

# Plan Comparison<sup>1</sup>

**2020-2021**
**2020**
**2021**

	<b>Silver 70 HMO 2250/50* + Child Dental</b>	<b>Silver 70 HMO 2250/55* + Child Dental</b>
FEATURES	Deductible HMO Plan	Deductible HMO Plan
<b>PLAN DEDUCTIBLE</b>		
Individual/Family (embedded)	\$2,250/\$4,500	\$2,250/\$4,500
<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	\$50	\$55
Urgent care visits	\$50	\$55
Specialty office visits	\$85	\$90
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	\$50	\$55
Most laboratory tests	\$40	\$55
Most X-rays and diagnostic testing	\$85	\$90
Most MRI/CT/PET scans	\$300	\$300 (after plan deductible)
Outpatient surgery (per procedure)	20%	30% (after plan deductible)
<b>EMERGENCY SERVICES</b>		
Emergency Department visits (waived if admitted directly to hospital)	\$400 (after plan deductible)	30% (after plan deductible)
Ambulance	\$250 (after plan deductible)	30% (after plan deductible)
<b>PRESCRIPTIONS</b>		
Generic drugs (up to a 30-day supply)	\$17 (after \$300 drug deductible)	\$17
Brand-name drugs (up to a 30-day supply)	\$65 (after \$300 drug deductible)	\$80 (after \$300 drug deductible)
Specialty drugs (up to a 30-day supply)	20% per prescription up to \$250 maximum (after \$300 drug deductible)	30% per prescription up to \$250 maximum (after \$300 drug deductible)
<b>HOSPITAL CARE</b>		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	20% (after plan deductible)	30% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	20% (after plan deductible)	30% (after plan deductible)
<b>MENTAL HEALTH SERVICES</b>		
In the medical office	\$50	\$55
In the hospital	20% (after plan deductible)	30% (after plan deductible)
<b>CHEMICAL DEPENDENCY SERVICES</b>		
In the medical office	\$50	\$55
In the hospital (detoxification only)	20% (after plan deductible)	30% (after plan deductible)
<b>OTHER</b>		
Televisits	\$0	\$0
Chiropractic and acupuncture	\$50 per visit for physician-referred acupuncture; chiropractic not covered	\$55 per visit for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (supplemental and base)	20%	30%
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)	\$45 per day	\$45 per day
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.