

Plan Comparison¹

2020-2021

2020

2021

| | Gold 80 HMO 250/25* + Child Dental | Gold 80 HMO 250/35* + Child Dental |
|--|--|--|
| FEATURES | Deductible HMO Plan | Deductible HMO Plan |
| PLAN DEDUCTIBLE | | |
| Individual/Family (embedded) | \$250/\$500 | \$250/\$500 |
| OUT-OF-POCKET MAXIMUM | | |
| Individual/Family (embedded) | \$7,800/\$15,600 | \$7,800/\$15,600 |
| IN THE MEDICAL OFFICE | | |
| Primary care visits | \$25 | \$35 |
| Urgent care visits | \$25 | \$35 |
| Specialty office visits | \$50 | \$55 |
| 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 | \$25 | \$35 |
| Most laboratory tests | \$25 | \$35 |
| Most X-rays and diagnostic testing | \$65 | \$55 |
| Most MRI/CT/PET scans | \$275 | \$250 (after plan deductible) |
| Outpatient surgery (per procedure) | \$340 | \$335 (after plan deductible) |
| EMERGENCY SERVICES | | |
| Emergency Department visits (waived if admitted directly to hospital) | \$250 (after plan deductible) | \$250 (after plan deductible) |
| Ambulance | \$250 (after plan deductible) | \$250 (after plan deductible) |
| PRESCRIPTIONS | | |
| Generic drugs (up to a 30-day supply) | \$15 | \$15 |
| Brand-name drugs (up to a 30-day supply) | \$50 | \$40 |
| Specialty drugs (up to a 30-day supply) | 20% per prescription up to \$250 maximum | 20% per prescription up to \$250 maximum |
| HOSPITAL CARE | | |
| Physicians' services, room and board, tests, medications, supplies, therapies, birth services | \$600 per day up to 5 days per admission (after plan deductible) | \$600 per day up to 5 days per admission |
| Skilled nursing facility care (up to 100 days per benefit period) | \$300 per day up to 5 days per admission (after plan deductible) | \$300 per day up to 5 days per admission |
| MENTAL HEALTH SERVICES | | |
| In the medical office | \$25 | \$35 |
| In the hospital | \$600 per day up to 5 days per admission (after plan deductible) | \$600 per day up to 5 days per admission |
| CHEMICAL DEPENDENCY SERVICES | | |
| In the medical office | \$25 | \$35 |
| In the hospital (detoxification only) | \$600 per day up to 5 days per admission (after plan deductible) | \$600 per day up to 5 days per admission |
| OTHER | | |
| Televisits | \$0 | \$0 |
| Chiropractic and acupuncture | \$25 per visit for physician-referred acupuncture; chiropractic not covered | \$35 per visit for physician-referred acupuncture; chiropractic not covered |
| Certain durable medical equipment (DME) (supplemental and base) | 20% | 20% |
| 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) | \$30 per visit | \$30 per visit |
| 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.