| Benefit Chart | Bronze 60 HMO |
|---|---|
| **Covered Services** | **2023** |
| **DEDUCTIBLES** | |
| Annual Deductible | Medical:<br>Individual $6,300 / Family $12,600<br>Drug:<br>Individual $500 / Family $1,000 |
| Out–of–Pocket Limit On Expenses | Individual $8,200/<br>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<br>(Deductible Applies after 1st<br>3 non-preventive visits)* |
| Specialist Visit | $95 Copay<br>(Deductible Applies after 1st<br>3 non-preventive visits)* |
| Acupuncture | $65 Copay<br>(Deductible Applies after 1st<br>3 non-preventive visits)* |
| Allergy Visit (Testing and Treatment) | $95 Copay<br>(Deductible Applies after 1st<br>3 non-preventive visits)* |
| Other Practitioner Office Visit | $65 Copay<br>(Deductible Applies after 1st<br>3 non-preventive visits)* |
| **Outpatient Services** | **Member Cost Share** |
| **Tests** | |
| Laboratory Tests | $40 Copay |
| X-Rays | 40% Coinsurance<br>(After Medical Deductible) |
| Imaging (CT/PET scans, MRIs) | 40% Coinsurance<br>(After Medical Deductible) |
| **Outpatient Surgery** | |
| Surgery - Facility Fee (e.g., Ambulatory Surgery Center) | 40% Coinsurance<br>(After Medical Deductible) |
| Physician/Surgeon Fees | 40% Coinsurance<br>(After Medical Deductible) |
| Outpatient Visit | 40% Coinsurance<br>(After Medical Deductible) |
| **Hospitalization Services** | |
| Facility Fee (e.g., Hospital Room) | 40% Coinsurance<br>(After Medical Deductible) |
| Physician/Surgeon Fees | 40% Coinsurance<br>(After Medical Deductible) |
| Delivery and All Inpatient Services (Hospital Services) | 40% Coinsurance |

| Benefit Chart | Bronze 60 HMO |
|---|---|
| **Covered Services** | **2023** |
| | (After Medical Deductible) |
| Delivery and All Inpatient Services (Professional Services) | 40% Coinsurance<br>(After Medical Deductible) |
| **Emergency Health Coverage** | |
| Emergency Room Services | 40% Coinsurance<br>(After Medical 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<br>(After Medical Deductible) |
| **Prescription Drug Coverage** | |
| Tier 1: Generic Drugs (30-Day Supply) | $18 Copay<br>(After Drug Deductible) |
| Tier 1: Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order | $36 Copay<br>(After Drug Deductible) |
| Tier 2: Preferred Brand Drugs (30-Day Supply) | 40% Coinsurance up to $500 per prescription<br>(After Drug Deductible) |
| Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order | 40% Coinsurance up to $1500 per prescription<br>(After Drug Deductible) |
| Tier 3: Non-Preferred Brand Drugs (30-Day Supply) | 40% Coinsurance up to $500 per prescription<br>(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<br>(After Drug Deductible) |
| Tier 4: Specialty Drugs (30-Day Supply) | 40% Coinsurance up to $500 per prescription<br>(After Drug Deductible) |
| **Medical Supplies/ Durable Medical Equipment** | |
| Medical Supplies | 40% Coinsurance<br>(After Medical Deductible) |
| Prosthetic Devices | 40% Coinsurance<br>(After Medical Deductible) |
| Durable Medical Equipment (Outpatient) | 40% Coinsurance<br>(After Medical Deductible) |
| **Mental Health Services** | |
| Mental/Behavioral Health Outpatient Office Visits | $65 Copay, (Deductible Applies after 1st 3 non-preventive visits) |
| Mental/ Behavioral Health Other Outpatient Items and Services | $65 Copay<br>(After Medical Deductible) |
| Mental/Behavioral Health Inpatient Facility Fee | 40% Coinsurance<br>(After Medical Deductible) |
| Mental/Behavioral Health Inpatient Professional Fee | 40% Coinsurance<br>(After Medical Deductible) |
| **Chemical Dependency Services** | |
| Substance Use Disorder Outpatient Office Visits | $65 Copay, (Deductible Applies after 1st 3 non-preventive visits) |

| Benefit Chart | Bronze 60 HMO |
|---|---|
| **Covered Services** | **2023** |
| Substance Use Disorder Other Outpatient Items and Services | $65 Copay<br>(After Medical Deductible) |
| Substance Use Disorder Inpatient Facility Services | 40% Coinsurance<br>(After Medical Deductible) |
| Substance Use Disorder Inpatient Professional Fee | 40% Coinsurance<br>(After Medical Deductible) |
| **Home Health Services** | |
| Home Health Care | 40% Coinsurance<br>(After Medical Deductible) |
| Rehabilitation Services | $65 Copay |
| Habilitation Services | $65 Copay |
| Skilled Nursing Care | 40% Coinsurance<br>(After Medical Deductible) |
| Hospice Services | $0 Copay |
| **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).