| Benefit Summary | Gold 80 HMO 0/30 +Child Dental |
|---|---|
| **Covered Services** | **2022** |
| **DEDUCTIBLES** | |
| Annual Deductible | Medical: Individual $250/ Family $500<br>Drug: Individual $0/ Family $0 |
| Out–of–Pocket Limit On Expenses | Individual $7,800/ Family $15,600 |
| **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 | $35 Copay |
| Specialist Visit | $55 Copay |
| Acupuncture | $35 Copay |
| Allergy Visit (Testing and Treatment) | $55 Copay |
| Other Practitioner Office Visit | $35 Copay |
| **Outpatient Services** | **Member Cost Share** |
| **Tests** | |
| Laboratory Tests | $35 Copay |
| X-Rays | $55 Copay |
| Imaging (CT/PET scans, MRIs) | $250 Copay (After Deductible) |
| **Outpatient Surgery** | |
| Surgery - Facility Fee (e.g., Ambulatory Surgery Center) | $300 Copay<br>(After Deductible) |
| Physician/Surgeon Fees | $35 Copay |
| Outpatient Visit | 20% Coinsurance |
| **Hospitalization Services** | |
| **Covered Services** | **2022** |
| Facility Fee (e.g., Hospital Room) | $600 Per Day (Up To First 5 Days)<br>(After Deductible) |
| Physician/Surgeon Fees | $0 Copay |
| Delivery and All Inpatient Services (Hospital Services) | $600 per day<br>(Up to the first Five Days) (After Deductible) |

| | |
|---|---|
| Delivery and All Inpatient Services (Professional Services) | $0 Copay |
| **Emergency Health Coverage** | |
| Emergency Room Services | $250 Copay<br>(After Deductible) |
| Emergency Room Physician Fee | $0 Copay |
| Urgent Care | $35 Copay |
| **Ambulance Services** | |
| Medical Transportation (Including Emergency and Non-emergency) | $250 Copay (After Deductible) |
| **Prescription Drug Coverage** | |
| Tier 1:Generic Drugs (30-Day Supply) | $15 Copay |
| Tier 1:Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order | $30 Copay |
| Tier 2: Preferred Brand Drugs (30-Day Supply) | $40 Copay |
| Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order | $80 Copay |
| Tier 3: Non-preferred Brand Drugs (30-Day Supply) | $70 Copay |
| Tier 3: Non-preferred Brand Drugs (90- Day Supply) Chinese Hospital Pharmacy, or Mail Order | $140 Copay |
| Tier 4: Specialty Drugs (30-Day Supply) | 20% Coinsurance up to<br>$250 per Prescription |
| **Medical Supplies/ Durable Medical Equipment** | |
| Medical Supplies | 20% Coinsurance |
| Prosthetic Devices | 20% Coinsurance |
| Durable Medical Equipment (Outpatient) | 20% Coinsurance |
| **Mental Health Services** | |
| Mental/Behavioral Health Outpatient Office Visits | $0 Copay |
| **Covered Services** | **2022** |
| Mental/ Behavioral Health Other Outpatient Items and Services | $35 Copay |
| Mental/Behavioral Health Inpatient Facility Fee | $600 Per Day (Up To First 5 Days)<br>(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 | $35 Copay |
| Substance Use Disorder Inpatient Facility Services | $600 Per Day (Up To First 5 Days)<br>(After Deductible) |
| Substance Use Disorder Inpatient Professional Fee | $0 Copay |
| **Home Health Services** | |
| Home Health Care | $30 Copay |
| Rehabilitation Services | $35 Copay |

| | |
|---|---|
| Habilitation Services | $35 Copay |
| Skilled Nursing Care | $300 Per Day<br>(Up to First Five Days) (After 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 Calendar Year<br>(or Contact Lenses in Lieu of Glasses) | $0 Copay |
| **Pediatric Dental (Ages 0-18) Administered by Delta Dental** | |
| Child Dental Diagnostic and Preventive Services | See Delta Dental EOC |