

Covered Services 2023 DEDUCTIBLES None Annual Deductible None Out-of-Pocket Limit On Expenses Individual \$3,000/ Family \$6,000 PROFESSIONAL SERVICES Member Cost Share Visit to a Health Care Provider's Office or Clinic Preventive Care/ Screening/ Immunization Preventive Care/ Screening/ Immunization \$0 Copay Family Planning (Consultation and Contraceptive Services \$0 Copay Diabetes Care Management \$0 Copay Diabetes Care Management \$0 Copay Diabetes Visit \$15 Copay Allergy Visit (Testing and Treatment) \$30 Copay Other Practitioner Office Visit \$15 Copay Outpatient Services Member Cost Share Tests \$20 Copay Laboratory Tests \$5 Copay X-Rays \$50 Copay Outpatient Surgeon Fees \$0 Copay Outpatient Surgeon Fees \$0 Copay Outpatient Surgeon Fees \$0 Copay Outpatient Visit \$150 Copay Physician/Surgeon Fees \$0 Copay Outpatient Surgeon Fees \$0	Benefit Chart	Jade 15 HMO Platinum
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Prescription Drug Coverage		\$100 Copay
	Tier 1: Generic Drugs (30-Day Supply)	\$5 Copay

Benefit Chart	Jade 15 HMO Platinum
Covered Services	2023
Tier 1: Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	\$10 Copay
Tier 2: Preferred Brand Drugs (30-Day Supply)	\$15 Copay
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	\$30 Copay
Tier 3: Non-Preferred Brand Drugs (30-Day Supply)	\$25 Copay
Tier 3: Non-Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	\$50 Copay
Tier 4: Specialty Drugs (30-Day Supply)	10% Coinsurance Up To \$250 Per Prescription
Medical Supplies/ Durable Medical Equipment	
Medical Supplies	50% Coinsurance
Prosthetic Devices	50% Coinsurance
Durable Medical Equipment (Outpatient)	50% Coinsurance
Mental Health Services	
Mental/Behavioral Health Outpatient Office Visits	\$15 Copay
Mental/ Behavioral Health Other Outpatient Items and Services	\$5 Copay
Mental/Behavioral Health Inpatient Facility Fee	\$150 Copay Per Day (Up To First 5 Days)
Mental/Behavioral Health Inpatient Professional Fee	\$0 Copay
Chemical Dependency Services	
Substance Use Disorder Outpatient Office Visits	\$15 Copay
Substance Use Disorder Other Outpatient Items and Services	\$5 Copay
Substance Use Disorder Inpatient Facility Services	\$150 Copay Per Day (Up To First 5 Days)
Substance Use Disorder Inpatient Professional Fee	\$0 Copay
Home Health Services	
Home Health Care	\$0 Copay
Rehabilitation Services	\$15 Copay
Habilitation Services	\$15 Copay
Skilled Nursing Care	\$0 Copay
Hospice Services	\$0 Copay
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	\$0 Copay
Glasses) Calendar Year	to copuj
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).