



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	Platinum 90 HMO 0/15 +Child Dental	
Covered Services	2021	2022
DEDUCTIBLES		
Annual Deductible	\$0	\$0
Out-of-Pocket Limit On Expenses	Individual \$4,500 / Family \$9,000	Individual \$4,500 / Family \$9,000
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	\$20 Copay	\$20 Copay
Specialist Visit	\$30 Copay	\$30 Copay
Acupuncture	\$20 Copay	\$20 Copay
Allergy Visit (Testing and Treatment)	\$30 Copay	\$30 Copay
Other Practitioner Office Visit	\$20 Copay	\$20 Copay
Outpatient Services		
Member Cost Share		
Tests		
Laboratory Tests	\$20 Copay	\$20 Copay
X-Rays	\$30 Copay	\$30 Copay
Imaging (CT/PET scans, MRIs)	\$100 Copay	\$100 Copay
Outpatient Surgery		
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	\$100 Copay	\$100 Copay
Physician/Surgeon Fees	\$25 Copay	\$25 Copay
Outpatient Visit	10% coinsurance	10% coinsurance
Hospitalization Services		
Facility Fee (e.g., Hospital Room)	\$250 Per Day (Up To First 5 Days)	\$250 Per Day (Up To First 5 Days)
Physician/Surgeon Fees	\$0 Copay	\$0 Copay

Benefit Comparison Chart	Platinum 90 HMO 0/15 +Child Dental	
	2021	2022
Covered Services		
Delivery and All Inpatient Services (Hospital Services)	\$250 Per Day (Up To First 5 Days)	\$250 per day (Up to the first Five Days)
Delivery and All Inpatient Services (Professional Services)	\$0 Copay	\$0 Copay
Emergency Health Coverage		
Emergency Room Services	\$150 Copay	\$150 Copay
Emergency Room Physician Fee	\$0 Copay	\$0 Copay
Urgent Care	\$20 Copay	\$20 Copay
Ambulance Services		
Medical Transportation (Including Emergency and Non-emergency)	\$150 Copay	\$150 Copay
Prescription Drug Coverage		
Tier 1:Generic Drugs (30-Day Supply)	\$5 Copay	\$5 Copay
Tier 1:Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	\$10 Copay	\$10 Copay
Tier 2: Preferred Brand Drugs (30-Day Supply)	\$20 Copay	\$20 Copay
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	\$40 Copay	\$40 Copay
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	\$30 Copay	\$30 Copay
Tier 3: Non-preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	\$60 Copay	\$60 Copay
Tier 4: Specialty Drugs (30-Day Supply)	10% Coinsurance up to \$250 per prescription	10% Coinsurance up to \$250 per prescription
Medical Supplies/ Durable Medical Equipment		
Medical Supplies	10% Coinsurance	10% Coinsurance
Prosthetic Devices	10% Coinsurance	10% Coinsurance
Durable Medical Equipment (Outpatient)	10% Coinsurance	10% Coinsurance
Mental Health Services		
Mental/Behavioral Health Outpatient Office Visits	\$20 Copay	\$20 Copay
Mental/ Behavioral Health Other Outpatient Items and Services	\$20 Copay	\$20 Copay
Mental/Behavioral Health Inpatient Facility Fee	\$250 Per Day (Up To First 5 Days)	\$250 Per Day (Up To First 5 Days)
Mental/Behavioral Health Inpatient Professional Fee	\$0 Copay	\$0 Copay
Chemical Dependency Services		

Benefit Comparison Chart	Platinum 90 HMO 0/15 +Child Dental	
Covered Services	2021	2022
Substance Use Disorder Outpatient Office Visits	\$20 Copay	\$20 Copay
Substance Use Disorder Other Outpatient Items and Services	\$20 Copay	\$20 Copay
Substance Use Disorder Inpatient Facility Services	\$250 Per Day (Up To First 5 Days)	\$250 Per Day (Up To First 5 Days)
Substance Use Disorder Inpatient Professional Fee	\$0 Copay	\$0 Copay
Home Health Services		
Home Health Care	\$20 copay	\$20 copay
Rehabilitation Services	\$20 copay	\$20 copay
Habilitation Services	\$20 copay	\$20 copay
Skilled Nursing Care	\$150 Per Day (Up to First Five Days)	\$150 Per Day (Up to First Five Days)
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