



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	Silver 70 HMO 2000/45 +Child Dental	
Covered Services	2021	2022
DEDUCTIBLES		
Annual Deductible	Medical: Individual \$2,250 / Family \$4,500 Drug: Individual \$300/ Family \$600	Medical: Individual \$2,250 / Family \$4,500 Drug: Individual \$300/ Family \$600
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	\$55 Copay	\$55 Copay
Specialist Visit	\$90 Copay	\$90 Copay
Acupuncture	\$55 Copay	\$55 Copay
Allergy Visit (Testing and Treatment)	\$90 Copay	\$90 Copay
Other Practitioner Office Visit	\$55 Copay	\$55 Copay
Outpatient Services	Member Cost Share	
Tests		
Laboratory Tests	\$55 Copay	\$55 Copay
X-Rays	\$90 Copay	\$90 Copay
Imaging (CT/PET scans, MRIs)	\$300 Copay (After Deductible)	\$300 Copay (After Deductible)
Outpatient Surgery		
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	30% Coinsurance (After Deductible)	30% Coinsurance (After Deductible)
Physician/Surgeon Fees	30% Coinsurance	30% Coinsurance
Outpatient Visit	30% Coinsurance	30% Coinsurance
Hospitalization Services		

Benefit Comparison Chart	Silver 70 HMO 2000/45 +Child Dental	
Covered Services	2021	2022
Facility Fee (e.g., Hospital Room)	30% Coinsurance (After Deductible)	30% Coinsurance (After Deductible)
Physician/Surgeon Fees	30% Coinsurance	30% Coinsurance
Delivery and All Inpatient Services (Hospital Services)	30% Coinsurance (After Deductible)	30% Coinsurance (After Deductible)
Delivery and All Inpatient Services (Professional Services)	30% Coinsurance	30% Coinsurance
Emergency Health Coverage		
Emergency Room Services	30% Coinsurance (After Deductible)	30% Coinsurance (After Deductible)
Emergency Room Physician Fee	\$0 Copay	\$0 Copay
Urgent Care	\$55 Copay	\$55 Copay
Ambulance Services		
Medical Transportation (Including Emergency and Non-emergency)	30% Coinsurance (After Deductible)	30% Coinsurance (After Deductible)
Prescription Drug Coverage		
Tier 1:Generic Drugs (30-Day Supply)	\$ 17 Copay	\$ 17 Copay
Tier 1:Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	\$34 Copay	\$34 Copay
Tier 2: Preferred Brand Drugs (30-Day Supply)	\$ 80 Copay (After Drug Deductible)	\$80 Copay (After Drug Deductible)
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	\$160 Copay (After Drug Deductible)	\$160 Copay (After Drug Deductible)
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	\$110 Copay (After Drug Deductible)	\$110 Copay (After Drug Deductible)
Tier 3: Non-preferred Brand Drugs (90- Day Supply) Chinese Hospital Pharmacy, or Mail Order	\$220 Copay (After Drug Deductible)	\$220 Copay (After Drug Deductible)
Tier 4: Specialty Drugs (30-Day Supply)	30% Coinsurance Up to \$250 Per Prescription (After Drug Deductible)	30% Coinsurance up to \$250 per prescription (After Drug Deductible)
Medical Supplies/ Durable Medical Equipment		
Medical Supplies	30% Coinsurance	30% Coinsurance
Prosthetic Devices	30% Coinsurance	30% Coinsurance
Durable Medical Equipment (Outpatient)	30% Coinsurance	30% Coinsurance
Mental Health Services		

Benefit Comparison Chart	Silver 70 HMO 2000/45 +Child Dental	
Covered Services	2021	2022
Mental/Behavioral Health Outpatient Office Visits	\$0 Copay	\$0 Copay
Mental/ Behavioral Health Other Outpatient Items and Services	\$55 Copay	\$55 Copay
Mental/Behavioral Health Inpatient Facility Fee	30% Coinsurance (After Deductible)	30% Coinsurance (After Deductible)
Mental/Behavioral Health Inpatient Professional Fee	30% Coinsurance	30% Coinsurance
Chemical Dependency Services		
Substance Use Disorder Outpatient Office Visits	\$0 Copay	\$0 Copay
Substance Use Disorder Other Outpatient Items and Services	\$55 Copay	\$55 Copay
Substance Use Disorder Inpatient Facility Services	30% Coinsurance (After Deductible)	30% Coinsurance (After Deductible)
Substance Use Disorder Inpatient Professional Fee	30% Coinsurance	30% Coinsurance
Home Health Services		
Home Health Care	\$45 Copay	\$45 Copay
Rehabilitation Services	\$55 Copay	\$55 Copay
Habilitation Services	\$55 copay	\$55 Copay
Skilled Nursing Care	30% Coinsurance (After Deductible)	30% 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