

# Plan Comparison<sup>1</sup>

2019-2020

**2019**

**2020**

FEATURES	Gold 80 PPO 0/30 + Child Dental		Gold 80 PPO 250/25 + 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)
<b>PLAN DEDUCTIBLE</b>				
Individual/Family (embedded)	\$0/\$0	\$1,000/\$2,000	\$250/\$500	\$1,000/\$2,000
<b>OUT-OF-POCKET MAXIMUM</b>				
Individual/Family (embedded)	\$7,200/\$14,400	\$14,400/\$28,800	\$7,800/\$15,600	\$15,600/\$31,200
<b>IN THE MEDICAL OFFICE</b>				
Primary care visits	\$30	40% (after plan deductible)	\$25	40% (after plan deductible)
Urgent care visits	\$30	40% (after plan deductible)	\$25	40% (after plan deductible)
Specialty office visits	\$55	40% (after plan deductible)	\$50	40% (after plan deductible)
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	20%	40% (after plan deductible)	20%	40% (after plan deductible)
Infertility services	50%	Not covered	50%	Not covered
Physical, occupational, and speech therapy	\$30	40% (after plan deductible)	\$25	40% (after plan deductible)
Most laboratory tests	\$35	40% (after plan deductible)	\$25	40% (after plan deductible)
Most X-rays and diagnostic testing	\$55	40% (after plan deductible)	\$65	40% (after plan deductible)
Most MRI/CT/PET scans	20%	40% (after plan deductible)	20%	40% (after plan deductible)
Outpatient surgery (per procedure)	20%	40% (after plan deductible)	20%	40% (after plan deductible)
<b>EMERGENCY SERVICES</b>				
Emergency Department visits (waived if admitted directly to hospital)	\$325	\$325	\$250 (after plan deductible)	\$250 (after plan deductible)
Ambulance	\$250	\$250	\$250 (after plan deductible)	\$250 (after plan deductible)
<b>PRESCRIPTIONS</b>				
Generic drugs	\$15 (up to a 30-day supply)		\$15 (up to a 30-day supply)	
Brand-name drugs	\$55 (up to a 30-day supply)		\$50 (up to a 30-day supply)	
Specialty drugs	20% per prescription up to \$250 maximum (up to a 30-day supply)		20% per prescription up to \$250 maximum (up to a 30-day supply)	
<b>HOSPITAL CARE</b>				
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	20%	40% (after plan deductible)	20% (after plan deductible)	40% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	20%	40% (after plan deductible)	20% (after plan deductible)	40% (after plan deductible)
<b>MENTAL HEALTH SERVICES</b>				
In the medical office	\$30	40% (after plan deductible)	\$25	40% (after plan deductible)
In the hospital	20%	40% (after plan deductible)	20% (after plan deductible)	40% (after plan deductible)
<b>CHEMICAL DEPENDENCY SERVICES</b>				
In the medical office	\$30	40% (after plan deductible)	\$25	40% (after plan deductible)
In the hospital (detoxification only)	20%	40% (after plan deductible)	20% (after plan deductible)	40% (after plan deductible)
<b>OTHER</b>				
Televisits	\$0	\$0	\$0	\$0
Chiropractic and acupuncture	\$30 per visit (acupuncture services only)	40% per visit (after plan deductible) (acupuncture services only)	\$25 per visit (acupuncture services only)	40% per visit (after plan deductible) (acupuncture services only)
Certain durable medical equipment (DME)	20% (supplemental and base)	40% (after plan deductible) (supplemental and base)	20% (supplemental and base)	40% (after plan deductible) (supplemental and base)
Certain prosthetic and orthotic devices	20%	40% (after plan deductible)	20%	40% (after plan deductible)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year	20% (after plan deductible)	1 pair of eyeglasses or contact lenses per year	20% (after plan deductible)
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)	20%	40% (after plan deductible)	20%	40% (after plan deductible)
Hospice care	\$0	40% (after plan deductible)	\$0	40% (after plan deductible)

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