

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

2020-2021

2020

2021

	<b>Silver 70 HMO 1650/55* + Child Dental Alt</b>	<b>Silver 70 HMO 1650/55* + Child Dental Alt</b>
FEATURES	Deductible HMO Plan	Deductible HMO Plan
<b>PLAN DEDUCTIBLE</b>		
Individual/Family (embedded)	\$1,650/\$3,300	\$1,650/\$3,300
<b>OUT-OF-POCKET MAXIMUM</b>		
Individual/Family (embedded)	\$7,800/\$15,600	\$8,200/\$16,400
<b>IN THE MEDICAL OFFICE</b>		
Primary care visits	\$55	\$55
Urgent care visits	\$55	\$55
Specialty office visits	\$80	\$80
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	\$65	\$65
Most laboratory tests	\$25	\$30
Most X-rays and diagnostic testing	\$75 (after plan deductible)	\$75
Most MRI/CT/PET scans	\$350 (after plan deductible)	\$350 (after plan deductible)
Outpatient surgery (per procedure)	40% (after plan deductible)	40% (after plan deductible)
<b>EMERGENCY SERVICES</b>		
Emergency Department visits (waived if admitted directly to hospital)	40% (after plan deductible)	40% (after plan deductible)
Ambulance	40% (after plan deductible)	40% (after plan deductible)
<b>PRESCRIPTIONS</b>		
Generic drugs (up to a 30-day supply)	\$20	\$20
Brand-name drugs (up to a 30-day supply)	\$75 (after \$350 drug deductible)	\$75 (after \$350 drug deductible)
Specialty drugs (up to a 30-day supply)	20% per prescription up to \$250 maximum (after \$350 drug deductible)	20% per prescription up to \$250 maximum (after \$350 drug deductible)
<b>HOSPITAL CARE</b>		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	40% (after plan deductible)	40% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	40% (after plan deductible)	40% (after plan deductible)
<b>MENTAL HEALTH SERVICES</b>		
In the medical office	\$55	\$55
In the hospital	40% (after plan deductible)	40% (after plan deductible)
<b>CHEMICAL DEPENDENCY SERVICES</b>		
In the medical office	\$55	\$55
In the hospital (detoxification only)	40% (after plan deductible)	40% (after plan deductible)
<b>OTHER</b>		
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)	40%	40%
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)	\$0	\$0
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.