



## 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	Gold 80 HMO 0/30 +Child Dental	
	2021	2022
<b>DEDUCTIBLES</b>		
Annual Deductible	Medical: Individual \$250/ Family \$500 Drug: Individual \$0/ Family \$0	Medical: Individual \$250/ Family \$500 Drug: Individual \$0/ Family \$0
Out-of-Pocket Limit On Expenses	Individual \$7,800/ Family \$15,600	Individual \$7,800/ Family \$15,600
<b>PROFESSIONAL SERVICES</b>	<b>Member Cost Share</b>	
<b>Visit to a Health Care Provider's Office or Clinic</b>		
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	\$35 Copay	\$35 Copay
Specialist Visit	\$55 Copay	\$55 Copay
Acupuncture	\$35 Copay	\$35 Copay
Allergy Visit (Testing and Treatment)	\$55 Copay	\$55 Copay
Other Practitioner Office Visit	\$35 Copay	\$35 Copay
<b>Outpatient Services</b>	<b>Member Cost Share</b>	
<b>Tests</b>		
Laboratory Tests	\$35 Copay	\$35 Copay
X-Rays	\$55 Copay	\$55 Copay
Imaging (CT/PET scans, MRIs)	\$250 Copay (After Deductible)	\$250 Copay (After Deductible)
<b>Outpatient Surgery</b>		
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	\$300 Copay (After Deductible)	\$300 Copay (After Deductible)
Physician/Surgeon Fees	\$35 Copay	\$35 Copay
Outpatient Visit	20% Coinsurance	20% Coinsurance
<b>Hospitalization Services</b>		

<b>Benefit Comparison Chart</b>	<b>Gold 80 HMO 0/30 +Child Dental</b>	
<b>Covered Services</b>	<b>2021</b>	<b>2022</b>
Facility Fee (e.g., Hospital Room)	\$600 Per Day (Up To First 5 Days) (After Deductible)	\$600 Per Day (Up To First 5 Days) (After Deductible)
Physician/Surgeon Fees	\$0 Copay	\$0 Copay
Delivery and All Inpatient Services (Hospital Services)	\$600 Per Day (Up To First 5 Days) (After Deductible)	\$600 per day (Up to the first Five Days) (After Deductible)
Delivery and All Inpatient Services (Professional Services)	\$0 Copay	\$0 Copay
<b>Emergency Health Coverage</b>		
Emergency Room Services	\$250 Copay (After Deductible)	\$250 Copay (After Deductible)
Emergency Room Physician Fee	\$0 Copay	\$0 Copay
Urgent Care	\$35 Copay	\$35 Copay
<b>Ambulance Services</b>		
Medical Transportation (Including Emergency and Non-emergency)	\$250 Copay (After Deductible)	\$250 Copay (After Deductible)
<b>Prescription Drug Coverage</b>		
Tier 1:Generic Drugs (30-Day Supply)	\$15 Copay	\$15 Copay
Tier 1:Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	\$30 Copay	\$30 Copay
Tier 2: Preferred Brand Drugs (30-Day Supply)	\$40 Copay	\$40 Copay
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	\$80 Copay	\$80 Copay
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	\$70 Copay	\$70 Copay
Tier 3: Non-preferred Brand Drugs (90- Day Supply) Chinese Hospital Pharmacy, or Mail Order	\$140 Copay	\$140 Copay
Tier 4: Specialty Drugs (30-Day Supply)	20% Coinsurance up to \$250 per Prescription	20% Coinsurance up to \$250 per Prescription
<b>Medical Supplies/ Durable Medical Equipment</b>		
Medical Supplies	20% Coinsurance	20% Coinsurance
Prosthetic Devices	20% Coinsurance	20% Coinsurance
Durable Medical Equipment (Outpatient)	20% Coinsurance	20% Coinsurance
<b>Mental Health Services</b>		
Mental/Behavioral Health Outpatient Office Visits	\$0 Copay	\$0 Copay

<b>Benefit Comparison Chart</b>	<b>Gold 80 HMO 0/30 +Child Dental</b>	
<b>Covered Services</b>	<b>2021</b>	<b>2022</b>
Mental/ Behavioral Health Other Outpatient Items and Services	\$35 Copay	\$35 Copay
Mental/Behavioral Health Inpatient Facility Fee	\$600 Per Day (Up To First 5 Days) (After Deductible)	\$600 Per Day (Up To First 5 Days) (After Deductible)
Mental/Behavioral Health Inpatient Professional Fee	\$0 Copay	\$0 Copay
<b>Chemical Dependency Services</b>		
Substance Use Disorder Outpatient Office Visits	\$0 Copay	\$0 Copay
Substance Use Disorder Other Outpatient Items and Services	\$35 Copay	\$35 Copay
Substance Use Disorder Inpatient Facility Services	\$600 Per Day (Up To First 5 Days) (After Deductible)	\$600 Per Day (Up To First 5 Days) (After Deductible)
Substance Use Disorder Inpatient Professional Fee	\$0 Copay	\$0 Copay
<b>Home Health Services</b>		
Home Health Care	\$30 Copay	\$30 Copay
Rehabilitation Services	\$35 Copay	\$35 Copay
Habilitation Services	\$35 Copay	\$35 Copay
Skilled Nursing Care	\$300 Per Day (Up to First Five Days) (After Deductible)	\$300 Per Day (Up to First Five Days) (After Deductible)
Hospice Services	\$0 Copay	\$0 Copay
<b>Pediatric Vision and Dental (Included in Plan)</b>		
<b>Pediatric Vision (Ages 0-18) Administered by VSP</b>		
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
<b>Pediatric Dental (Ages 0-18) Administered by Delta Dental</b>		
Child Dental Diagnostic and Preventive Services	See Delta Dental EOC	See Delta Dental EOC