

Changes we're making to your current health plan

The difference between your 2022 monthly rate and your current rate is due to:

- Costs associated with the administration and delivery of essential health benefits.
- Changes to your benefit design that include(s):

Benefit Comparison Chart	Bronze 60 HMO 6300/75 +Child Dental	
Covered Services	2021	2022
DEDUCTIBLES		
Annual Deductible	Medical: Individual \$6,300/ Family \$12,600 Drug: Individual \$500/ Family \$1,000	Medical: Individual \$6,300/ Family \$12,600 Drug: Individual \$500/ Family \$1,000
Out-of-Pocket Limit On Expenses	Individual \$8,200/ Family \$16,400	Individual \$8,200/ Family \$16,400
PROFESSIONAL SERVICES	Member Cost Share	
Visit to a Health Care Provider's Office or Clinic		
Preventive Care/ Screening/ Immunization	\$0 Copay	\$0 Copay
Family Planning (Consultation and Contraceptive Services)	\$0 Copay	\$0 Copay
Prenatal Care and Preconception Visits	\$0 Copay	\$0 Copay
Diabetes Care Management	\$0 Copay	\$0 Copay
Diabetes Education	\$0 Copay	\$0 Copay
Primary Care Visit to Treat an Injury or Illness	\$65 Copay (Deductible Applies after 1st 3 non-preventive visits)	\$65 Copay (Deductible Applies after 1st 3 non-preventive visits)
Specialist Visit	\$95 Copay (Deductible Applies after 1st 3 non-preventive visits)	\$95 Copay (Deductible Applies after 1st 3 non-preventive visits)
Acupuncture	\$65 Copay (Deductible Applies after 1st 3 non-preventive visits)	\$65 Copay (Deductible Applies after 1st 3 non-preventive visits)
Allergy Visit (Testing and Treatment)	\$95 Copay (Deductible Applies after 1st 3 non-preventive visits)	\$95 Copay (Deductible Applies after 1st 3 non-preventive visits)
Other Practitioner Office Visit	\$65 Copay	\$65 Copay (Deductible Applies after

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Covered Services	2021	2022
	(Deductible Applies after 1st 3 non-preventive visits)	1st 3 non-preventive visits)
Outpatient Services	Member Cost Share	
Tests		
Laboratory Tests	\$40 copay	\$40 copay
X-Rays	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Imaging (CT/PET scans, MRIs)	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Outpatient Surgery		
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Physician/Surgeon Fees	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Outpatient Visit	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Hospitalization Services		
Facility Fee (e.g., Hospital Room)	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Physician/Surgeon Fees	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Delivery and All Inpatient Services (Hospital Services)	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Delivery and All Inpatient Services (Professional Services)	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Emergency Health Coverage		
Emergency Room Services	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Emergency Room Physician Fee	\$0 Copay	\$0 Copay
Urgent Care	\$65 Copay, (Deductible Applies after 1st 3 non-preventive visits)	\$65 Copay, (Deductible Applies after 1st 3 non-preventive visits)
Ambulance Services		
Medical Transportation (Including Emergency and Non-emergency)	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Prescription Drug Coverage		
Tier 1:Generic Drugs (30-Day Supply)	\$18 Copay (After Drug Deductible)	\$18 Copay (After Drug Deductible)
Tier 1:Generic Drugs (90-Day Supply)	\$36 Copay	\$36 Copay

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Covered Services	2021	2022
Chinese Hospital Pharmacy, or Mail Order	(After Drug Deductible)	(After Drug Deductible)
Tier 2: Preferred Brand Drugs (30-Day Supply)	40% Coinsurance up to \$500 per prescription (After Drug Deductible)	40% Coinsurance up to \$500 per prescription (After Drug Deductible)
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	40% Coinsurance up to \$1500 per prescription (After Drug Deductible)	40% Coinsurance up to \$1500 per prescription (After Drug Deductible)
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	40% Coinsurance up to \$500 per prescription (After Drug Deductible)	40% Coinsurance up to \$500 per prescription (After Drug Deductible)
Tier 3: Non-preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	40% Coinsurance up to \$1500 per prescription (After Drug Deductible)	40% Coinsurance up to \$1500 per prescription (After Drug Deductible)
Tier 4: Specialty Drugs (30-Day Supply)	40% Coinsurance up to \$500 per prescription (After Drug Deductible)	40% Coinsurance up to \$500 per prescription (After Drug Deductible)
Medical Supplies/ Durable Medical Equipment		
Medical Supplies	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Prosthetic Devices	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Durable Medical Equipment (Outpatient)	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Mental Health Services		
Mental/Behavioral Health Outpatient Office Visits	\$0 Copay	\$0 Copay
Mental/ Behavioral Health Other Outpatient Items and Services	40% coinsurance, maximum \$65 Copay (After Deductible)	40% coinsurance, maximum \$65 Copay (After Deductible)
Mental/Behavioral Health Inpatient Facility Fee	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Mental/Behavioral Health Inpatient Professional Fee	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Chemical Dependency Services		
Substance Use Disorder Outpatient Office Visits	\$0 Copay	\$0 Copay
Substance Use Disorder Other Outpatient Items and Services	40% coinsurance, maximum \$65 Copay (After Deductible)	40% coinsurance, maximum \$65 Copay (After Deductible)
Substance Use Disorder Inpatient	40% Coinsurance	40% Coinsurance

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Covered Services	2021	2022
Facility Services	(After Deductible)	(After Deductible)
Substance Use Disorder Inpatient Professional Fee	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Home Health Services		
Home Health Care	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Rehabilitation Services	\$65 copay	\$65 copay
Habilitation Services	\$65 copay	\$65 copay
Skilled Nursing Care	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Hospice Services	\$0 Copay	\$0 Copay
Pediatric Vision and Dental (Included in Plan)		
Pediatric Vision (Ages 0-18) Administered by VSP		
Eye Exam Including Refraction and Dilation Per Year	\$0 Copay	\$0 Copay
1 Pair of Glasses Per Year (or Contact Lenses in Lieu of Glasses) Calendar Year	\$0 Copay	\$0 Copay
Pediatric Dental (Ages 0-18) Administered by Delta Dental		
Child Dental Diagnostic and Preventive Services	See Delta Dental EOC	See Delta Dental EOC