



### Changes we're making to your current health plan

The difference between your 2023 monthly rate and your current rate is due to:

- Costs associated with the administration and delivery of essential health benefits.
- Changes to your benefit design that include(s):

Benefit Comparison Chart	Opal 50 HMO Silver	
Covered Services	2022	2023
<b>DEDUCTIBLES</b>		
Annual Deductible	Individual \$3,000/ Family \$6,000 Drug: Individual \$300 / Family \$600	Medical: Individual \$3,800/ Family \$7,600 Drug: Individual \$700 / Family \$1,400
Out-of-Pocket Limit On Expenses	Individual \$8,200 / Family \$16,400	Individual \$9,100 / Family \$18,200
<b>PROFESSIONAL SERVICES</b>	<b>Member Cost Share</b>	
<b>Visit to a Health Care Provider's Office or Clinic</b>		
Preventive Care/ Screening/ Immunization	\$0 Copay	\$0 Copay
Family Planning (Consultation and Contraceptive Services)	\$0 Copay	\$0 Copay
Prenatal Care and Preconception Visits	\$0 Copay	\$0 Copay
Diabetes Care Management	\$0 Copay	\$0 Copay
Diabetes Education	\$0 Copay	\$0 Copay
Primary Care Visit to Treat an Injury or Illness	\$50 Copay	\$50 Copay
Specialist Visit	\$50 Copay	\$50 Copay
Acupuncture	\$50 Copay	\$50 Copay
Allergy Visit (Testing and Treatment)	\$50 Copay	\$50 Copay
Other Practitioner Office Visit	\$50 Copay	\$50 Copay
<b>Outpatient Services</b>	<b>Member Cost Share</b>	
<b>Tests</b>		
Laboratory Tests	\$25 Copay	\$25 Copay
X-Rays	\$75 Copay	\$75 Copay
Imaging (CT/PET scans, MRIs)	\$275 Copay	\$275 Copay
<b>Outpatient Surgery</b>		
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	\$300 (Chinese Hospital) / \$750 (Other Facilities) (After Deductible)	\$300 (Chinese Hospital) / \$750 (Other Facilities) (After Deductible)
Physician/Surgeon Fees	\$0 Copay	\$0 Copay
Outpatient Visit	\$0 Copay	\$0 Copay
<b>Hospitalization Services</b>		
Facility Fee (e.g., Hospital Room)	\$250 Copay / Day	\$250 Copay / Day

Benefit Comparison Chart	Opal 50 HMO Silver	
	2022	2023
<b>Covered Services</b>		
	(Chinese Hospital) \$750 Copay / Day (Other Facilities) (Up to First 5 Days) (After Deductible)	(Chinese Hospital) \$750 Copay / Day (Other Facilities) (Up to First 5 Days) (After Deductible)
Physician/Surgeon Fees	\$0 Copay	\$0 Copay
Delivery and All Inpatient Services (Hospital Services)	\$250 copay per day (Up to the first 5 days) (After Deductible)	\$250 copay per day (Up to the first 5 days) (After Deductible)
Delivery and All Inpatient Services (Professional Services)	\$0 Copay	\$0 Copay
<b>Emergency Health Coverage</b>		
Emergency Room Services	\$300 Copay (After Deductible)	\$300 Copay (After Deductible)
Emergency Room Physician Fee	\$0 Copay	\$0 Copay
Urgent Care	\$50 Copay	\$50 Copay
<b>Ambulance Services</b>		
Medical Transportation (Including Emergency and Non-emergency)	\$100 copay (After Deductible)	\$100 copay (After Deductible)
<b>Prescription Drug Coverage</b>		
Tier 1:Generic Drugs (30-Day Supply)	\$15 Copay (After Drug Deductible)	\$15 Copay (After Drug Deductible)
Tier 1:Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	\$30 Copay	\$30 Copay
Tier 2: Preferred Brand Drugs (30- Day Supply)	\$50 Copay (After Drug Deductible)	\$50 Copay (After Drug Deductible)
Tier 2: Preferred Brand Drugs (90- Day Supply) Chinese Hospital Pharmacy, or Mail Order	\$100 Copay (After Drug Deductible)	\$100 Copay (After Drug Deductible)
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	\$70 Copay (After Drug Deductible)	\$70 Copay (After Drug Deductible)
Tier 3: Non-preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	\$140 Copay (After Drug Deductible)	\$140 Copay (After Drug Deductible)
Tier 4: Specialty Drugs (30-Day Supply)	20% Coinsurance Up to \$250 Per Prescription (After Drug Deductible)	20% Coinsurance Up to \$250 Per Prescription (After Drug Deductible)
<b>Medical Supplies/ Durable Medical Equipment</b>		
Medical Supplies	50% coinsurance (After Drug Deductible)	50% coinsurance (After Drug Deductible)
Prosthetic Devices	50% coinsurance (After Drug Deductible)	50% coinsurance (After Drug Deductible)
Durable Medical Equipment (Outpatient)	50% coinsurance (After Drug Deductible)	50% coinsurance (After Drug Deductible)

<b>Benefit Comparison Chart</b>	<b>Opal 50 HMO Silver</b>	
<b>Covered Services</b>	<b>2022</b>	<b>2023</b>
<b>Mental Health Services</b>		
Mental/Behavioral Health Outpatient Office Visits	\$50 Copay	\$50 Copay
Mental/ Behavioral Health Other Outpatient Items and Services	\$50 Copay	\$50 Copay
Mental/Behavioral Health Inpatient Facility Fee	\$ 250 copay/day (Up to first 5 days) (After Deductible)	\$250 copay/day (Up to first 5 days) (After Deductible)
Mental/Behavioral Health Inpatient Professional Fee	\$0 Copay	\$0 Copay
<b>Chemical Dependency Services</b>		
Substance Use Disorder Outpatient Office Visits	\$50 Copay	\$50 Copay
Substance Use Disorder Other Outpatient Items and Services	\$50 Copay	\$50 Copay
Substance Use Disorder Inpatient Facility Services	\$250 copay/day (Up to first 5 days) (After Deductible)	\$250 copay/day (Up to first 5 days) (After Deductible)
Substance Use Disorder Inpatient Professional Fee	\$0 Copay	\$0 Copay
<b>Home Health Services</b>		
Home Health Care	\$0 copay (After Deductible)	\$0 copay (After Deductible)
Rehabilitation Services	\$50 Copay	\$50 Copay
Habilitation Services	\$50 Copay	\$50 Copay
Skilled Nursing Care	1st 10 days at no charge; then \$100 per day (After Deductible)	1st 10 days at no charge; then \$100 per day (After Deductible)
Hospice Services	\$0 copay (After Deductible)	\$0 copay (After Deductible)
<b>Pediatric Vision and Dental (Included in Plan)</b>		
<b>Pediatric Vision (Ages 0-18) Administered by VSP</b>		
Eye Exam Including Refraction and Dilation Per Year	\$0 Copay	\$0 Copay
1 Pair of Glasses Per Year (or Contact Lenses in Lieu of Glasses) Calendar Year	\$0 Copay	\$0 Copay
<b>Pediatric Dental (Ages 0-18) Administered by Delta Dental</b>		
Child Dental Diagnostic and Preventive Services	See Delta Dental EOC	No Charge