

<b>Benefit Chart</b>	<b>Gold 80 HMO + Child Dental</b>
<b>Covered Services</b>	<b>2023</b>
<b>DEDUCTIBLES</b>	
Annual Deductible	Medical: Individual \$250 / Family \$500 Drug: Individual \$0 / Family \$0
Out-of-Pocket Limit On Expenses	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
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	\$35 Copay
Specialist Visit	\$55 Copay
Acupuncture	\$35 Copay
Allergy Visit (Testing and Treatment)	\$55 Copay
Other Practitioner Office Visit	\$35 Copay
<b>Outpatient Services</b>	<b>Member Cost Share</b>
<b>Tests</b>	
Laboratory Tests	\$35 Copay
X-Rays	\$55 Copay
Imaging (CT/PET scans, MRIs)	\$250 Copay (After Deductible)
<b>Outpatient Surgery</b>	
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	\$300 Copay (After Deductible)
Physician/Surgeon Fees	\$35 Copay
Outpatient Visit	20% Coinsurance
<b>Hospitalization Services</b>	
Facility Fee (e.g., Hospital Room)	\$600 Per Day (Up To First 5 Days) (After Deductible)
Physician/Surgeon Fees	\$0 Copay
Delivery and All Inpatient Services (Hospital Services)	\$600 per day (Up To First 5 Days) (After Deductible)
Delivery and All Inpatient Services (Professional Services)	\$0 Copay
<b>Emergency Health Coverage</b>	
Emergency Room Services	\$250 Copay (After Deductible)
Emergency Room Physician Fee	\$0 Copay

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<b>Covered Services</b>	<b>2023</b>
Urgent Care	\$35 Copay
<b>Ambulance Services</b>	
Medical Transportation (Including Emergency and Non-Emergency)	\$250 Copay (After Deductible)
<b>Prescription Drug Coverage</b>	
Tier 1: Generic Drugs (30-Day Supply)	\$15 Copay
Tier 1: Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	\$30 Copay
Tier 2: Preferred Brand Drugs (30-Day Supply)	\$40 Copay
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	\$80 Copay
Tier 3: Non-Preferred Brand Drugs (30-Day Supply)	\$70 Copay
Tier 3: Non-Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	\$140 Copay
Tier 4: Specialty Drugs (30-Day Supply)	20% Coinsurance up to \$250 per Prescription
<b>Medical Supplies/ Durable Medical Equipment</b>	
Medical Supplies	20% Coinsurance
Prosthetic Devices	20% Coinsurance
Durable Medical Equipment (Outpatient)	20% Coinsurance
<b>Mental Health Services</b>	
Mental/Behavioral Health Outpatient Office Visits	\$0 Copay
Mental/ Behavioral Health Other Outpatient Items and Services	\$35 Copay
Mental/Behavioral Health Inpatient Facility Fee	\$600 Per Day (Up To First 5 Days) (After Deductible)
Mental/Behavioral Health Inpatient Professional Fee	\$0 Copay
<b>Chemical Dependency Services</b>	
Substance Use Disorder Outpatient Office Visits	\$0 Copay
Substance Use Disorder Other Outpatient Items and Services	\$35 Copay
Substance Use Disorder Inpatient Facility Services	\$600 Per Day (Up To First 5 Days) (After Deductible)
Substance Use Disorder Inpatient Professional Fee	\$0 Copay
<b>Home Health Services</b>	
Home Health Care	\$30 Copay
Rehabilitation Services	\$35 Copay
Habilitation Services	\$35 Copay
Skilled Nursing Care	\$300 Per Day (Up to First Five Days) (After Deductible)
Hospice Services	\$0 Copay

<b>Benefit Chart</b>	<b>Gold 80 HMO + Child Dental</b>
<b>Covered Services</b>	<b>2023</b>
<b>Pediatric Vision and Dental (Included in Plan)</b>	
<b>Pediatric Vision (Ages 0-18)</b>	
<b>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)</b>	
<b>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>).