

Plan Comparison¹

2020-2021

2020

2021

	Silver 70 HMO 1800/55* + Child Dental Alt	Silver 70 HMO 2100/55* + Child Dental Alt
FEATURES	Deductible HMO Plan	Deductible HMO Plan
PLAN DEDUCTIBLE		
Individual/Family (embedded)	\$1,800/\$3,600	\$2,100/\$4,200
OUT-OF-POCKET MAXIMUM		
Individual/Family (embedded)	\$7,800/\$15,600	\$8,200/\$16,400
IN THE MEDICAL OFFICE		
Primary care visits	\$55	\$55
Urgent care visits	\$55	\$55
Specialty office visits	\$75	\$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 (after plan deductible)	\$30
Most X-rays and diagnostic testing	\$55 (after plan deductible)	\$75
Most MRI/CT/PET scans	\$350 (after plan deductible)	\$350 (after plan deductible)
Outpatient surgery (per procedure)	45% (after plan deductible)	45% (after plan deductible)
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	45% (after plan deductible)	45% (after plan deductible)
Ambulance	45% (after plan deductible)	45% (after plan deductible)
PRESCRIPTIONS		
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 \$500 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 \$500 drug deductible)
HOSPITAL CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	45% (after plan deductible)	45% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	45% (after plan deductible)	45% (after plan deductible)
MENTAL HEALTH SERVICES		
In the medical office	\$55	\$55
In the hospital	45% (after plan deductible)	45% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES		
In the medical office	\$55	\$55
In the hospital (detoxification only)	45% (after plan deductible)	45% (after plan deductible)
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)	45%	45%
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

¹This is a benefit comparison only. The changes have been highlighted. For limitations, exclusions, or exceptions, refer to the plan highlights or your EOC.