Benefit Chart	Bronze 60 HMO + Child Dental
Covered Services	**2023**
DEDUCTIBLES	
Annual Deductible	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
PROFESSIONAL SERVICES	**Member Cost Share**
Visit to a Health Care Provider's Office or Clinic	
Preventive Care/ Screening/ Immunization	$0 Copay
Family Planning (Consultation and Contraceptive Services	$0 Copay
Prenatal Care and Preconception Visits	$0 Copay
Diabetes Care Management	$0 Copay
Diabetes Education	$0 Copay
Primary Care Visit to Treat an Injury or Illness	$65 Copay (Deductible Applies after 1st 3 non-preventive visits)
Specialist Visit	$95 Copay (Deductible Applies after 1st 3 non-preventive visits)
Acupuncture	$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)
Other Practitioner Office Visit	$65 Copay (Deductible Applies after 1st 3 non-preventive visits)
Outpatient Services	**Member Cost Share**
Tests	
Laboratory Tests	$40 copay
X-Rays	40% Coinsurance (After Deductible)
Imaging (CT/PET scans, MRIs)	40% Coinsurance (After Deductible)
Outpatient Surgery	
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	40% Coinsurance (After Deductible)
Physician/Surgeon Fees	40% Coinsurance (After Deductible)
Outpatient Visit	40% Coinsurance (After Deductible)
Hospitalization Services	

Benefit Chart	Bronze 60 HMO + Child Dental
Covered Services	**2023**
Facility Fee (e.g., Hospital Room)	40% Coinsurance (After Deductible)
Physician/Surgeon Fees	40% Coinsurance (After Deductible)
Delivery and All Inpatient Services (Hospital Services)	40% Coinsurance (After Deductible)
Delivery and All Inpatient Services (Professional Services)	40% Coinsurance (After Deductible)
Emergency Health Coverage	
Emergency Room Services	40% Coinsurance (After Deductible)
Emergency Room Physician Fee	$0 Copay
Urgent Care	$65 Copay, (Deductible Applies after 1st 3 non-preventive visits)
Ambulance Services	
Medical Transportation (Including Emergency and Non-Emergency)	40% Coinsurance (After Deductible)
Prescription Drug Coverage	
Tier 1: Generic Drugs (30-Day Supply)	$18 Copay (After Drug Deductible)
Tier 1: Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$36 Copay (After Drug Deductible)
Tier 2: Preferred Brand Drugs (30-Day Supply)	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)
Tier 3: Non-Preferred Brand Drugs (30-Day Supply)	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)
Tier 4: Specialty Drugs (30-Day Supply)	40% Coinsurance up to $500 per prescription (After Drug Deductible)
Medical Supplies/ Durable Medical Equipment	
Medical Supplies	40% Coinsurance (After Deductible)
Prosthetic Devices	40% Coinsurance (After Deductible)
Durable Medical Equipment (Outpatient)	40% Coinsurance (After Deductible)
Mental Health Services	
Mental/Behavioral Health Outpatient Office Visits	$0 Copay

Benefit Chart	Bronze 60 HMO + Child Dental
Covered Services	**2023**
Mental/ Behavioral Health Other Outpatient Items and Services	40% coinsurance, maximum $65 Copay (After Deductible)
Mental/Behavioral Health Inpatient Facility Fee	40% Coinsurance (After Deductible)
Mental/Behavioral Health Inpatient Professional Fee	40% Coinsurance (After Deductible)
Chemical Dependency Services	
Substance Use Disorder Outpatient Office Visits	$0 Copay
Substance Use Disorder Other Outpatient Items and Services	40% coinsurance, maximum $65 Copay (After Deductible)
Substance Use Disorder Inpatient Facility Services	40% Coinsurance (After Deductible)
Substance Use Disorder Inpatient Professional Fee	40% Coinsurance (After Deductible)
Home Health Services	
Home Health Care	40% Coinsurance (After Deductible)
Rehabilitation Services	$65 copay
Habilitation Services	$65 copay
Skilled Nursing Care	40% Coinsurance (After Deductible)
Hospice Services	$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
1 Pair of Glasses Per Year (or Contact Lenses in Lieu of Glasses) Calendar Year	$0 Copay
Pediatric Dental (Ages 0-18) Administered by Delta Dental	
Child Dental Diagnostic and Preventive Services	See Delta Dental EOC

Footnotes: *Preventive care services are not subject to the deductible.

Medical / RX cost-sharing contributes toward annual deductible.

You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use, unless the service is not subject to the deductible. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st).