

Plan Comparison¹

2019-2020

	2019	2020
	Silver 70 HMO 2000/45* + Child Dental	Silver 70 HMO 2250/50* + Child Dental
FEATURES	Deductible HMO Plan	Deductible HMO Plan
PLAN DEDUCTIBLE		
Individual/Family	\$2,000/\$4,000 (embedded)	\$2,250/\$4,500 (embedded)
OUT-OF-POCKET MAXIMUM		
Individual/Family	\$7,550/\$15,100 (embedded)	\$7,800/\$15,600 (embedded)
IN THE MEDICAL OFFICE		
Primary care visits	\$45	\$50
Urgent care visits	\$45	\$50
Specialty office visits	\$80	\$85
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	\$45	\$50
Most laboratory tests	\$40	\$40
Most X-rays and diagnostic testing	\$75	\$85
Most MRI/CT/PET scans	\$300	\$300
Outpatient surgery (per procedure)	20%	20%
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	\$350	\$400 (after plan deductible)
Ambulance	\$250 (after plan deductible)	\$250 (after plan deductible)
PRESCRIPTIONS		
Generic drugs	\$15 (after \$200 drug deductible) (up to a 30-day supply)	\$17 (after \$300 drug deductible) (up to a 30-day supply)
Brand-name drugs	\$55 (after \$200 drug deductible) (up to a 30-day supply)	\$65 (after \$300 drug deductible) (up to a 30-day supply)
Specialty drugs	20% per prescription up to \$250 maximum (after \$200 drug deductible) (up to a 30-day supply)	20% per prescription up to \$250 maximum (after \$300 drug deductible) (up to a 30-day supply)
HOSPITAL CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	20% (after plan deductible)	20% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	20% (after plan deductible)	20% (after plan deductible)
MENTAL HEALTH SERVICES		
In the medical office	\$45	\$50
In the hospital	20% (after plan deductible)	20% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES		
In the medical office	\$45	\$50
In the hospital (detoxification only)	20% (after plan deductible)	20% (after plan deductible)
OTHER		
Televisits	\$0	\$0
Chiropractic and acupuncture	\$45 per visit for physician-referred acupuncture; chiropractic not covered	\$50 per visit for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME)	20% (base only)	20% (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)	\$45 per day	\$45 per day
Hospice care	\$0	\$0

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