealth Premier Benefits Grid

Covered Services	Commonwealth Enhanced		Commonwealth Premier	
	In-network	Out-of-Network	In-network	Out-of-Network
Annual Deductible (excludes office visit co-pay, preventive care services, outpatient diagnostic testing, urgent care center, prescription drugs, chiropractic services and hospital emergency room services)	Single - $250 Family - $500	Single - $500 Family - $1,000	Single - $250 Family - $500	Single - $500 Family - $1,000
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - $1,250 Family - $2,500	Single - $2,500 Family - $5,000	Single - $1,000 Family - $2,000	Single - $2,000 Family - $4,000
Lifetime maximum	Unlimited		Unlimited	
In-hospital care – provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	20%*	40%*	10%*	30%*
Outpatient services – physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well child care, immunizations, injections, lab fees, x-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site).	$10 co-pay	40%*	$10 co-pay	30%*
Outpatient diagnostic testing – laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	$10 co-pay	40%*	$10 co-pay	30%*
Ambulatory hospital and outpatient surgery services – outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	20%*	40%*	10%*	30%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	$10 co-pay per visit	40%*	$10 co-pay per visit	30%*
	$400 maximum benefit per covered individual per plan year		$400 maximum benefit per covered individual per plan year	
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	$50 co-pay plus 20%	$50 co-pay plus 40%	$50 co-pay plus 10%	$50 co-pay plus 30%*
Emergency room physician charges	20%	40%	10%	30%*
Urgent care center treatment	$20 co-pay	40%*	$20 co-pay	30%*
Ambulance services	20%*	20%*	10%*	30%*
Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit co-pay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no co-pay required.	$10 co-pay in-hospital care co-insurance applies*	40%*	$10 co-pay in-hospital care co-insurance applies*	30%*

Covered Services	Commonwealth Enhanced		Commonwealth Premier	
	In-network	Out-of-Network	In-network	Out-of-Network
Prescription drugs – Retail (30 day supply) 1st Tier 2nd Tier 3rd Tier	 $5** $15** $30**	 40% 40% 40%	 $5** $15** $30**	 30% 30% 30%
Prescription drugs – Mail Order (90 day supply) 1st Tier 2nd Tier 3rd Tier	 $10 $30 $60		 $10 $30 $60	
Audiometric services in conjunction with a disease, illness or injury	50%*	50%*	10%*	30%*
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	$10 co-pay	40%*	$10 co-pay	30%*
Autism Service				
▪ Rehabilitative and therapeutic care services	$10 co-pay	40%*	$10 co-pay	30%*
▪ Respite care for children ages two through 21 ($500 maximum per month)	50%*	50%*	10%*	30%*
Hospice care – subject to precertification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	20%*	40%*	10%*	30%*
Prosthetic devices	20%*	40%*	10%*	30%*
Home health – limited to 60 visits per year	20%*	40%*	10%*	30%*
Physical therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*
Occupational therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*
Cardiac rehabilitation therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*
Speech therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*
Skilled nursing facility services – limited to 30 days per year	20%*	40%*	10%*	30%*
Hearing aids – individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	20%*	40%*	10%*	30%*

*subject to annual deductible
** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to $10 2nd Tier and $20 3rd Tier.