Benefit Chart	ActiveChoice - PPO Silver (In-Network)
Covered Services	**2023**
DEDUCTIBLES	
Annual Deductible	Individual $2,500/ Family $5,000(A) (Combined Medical/ Drug Deductible)
Out–of–Pocket Limit On Expenses	Individual $7,700/ Family $15,400
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	$0 Copay for 1st (3) PCP Visits (Deductible Does Not Apply), Then $50 Copay (After Deductible)
Specialist Visit	$50 Copay (After Deductible)
Acupuncture	$0 Copay for 1st (3) Visits (Deductible Does Not Apply), Then $50 Copay (After Deductible)
Allergy Visit (Testing and Treatment)	$50 Copay (After Deductible)
Other Practitioner Office Visit	$0 Copay for 1st (3) Visits (Deductible Does Not Apply), Then $50 Copay (After Deductible)
Outpatient Services	**Member Cost Share**
Tests	
Laboratory Tests	$10 Copay (After Deductible)
X-Rays	$50 Copay (After Deductible)
Imaging (CT/PET scans, MRIs)	$200 Copay (After Deductible)
Outpatient Surgery	
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	20% Coinsurance (Chinese Hospital)/ 40% Coinsurance (Other Contracted Facilities) (After Deductible)

Benefit Chart	ActiveChoice - PPO Silver (In-Network)
Covered Services	**2023**
Physician/Surgeon Fees	20% Coinsurance (Chinese Hospital)/ 40% Coinsurance (Other Contracted Facilities) (After Deductible)
Outpatient Visit	20% Coinsurance (Chinese Hospital)/ 40% Coinsurance (Other Contracted Facilities) (After Deductible)
Hospitalization Services	
Facility Fee (e.g., Hospital Room)	20% Coinsurance (Chinese Hospital)/ 40% Coinsurance (Other Facilities) (Up To First 5 Days) (After Deductible)
Physician/Surgeon Fees	$0 Copay
Delivery and All Inpatient Services (Hospital Services)	20% Coinsurance (Up To First 5 Days) (After Deductible)
Delivery and All Inpatient Services (Professional Services)	$0 Copay
Emergency Health Coverage	
Emergency Room Services	$200 Copay (After Deductible)
Emergency Room Physician Fee	$0 Copay
Urgent Care	$50 Copay (After Deductible)
Ambulance Services	
Medical Transportation (Including Emergency and Non-Emergency)	30% Coinsurance (After Deductible)
Prescription Drug Coverage	
Tier 1: Generic Drugs (30-Day Supply)	$15 Copay (After Deductible)
Tier 1: Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$30 Copay (After Deductible)
Tier 2: Preferred Brand Drugs (30-Day Supply)	$50 Copay (After Deductible)
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$100 Copay (After Deductible)
Tier 3: Non-Preferred Brand Drugs (30-Day Supply)	$70 Copay (After Deductible)
Tier 3: Non-Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$140 Copay (After Deductible)
Tier 4: Specialty Drugs (30-Day Supply)	20% Coinsurance Up To $250 Per Prescription (After Deductible)
Medical Supplies/ Durable Medical Equipment	
Medical Supplies	20% Coinsurance (After Deductible)

Benefit Chart	ActiveChoice - PPO Silver (In-Network)
Covered Services	**2023**
Prosthetic Devices	20% Coinsurance (After Deductible)
Durable Medical Equipment (Outpatient)	20% Coinsurance (After Deductible)
Mental Health Services	
Mental/Behavioral Health Outpatient Office Visits	$0 Copay
Mental/ Behavioral Health Other Outpatient Items and Services	$10 Copay (After Deductible)
Mental/Behavioral Health Inpatient Facility Fee	20% Coinsurance (Up To First 5 Days) (After Deductible)
Mental/Behavioral Health Inpatient Professional Fee	$0 Copay
Chemical Dependency Services	
Substance Use Disorder Outpatient Office Visits	$0 Copay
Substance Use Disorder Other Outpatient Items and Services	$10 Copay (After Deductible)
Substance Use Disorder Inpatient Facility Services	20% Coinsurance (Up To First 5 Days) (After Deductible)
Substance Use Disorder Inpatient Professional Fee	$0 Copay
Home Health Services	
Home Health Care	$25 copay (After Deductible)
Rehabilitation Services	$45 Copay (After Deductible)
Habilitation Services	$45 Copay (After Deductible)
Skilled Nursing Care	40% Coinsurance (After Deductible)
Hospice Services	$0 Copay (After Deductible)
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)

Benefit Chart	ActiveChoice - PPO Silver (Out-of-Network)
Covered Services	**2023**
DEDUCTIBLES	
Annual Deductible	Individual $2,500/ Family $5,000(A) (Combined Medical/ Drug Deductible)
Out–of–Pocket Limit On Expenses	Individual $7,700/ Family $15,400
PROFESSIONAL SERVICES	**Member Cost Share**
Visit to a Health Care Provider's Office or Clinic	
Preventive Care/ Screening/ Immunization	50% Coinsurance (After Deductible)
Family Planning (Consultation and Contraceptive Services	50% Coinsurance (After Deductible)
Prenatal Care and Preconception Visits	50% Coinsurance (After Deductible)
Diabetes Care Management	50% Coinsurance (After Deductible)
Diabetes Education	50% Coinsurance (After Deductible)
Primary Care Visit to Treat an Injury or Illness	50% Coinsurance (After Deductible)
Specialist Visit	50% Coinsurance (After Deductible)
Acupuncture	50% Coinsurance (After Deductible)
Allergy Visit (Testing and Treatment)	50% Coinsurance (After Deductible)
Other Practitioner Office Visit	50% Coinsurance (After Deductible)
Outpatient Services	**Member Cost Share**
Tests	
Laboratory Tests	50% Coinsurance (After Deductible)
X-Rays	50% Coinsurance (After Deductible)
Imaging (CT/PET scans, MRIs)	50% Coinsurance (After Deductible)
Outpatient Surgery	
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	50% Coinsurance (After Deductible)
Physician/Surgeon Fees	50% Coinsurance (After Deductible)
Outpatient Visit	50% Coinsurance (After Deductible)
Hospitalization Services	
Facility Fee (e.g., Hospital Room)	50% Coinsurance (After Deductible)
Physician/Surgeon Fees	50% Coinsurance (After Deductible)

Benefit Chart	ActiveChoice - PPO Silver (Out-of-Network)
Covered Services	**2023**
Delivery and All Inpatient Services (Hospital Services)	50% Coinsurance (After Deductible)
Delivery and All Inpatient Services (Professional Services)	50% Coinsurance (After Deductible)
Emergency Health Coverage	
Emergency Room Services	$200 Copay (After Deductible)
Emergency Room Physician Fee	$0 Copay
Urgent Care	$50 Copay (After Deductible)
Ambulance Services	
Medical Transportation (Emergency)	30% Coinsurance (After Deductible)
Medical Transportation (Non-Emergency)	50% Coinsurance (After Deductible)
Prescription Drug Coverage	
Tier 1: Generic Drugs (30-Day Supply)	Not Covered
Tier 1: Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	Not Covered
Tier 2: Preferred Brand Drugs (30-Day Supply)	Not Covered
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	Not Covered
Tier 3: Non-Preferred Brand Drugs (30-Day Supply)	Not Covered
Tier 3: Non-Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	Not Covered
Tier 4: Specialty Drugs (30-Day Supply)	Not Covered
Medical Supplies/ Durable Medical Equipment	
Medical Supplies	50% Coinsurance (After Deductible)
Prosthetic Devices	50% Coinsurance (After Deductible)
Durable Medical Equipment (Outpatient)	50% Coinsurance (After Deductible)
Mental Health Services	
Mental/Behavioral Health Outpatient Office Visits	50% Coinsurance (After Deductible)
Mental/ Behavioral Health Other Outpatient Items and Services	50% Coinsurance (After Deductible)
Mental/Behavioral Health Inpatient Facility Fee	50% Coinsurance (After Deductible)
Mental/Behavioral Health Inpatient Professional Fee	50% Coinsurance (After Deductible)
Chemical Dependency Services	
Substance Use Disorder Outpatient Office Visits	50% Coinsurance (After Deductible)
Substance Use Disorder Other Outpatient Items and Services	50% Coinsurance (After Deductible)
Substance Use Disorder Inpatient Facility Services	50% Coinsurance (After Deductible)
Substance Use Disorder Inpatient Professional Fee	50% Coinsurance (After Deductible)

Benefit Chart	ActiveChoice - PPO Silver (Out-of-Network)
Covered Services	**2023**
Home Health Services	
Home Health Care	50% Coinsurance (After Deductible)
Rehabilitation Services	50% Coinsurance (After Deductible)
Habilitation Services	50% Coinsurance (After Deductible)
Skilled Nursing Care	50% Coinsurance (After Deductible)
Hospice Services	50% Coinsurance (After Deductible)
Pediatric Vision and Dental (Included in Plan)	
Pediatric Vision (Ages 0-18) Administered by VSP	
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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.

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