

Plan Comparison¹

2022-2023

2022

2023

	Platinum 90 HMO 0/20* + Child Dental	Platinum 90 HMO 0/20* + Child Dental
FEATURES	Copay HMO Plan	Copay HMO Plan
PLAN DEDUCTIBLE Embedded	\$0	\$0
OUT-OF-POCKET MAXIMUM Embedded	\$4,500/\$9,000	\$4,500/\$9,000
IN THE MEDICAL OFFICE		
Primary care visits	\$20	\$20
Urgent care visits	\$20	\$20
Specialty office visits	\$30	\$30
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
Fertility services	Not covered	Not covered
Physical, occupational, and speech therapy	\$20	\$20
Most laboratory tests	\$20	\$20
Most X-rays and diagnostic testing	\$30	\$30
Most MRI/CT/PET scans	\$100	\$100
Outpatient surgery (per procedure)	\$125	\$125
EMERGENCY SERVICES		
Emergency department visits (waived if admitted directly to hospital)	\$150	\$150
Ambulance	\$150	\$150
PRESCRIPTIONS		
Generic drugs (up to a 30-day supply)	\$5	\$5
Brand-name drugs (up to a 30-day supply)	\$20	\$20
Specialty drugs (up to a 30-day supply)	10% per prescription up to \$250 maximum	10% per prescription up to \$250 maximum
HOSPITAL INPATIENT CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	\$250 per day up to 5 days per admission	\$250 per day up to 5 days per admission
Skilled nursing facility care (up to 100 days per benefit period)	\$150 per day up to 5 days per admission	\$150 per day up to 5 days per admission
MENTAL HEALTH SERVICES		
Outpatient (in the medical office)	\$20	\$0
Inpatient (in the hospital)	\$250 per day up to 5 days per admission	\$250 per day up to 5 days per admission
SUBSTANCE USE DISORDER SERVICES		
Outpatient (in the medical office)	\$20	\$0
Inpatient (in the hospital) - detoxification only	\$250 per day up to 5 days per admission	\$250 per day up to 5 days per admission
OTHER	\$0	\$0
Televisits		
Acupuncture	\$20 per visit for physician-referred acupuncture	\$20 per visit for physician-referred acupuncture
Certain durable medical equipment (DME) (supplemental and base)	10%	10%
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)	\$20 per visit	\$20 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.