| Benefit Chart | Amber 50 HMO Silver |
|---|---|
| **Covered Services** | **2023** |
| **DEDUCTIBLES** | |
| Annual Deductible | Medical: Individual $2,750/ Family $5,500<br>Drug: Individual $275/ Family $550 |
| Out–of–Pocket Limit On Expenses | Individual $7,500/ Family $15,000 |
| **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 | $0 Copay for 1st (3) PCP Visits (Deductible Does Not Apply), Then $50 Copay (After Medical Deductible) |
| Specialist Visit | $50 Copay (After Medical Deductible) |
| Acupuncture | $0 Copay for 1st (3) Visits (Deductible Does Not Apply), Then $50 Copay (After Medical Deductible) |
| Allergy Visit (Testing and Treatment) | $50 Copay (After Medical Deductible) |
| Other Practitioner Office Visit | $0 Copay for 1st (3) Visits (Deductible Does Not Apply), Then $50 Copay (After Medical Deductible) |
| **Outpatient Services** | **Member Cost Share** |
| **Tests** | |
| Laboratory Tests | $25 Copay (After Medical Deductible) |
| X-Rays | $50 Copay (After Medical Deductible) |
| Imaging (CT/PET scans, MRIs) | $350 Copay (After Medical Deductible) |
| **Outpatient Surgery** | |
| Surgery - Facility Fee (e.g., Ambulatory Surgery Center) | $400 (Chinese Hospital)/ $1,200 (Other Contracted Facilities) (After Medical Deductible) |
| Physician/Surgeon Fees | $0 Copay (After Medical Deductible) |

| Benefit Chart | Amber 50 HMO Silver |
|---|---|
| **Covered Services** | **2023** |
| Outpatient Visit | $0 Copay |
| **Hospitalization Services** | |
| Facility Fee (e.g., Hospital Room) | $500 Copay<br>(Chinese Hospital)/<br>$1,500 Copay<br>(Other Contracted Facilities)<br>(Up To First 5 Days)<br>(After Medical Deductible) |
| Physician/Surgeon Fees | $0 Copay |
| Delivery and All Inpatient Services (Hospital Services) | $500 Copay Per Day<br>(Up to the First 5 Days)<br>(After Medical Deductible) |
| Delivery and All Inpatient Services (Professional Services) | $0 Copay |
| **Emergency Health Coverage** | |
| Emergency Room Services | $300 Copay<br>(After Medical Deductible) |
| Emergency Room Physician Fee | $0 Copay |
| Urgent Care | $50 Copay<br>(After Medical Deductible) |
| **Ambulance Services** | |
| Medical Transportation (Including Emergency and Non-Emergency) | $100 Copay<br>(After Medical Deductible) |
| **Prescription Drug Coverage** | |
| 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) | $50 Copay<br>(After Drug Deductible) |
| Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order | $100 Copay<br>(After Drug Deductible) |
| Tier 3: Non-Preferred Brand Drugs (30-Day Supply) | $70 Copay<br>(After Drug Deductible) |
| Tier 3: Non-Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order | $140 Copay<br>(After Drug Deductible) |
| Tier 4: Specialty Drugs (30-Day Supply) | 20% Coinsurance Up to<br>$250 Per Prescription<br>(After Drug Deductible) |
| **Medical Supplies/ Durable Medical Equipment** | |
| Medical Supplies | 50% Coinsurance<br>(After Medical Deductible) |
| Prosthetic Devices | 50% Coinsurance<br>(After Medical Deductible) |
| Durable Medical Equipment (Outpatient) | 50% Coinsurance<br>(After Medical Deductible) |
| **Mental Health Services** | |
| Mental/Behavioral Health Outpatient Office Visits | $0 Copay for<br>1st (3) Visits<br>(Deductible Does Not Apply),<br>Then $50 Copay<br>(After Medical Deductible) |

| Benefit Chart | Amber 50 HMO Silver |
|---|---|
| **Covered Services** | **2023** |
| Mental/ Behavioral Health Other Outpatient Items and Services | $25 Copay<br>(After Medical Deductible) |
| Mental/Behavioral Health Inpatient Facility Fee | $500 Copay Per Day<br>(Up To First 5 Days)<br>(After Medical Deductible) |
| Mental/Behavioral Health Inpatient Professional Fee | $0 Copay |
| **Chemical Dependency Services** | |
| Substance Use Disorder Outpatient Office Visits | $0 Copay for<br>1st (3) Visits<br>(Deductible Does Not Apply),<br>Then $50 Copay<br>(After Medical Deductible) |
| Substance Use Disorder Other Outpatient Items and Services | $25 Copay<br>(After Medical Deductible) |
| Substance Use Disorder Inpatient Facility Services | $500 Copay Per Day<br>(Up To First 5 Days)<br>(After Medical Deductible) |
| Substance Use Disorder Inpatient Professional Fee | $0 Copay |
| **Home Health Services** | |
| Home Health Care | $0 Copay<br>(After Medical Deductible) |
| Rehabilitation Services | $45 Copay<br>(After Medical Deductible) |
| Habilitation Services | $45 Copay<br>(After Medical Deductible) |
| Skilled Nursing Care | 1st 10 Days At No Charge;<br>Then $100 Copay Per Day<br>(After Medical Deductible) |
| Hospice Services | $0 Copay<br>(After Medical Deductible) |
| **Pediatric Vision and Dental (Included in Plan)** | |
| **Pediatric Vision (Ages 0-18)<br>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)<br>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)