

# Plan Comparison<sup>1</sup>

2020-2021

**2020**

**2021**

FEATURES	Platinum 90 PPO 0/15 + Child Dental		Platinum 90 PPO 0/15 + 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	Individual – \$500 Family – \$1,000	\$0	Individual – \$500 Family – \$1,000
<b>OUT-OF-POCKET MAXIMUM</b> Individual/Family (Embedded)	Individual – \$4,500 Family – \$9,000	Individual – \$9,000 Family – \$18,000	Individual – \$4,500 Family – \$9,000	Individual – \$9,000 Family – \$18,000
<b>IN THE MEDICAL OFFICE</b>				
Primary care visits	\$15	30% (after plan deductible)	\$15	30% (after plan deductible)
Urgent care visits	\$15	30% (after plan deductible)	\$15	30% (after plan deductible)
Specialty office visits	\$30	30% (after plan deductible)	\$30	30% (after plan deductible)
Preventive exams, vaccines (immunizations)	\$0	30%	\$0	30%
Prenatal care	\$0	30%	\$0	30%
Postpartum care	\$0	30%	\$0	30%
Well-child preventive care visits	\$0	30%	\$0	30%
Allergy injections	10% per visit	30% per visit (after plan deductible)	10% per visit	30% per visit (after plan deductible)
Infertility services	50%	Not covered	50%	Not covered
Physical, occupational, and speech therapy	\$15	30% (after plan deductible)	\$15	30% (after plan deductible)
Most laboratory tests	\$15	30% (after plan deductible)	\$15	30% (after plan deductible)
Most X-rays and diagnostic testing	\$30	30% (after plan deductible)	\$30	30% (after plan deductible)
Most MRI/CT/PET scans	10%	30% (after plan deductible)	10%	30% (after plan deductible)
Outpatient surgery (per procedure)	10%	30% (after plan deductible)	10%	30% (after plan deductible)
<b>EMERGENCY SERVICES</b>				
Emergency Department visits (waived if admitted directly to hospital)	\$150	\$150	\$200	\$200
Ambulance	\$150	\$150	\$150	\$150
<b>PRESCRIPTIONS</b>				
Generic drugs (up to a 30-day supply)		\$5		\$10
Brand-name drugs (up to a 30-day supply)		\$15		\$25
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	10%	30% (after plan deductible)	10%	30% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	10%	30% (after plan deductible)	10%	30% (after plan deductible)
<b>MENTAL HEALTH SERVICES</b>				
In the medical office	\$15	30% (after plan deductible)	\$15	30% (after plan deductible)
In the hospital	10%	30% (after plan deductible)	10%	30% (after plan deductible)
<b>CHEMICAL DEPENDENCY SERVICES</b>				
In the medical office	\$15	30% (after plan deductible)	\$15	30% (after plan deductible)
In the hospital (detoxification only)	10%	30% (after plan deductible)	10%	30% (after plan deductible)
<b>OTHER</b>				
Televisits	\$0	\$0	\$0	\$0
Chiropractic and acupuncture	\$15 per visit (acupuncture services only)	30% per visit (after plan deductible) (acupuncture services only)	\$15 per visit (acupuncture services only)	30% per visit (after plan deductible) (acupuncture services only)
Certain durable medical equipment (DME) (supplemental and base)	10%	30% (after plan deductible)	10%	30% (after plan deductible)
Certain prosthetic and orthotic devices	10%	30% (after plan deductible)	10%	30% (after plan deductible)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year	10% (after plan deductible)	1 pair of eyeglasses or contact lenses per year	10% (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)	10%	30% (after plan deductible)	10%	30% (after plan deductible)
Hospice care	\$0	30% (after plan deductible)	\$0	30% (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.