

<b>Benefit Chart</b>	<b>Bronze 60 HDHP HMO +Child Dental</b>
<b>Covered Services</b>	<b>2023</b>
<b>DEDUCTIBLES</b>	
Annual Deductible	Individual \$7,000/ Family \$14,000 (Combined Medical/Drug Deductible)
Out-of-Pocket Limit On Expenses	Individual \$7,000 / Family \$14,000
<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
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	Full cost until out-of-pocket is met
Specialist Visit	Full cost until out-of-pocket is met
Acupuncture	Full cost until out-of-pocket is met
Allergy Visit (Testing and Treatment)	Full cost until out-of-pocket is met
Other Practitioner Office Visit	Full cost until out-of-pocket is met
<b>Outpatient Services</b>	<b>Member Cost Share</b>
<b>Tests</b>	
Laboratory Tests	Full cost until out-of-pocket is met
X-Rays	Full cost until out-of-pocket is met
Imaging (CT/PET scans, MRIs)	Full cost until out-of-pocket is met
<b>Outpatient Surgery</b>	
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	Full cost until out-of-pocket is met
Physician/Surgeon Fees	Full cost until out-of-pocket is met
Outpatient Visit	Full cost until out-of-pocket is met
<b>Hospitalization Services</b>	
Facility Fee (e.g., Hospital Room)	Full cost until out-of-pocket is met
Physician/Surgeon Fees	Full cost until out-of-pocket is met
Delivery and All Inpatient Services (Hospital Services)	Full cost until out-of-pocket is met
Delivery and All Inpatient Services (Professional Services)	Full cost until out-of-pocket is met
<b>Emergency Health Coverage</b>	
Emergency Room Services	Full cost until out-of-pocket is met
Emergency Room Physician Fee	Full cost until out-of-pocket is met
Urgent Care	Full cost until out-of-pocket is met
<b>Ambulance Services</b>	
Medical Transportation (Including Emergency and Non-Emergency)	Full cost until out-of-pocket is met
<b>Prescription Drug Coverage</b>	
Tier 1: Generic Drugs (30-Day Supply)	Full cost until out-of-pocket is met
Tier 1: Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	Full cost until out-of-pocket is met
Tier 2: Preferred Brand Drugs (30-Day Supply)	Full cost until out-of-pocket is met
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	Full cost until out-of-pocket is met

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Tier 3: Non-Preferred Brand Drugs (30-Day Supply)	Full cost until out-of-pocket is met
Tier 3: Non-Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	Full cost until out-of-pocket is met
Tier 4: Specialty Drugs (30-Day Supply)	Full cost until out-of-pocket is met
<b>Medical Supplies/ Durable Medical Equipment</b>	
Medical Supplies	Full cost until out-of-pocket is met
Prosthetic Devices	Full cost until out-of-pocket is met
Durable Medical Equipment (Outpatient)	Full cost until out-of-pocket is met
<b>Mental Health Services</b>	
Mental/Behavioral Health Outpatient Office Visits	\$0 Copay
Mental/ Behavioral Health Other Outpatient Items and Services	Full cost until out-of-pocket is met
Mental/Behavioral Health Inpatient Facility Fee	Full cost until out-of-pocket is met
Mental/Behavioral Health Inpatient Professional Fee	Full cost until out-of-pocket is met
<b>Chemical Dependency Services</b>	
Substance Use Disorder Outpatient Office Visits	Full cost until out-of-pocket is met
Substance Use Disorder Other Outpatient Items and Services	Full cost until out-of-pocket is met
Substance Use Disorder Inpatient Facility Services	Full cost until out-of-pocket is met
Substance Use Disorder Inpatient Professional Fee	Full cost until out-of-pocket is met
<b>Home Health Services</b>	
Home Health Care	Full cost until out-of-pocket is met
Rehabilitation Services	Full cost until out-of-pocket is met
Habilitation Services	Full cost until out-of-pocket is met
Skilled Nursing Care	Full cost until out-of-pocket is met
Hospice Services	Full cost until out-of-pocket is met
<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
1 Pair of Glasses Per Year (or Contact Lenses in Lieu of Glasses) Calendar Year	\$0 Copay
<b>Pediatric Dental (Ages 0-18) Administered by Delta Dental</b>	
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 1<sup>st</sup>).