Plan Comparison[1]

2019–2020

	2019	2020
	Platinum 90 HMO 0/15* + Child Dental	**Platinum 90 HMO 0/15* + Child Dental**
FEATURES	**Copay HMO Plan**	**Copay HMO Plan**
PLAN DEDUCTIBLE		
Individual/Family	$0	$0
OUT-OF-POCKET MAXIMUM		
Individual/Family	$3,350/$6,700 (embedded)	$4,500/$9,000 (embedded)
IN THE MEDICAL OFFICE		
Primary care visits	$15	$15
Urgent care visits	$15	$15
Specialty office visits	$30	$30
Preventive exams, vaccines (immunizations)	$0	$0
Prenatal care	$0	$0
Postpartum care	$0	$0
Well-child preventive care visits	$0	$0
Allergy injections	$5	$5
Infertility services	Not covered	Not covered
Physical, occupational, and speech therapy	$15	$15
Most laboratory tests	$15	$15
Most X-rays and diagnostic testing	$30	$30
Most MRI/CT/PET scans	$75	$75
Outpatient surgery (per procedure)	$125	$125
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	$150	$150
Ambulance	$150	$150
PRESCRIPTIONS		
Generic drugs	$5 (up to a 30-day supply)	$5 (up to a 30-day supply)
Brand-name drugs	$15 (up to a 30-day supply)	$15 (up to a 30-day supply)
Specialty drugs	10% per prescription up to $250 maximum (up to a 30-day supply)	10% per prescription up to $250 maximum (up to a 30-day supply)
HOSPITAL CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$250 per day up to 5 days per admission	$250 per day up to 5 days per admission
Skilled nursing facility care (up to 100 days per benefit period)	$150 per day up to 5 days per admission	$150 per day up to 5 days per admission
MENTAL HEALTH SERVICES		
In the medical office	$15	$15
In the hospital	$250 per day up to 5 days per admission	$250 per day up to 5 days per admission
CHEMICAL DEPENDENCY SERVICES		
In the medical office	$15	$15
In the hospital (detoxification only)	$250 per day up to 5 days per admission	$250 per day up to 5 days per admission
OTHER		
Televisits	$0	$0
Chiropractic and acupuncture	$15 per visit for physician-referred acupuncture; chiropractic not covered	$15 per visit for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME)	10% (base only)	10% (supplemental and base)
Certain prosthetic and orthotic devices	$0	$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year	1 pair of eyeglasses or contact lenses per year
Pediatric vision exam	$0	$0
Adult optical (eyewear)	Not covered	Not covered
Adult vision exam (for eye refraction)	$0	$0
Home health care (up to 100 visits per year)	$20 per visit	$20 per visit
Hospice care	$0	$0

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