

Plan Comparison¹

2019-2020

2019

2020

FEATURES	Bronze 60 PPO 6300/75 + Child Dental		Bronze 60 PPO 6300/65 + Child Dental	
	Participating Provider Tier (in-network)	Non-Participating Provider Tier (out-of-network)	Participating Provider Tier (in-network)	Non-Participating Provider Tier (out-of-network)
PLAN DEDUCTIBLE				
Individual/Family (embedded)	\$6,300/\$12,600	\$12,600/\$25,200	\$6,300/\$12,600	\$12,600/\$25,200
OUT-OF-POCKET MAXIMUM				
Individual/Family (embedded)	\$7,550/\$15,100	\$15,100/\$30,200	\$7,800/\$15,600	\$15,600/\$31,200
IN THE MEDICAL OFFICE				
Primary care visits	\$75 (after plan deductible)	100% (up to out-of-pocket maximum)	\$65 (after plan deductible)	100% (up to out-of-pocket maximum)
Urgent care visits	\$75 (after plan deductible)	100% (up to out-of-pocket maximum)	\$65 (after plan deductible)	100% (up to out-of-pocket maximum)
Specialty office visits	\$105 (after plan deductible)	100% (up to out-of-pocket maximum)	\$95 (after plan deductible)	100% (up to out-of-pocket maximum)
Preventive exams, vaccines (immunizations)	\$0	40%	\$0	40%
Prenatal care	\$0	40%	\$0	40%
Postpartum care	\$0	40%	\$0	40%
Well-child preventive care visits	\$0	40%	\$0	40%
Allergy injections	100% (up to out-of-pocket maximum)	100% (up to out-of-pocket maximum)	\$65	100% (up to out-of-pocket maximum)
Infertility services	100% (up to out-of-pocket maximum)	Not covered	40% (after plan deductible)	Not covered
Physical, occupational, and speech therapy	\$75	100% (up to out-of-pocket maximum)	\$65	100% (up to out-of-pocket maximum)
Most laboratory tests	\$40	100% (up to out-of-pocket maximum)	\$40	100% (up to out-of-pocket maximum)
Most X-rays and diagnostic testing	100% (up to out-of-pocket maximum)	100% (up to out-of-pocket maximum)	40% (after plan deductible)	100% (up to out-of-pocket maximum)
Most MRI/CT/PET scans	100% (up to out-of-pocket maximum)	100% (up to out-of-pocket maximum)	40% (after plan deductible)	100% (up to out-of-pocket maximum)
Outpatient surgery (per procedure)	100% (up to out-of-pocket maximum)	100% (up to out-of-pocket maximum)	40% (after plan deductible)	100% (up to out-of-pocket maximum)
EMERGENCY SERVICES				
Emergency Department visits (waived if admitted directly to hospital)	100% (up to out-of-pocket maximum)	100% (up to out-of-pocket maximum)	40% (after plan deductible)	40% (up to out-of-pocket maximum)
Ambulance	100% (up to out-of-pocket maximum)	100% (up to out-of-pocket maximum)	40% (after plan deductible)	40% (up to out-of-pocket maximum)
PRESCRIPTIONS				
Generic drugs	100% per prescription up to \$500 maximum (after \$500 drug deductible) (up to a 30-day supply)		\$18 (after \$500 drug deductible) (up to a 30-day supply)	
Brand-name drugs	100% per prescription up to \$500 maximum (after \$500 drug deductible) (up to a 30-day supply)		40% per prescription up to \$500 maximum (after \$500 drug deductible) (up to a 30-day supply)	
Specialty drugs	100% per prescription up to \$500 maximum (after \$500 drug deductible) (up to a 30-day supply)		40% per prescription up to \$500 maximum (after \$500 drug deductible) (up to a 30-day supply)	
HOSPITAL CARE				
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	100% (up to out-of-pocket maximum)	100% (up to out-of-pocket maximum)	40% (after plan deductible)	100% (up to out-of-pocket maximum)
Skilled nursing facility care (up to 100 days per benefit period)	100% (up to out-of-pocket maximum)	100% (up to out-of-pocket maximum)	40% (after plan deductible)	100% (up to out-of-pocket maximum)
MENTAL HEALTH SERVICES				
In the medical office	\$75 (after plan deductible)	100% (up to out-of-pocket maximum)	\$65 (after plan deductible)	100% (up to out-of-pocket maximum)
In the hospital	100% (up to out-of-pocket maximum)	100% (up to out-of-pocket maximum)	40% (after plan deductible)	100% (up to out-of-pocket maximum)
CHEMICAL DEPENDENCY SERVICES				
In the medical office	\$75 (after plan deductible)	100% (up to out-of-pocket maximum)	\$65 (after plan deductible)	100% (up to out-of-pocket maximum)
In the hospital (detoxification only)	100% (up to out-of-pocket maximum)	100% (up to out-of-pocket maximum)	40% (after plan deductible)	100% (up to out-of-pocket maximum)
OTHER				
Televisits	\$0	\$0	\$0	\$0
Chiropractic and acupuncture	\$75 per visit (after plan deductible) (acupuncture services only)	100% per visit (up to out-of-pocket maximum) (acupuncture services only)	\$65 per visit (after plan deductible) (acupuncture services only)	100% per visit (up to out-of-pocket maximum) (acupuncture services only)
Certain durable medical equipment (DME)	100% (up to out-of-pocket maximum) (supplemental and base)	100% (up to out-of-pocket maximum) (supplemental and base)	40% (after plan deductible) (supplemental and base)	100% (up to out-of-pocket maximum) (supplemental and base)
Certain prosthetic and orthotic devices	100% (up to out-of-pocket maximum)	100% (up to out-of-pocket maximum)	40% (after plan deductible)	100% (up to out-of-pocket maximum)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year	100% (up to out-of-pocket maximum)	1 pair of eyeglasses or contact lenses per year	100% (up to out-of-pocket maximum)
Pediatric vision exam	\$0	\$0 (after plan deductible)	\$0	\$0 (after plan deductible)
Adult optical (eyewear)	Not covered	Not covered	Not covered	Not covered
Adult vision exam (for eye refraction)	\$0	Not covered	\$0	Not covered
Home health care (up to 100 visits per year)	100% (up to out-of-pocket maximum)	100% (up to out-of-pocket maximum)	40% (after plan deductible)	100% (up to out-of-pocket maximum)
Hospice care	\$0	100% (up to out-of-pocket maximum)	\$0	100% (up to out-of-pocket maximum)

¹This is a benefit comparison only. The changes have been highlighted. For limitations, exclusions, or exceptions, refer to the plan highlights or your EOC.