

## Plan Comparison<sup>1</sup>

2020-2021

2020

2021

	<b>Platinum 90 HMO 0/15* + Child Dental</b>	<b>Platinum 90 HMO 0/20* + Child Dental</b>
<b>FEATURES</b>	<b>Copay HMO Plan</b>	<b>Copay HMO Plan</b>
<b>PLAN DEDUCTIBLE</b>		
Individual/Family	\$0	\$0
<b>OUT-OF-POCKET MAXIMUM</b>		
Individual/Family (embedded)	\$4,500/\$9,000	\$4,500/\$9,000
<b>IN THE MEDICAL OFFICE</b>		
Primary care visits	\$15	\$20
Urgent care visits	\$15	\$20
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 per visit	\$5 per visit
Infertility services	Not covered	Not covered
Physical, occupational, and speech therapy	\$15	\$20
Most laboratory tests	\$15	\$20
Most X-rays and diagnostic testing	\$30	\$30
Most MRI/CT/PET scans	\$75	\$100
Outpatient surgery (per procedure)	\$125	\$125
<b>EMERGENCY SERVICES</b>		
Emergency Department visits (waived if admitted directly to hospital)	\$150	\$150
Ambulance	\$150	\$150
<b>PRESCRIPTIONS</b>		
Generic drugs (up to a 30-day supply)	\$5	\$5
Brand-name drugs (up to a 30-day supply)	\$15	\$20
Specialty drugs (up to a 30-day supply)	10% per prescription up to \$250 maximum	10% per prescription up to \$250 maximum
<b>HOSPITAL CARE</b>		
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
<b>MENTAL HEALTH SERVICES</b>		
In the medical office	\$15	\$20
In the hospital	\$250 per day up to 5 days per admission	\$250 per day up to 5 days per admission
<b>CHEMICAL DEPENDENCY SERVICES</b>		
In the medical office	\$15	\$20
In the hospital (detoxification only)	\$250 per day up to 5 days per admission	\$250 per day up to 5 days per admission
<b>OTHER</b>		
Televisits	\$0	\$0
Chiropractic and acupuncture	\$15 per visit for physician-referred acupuncture; chiropractic not covered	\$20 per visit for physician-referred acupuncture; chiropractic not covered
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)	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

<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.