

Plan Comparison¹

2020-2021

2020

2021

	Platinum 90 HMO 0/10* + Child Dental Alt	Platinum 90 HMO 0/10* + Child Dental Alt
FEATURES	Copay HMO Plan	Copay HMO Plan
PLAN DEDUCTIBLE		
Individual/Family	\$0	\$0
OUT-OF-POCKET MAXIMUM		
Individual/Family (embedded)	\$3,000/\$6,000	\$3,000/\$6,000
IN THE MEDICAL OFFICE		
Primary care visits	\$10	\$10
Urgent care visits	\$10	\$10
Specialty office visits	\$20	\$20
Preventive exams, vaccines (immunizations)	\$0	\$0
Prenatal care	\$0	\$0
Postpartum care	\$0	\$0
Well-child preventive care visits	\$0	\$0
Allergy injections	\$5 per visit	\$5 per visit
Infertility services	Not covered	Not covered
Physical, occupational, and speech therapy	\$10	\$10
Most laboratory tests	\$20	\$20
Most X-rays and diagnostic testing	\$40	\$40
Most MRI/CT/PET scans	\$150	\$150
Outpatient surgery (per procedure)	\$300	\$300
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	\$200	\$200
Ambulance	\$150	\$150
PRESCRIPTIONS		
Generic drugs (up to a 30-day supply)	\$5	\$5
Brand-name drugs (up to a 30-day supply)	\$15	\$15
Specialty drugs (up to a 30-day supply)	10% per prescription up to \$250 maximum	10% per prescription up to \$250 maximum
HOSPITAL CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	\$500 per admission	\$500 per admission
Skilled nursing facility care (up to 100 days per benefit period)	\$250 per admission	\$250 per admission
MENTAL HEALTH SERVICES		
In the medical office	\$10	\$10
In the hospital	\$500 per admission	\$500 per admission
CHEMICAL DEPENDENCY SERVICES		
In the medical office	\$10	\$10
In the hospital (detoxification only)	\$500 per admission	\$500 per admission
OTHER		
Televisits	\$0	\$0
Chiropractic and acupuncture	\$15 per visit (20 combined visits per year)	\$15 per visit (20 combined visits per year)
Certain durable medical equipment (DME) (supplemental and base)	10%	10%
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)	\$175 allowance	\$175 allowance
Adult vision exam (for eye refraction)	\$0	\$0
Home health care (up to 100 visits per year)	\$0	\$0
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.