Benefit Chart	Silver 94 HMO
Covered Services	**2023**
DEDUCTIBLES	
Annual Deductible	Medical: Individual $75 / Family $150
Out–of–Pocket Limit On Expenses	Individual: $900 / Family $1,800
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	$5 Copay
Specialist Visit	$8 Copay
Acupuncture	$5 Copay
Allergy Visit (Testing and Treatment)	$8 Copay
Other Practitioner Office Visit	$5 Copay
Outpatient Services	**Member Cost Share**
Tests	
Laboratory Tests	$8 Copay
X-Rays	$8 Copay
Imaging (CT/PET scans, MRIs)	$50 Copay
Outpatient Surgery	
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	10% Coinsurance
Physician/Surgeon Fees	10% Coinsurance
Outpatient Visit	10% Coinsurance
Hospitalization Services	
Facility Fee (e.g., Hospital Room)	10% Coinsurance (After Medical Deductible)
Physician/Surgeon Fees	10% Coinsurance
Delivery and All Inpatient Services (Hospital Services)	10% Coinsurance (After Medical Deductible)
Delivery and All Inpatient Services (Professional Services)	10% Coinsurance
Emergency Health Coverage	
Emergency Room Services	$50 Copay
Emergency Room Physician Fee	$0 Copay
Urgent Care	$5 Copay
Ambulance Services	
Medical Transportation (Including Emergency and Non-Emergency)	$30 Copay
Prescription Drug Coverage	
Tier 1: Generic Drugs (30-Day Supply)	$3 Copay
Tier 1: Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$6 Copay
Tier 2: Preferred Brand Drugs (30-Day Supply)	$10 Copay
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$20 Copay

Benefit Chart	Silver 94 HMO
Covered Services	**2023**
Tier 3: Non-Preferred Brand Drugs (30-Day Supply)	$15 Copay
Tier 3: Non-Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$30 Copay
Tier 4: Specialty Drugs (30-Day Supply)	10% Coinsurance up to $150 per prescription
Medical Supplies/ Durable Medical Equipment	
Medical Supplies	10% Coinsurance
Prosthetic Devices	10% Coinsurance
Durable Medical Equipment (Outpatient)	10% Coinsurance
Mental Health Services	
Mental/Behavioral Health Outpatient Office Visits	$5 Copay
Mental/ Behavioral Health Other Outpatient Items and Services	$5 Copay
Mental/Behavioral Health Inpatient Facility Fee	10% Coinsurance (After Medical Deductible)
Mental/Behavioral Health Inpatient Professional Fee	10% Coinsurance
Chemical Dependency Services	
Substance Use Disorder Outpatient Office Visits	$5 Copay
Substance Use Disorder Other Outpatient Items and Services	$5 Copay
Substance Use Disorder Inpatient Facility Services	10% Coinsurance (After Medical Deductible)
Substance Use Disorder Inpatient Professional Fee	10% Coinsurance
Home Health Services	
Home Health Care	$3 Copay
Rehabilitation Services	$5 Copay
Habilitation Services	$5 Copay
Skilled Nursing Care	10% Coinsurance (After Medical Deductible)
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 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).