Changes we're making to your current health plan

The difference between your 2021 monthly rate and your current rate is due to:

- Costs associated with the administration and delivery of essential health benefits.
- Changes to your benefit design that include(s):

Benefit Comparison Chart	Opal 25 HMO Gold	
Covered Services	**2020**	**2021**
DEDUCTIBLES		
Annual Deductible	Medical: Individual $2,000 / Family $4,000 Drug: Individual $250 /Family $500	Medical: Individual $2,000 / Family $4,000 Drug: Individual $250 /Family $500
Out–of–Pocket Limit On Expenses	Individual $5,000/ Family $ 10,000	Individual $5,000/ Family $ 10,000
PROFESSIONAL SERVICES	**Member Cost Share**	
Visit to a Health Care Provider's Office or Clinic		
Preventive Care/ Screening/ Immunization	$0 Copay	$0 Copay
Family Planning (Consultation and Contraceptive Services	$0 Copay	$0 Copay
Prenatal Care and Preconception Visits	$0 Copay	$0 Copay
Diabetes Care Management	$0 Copay	$0 Copay
Diabetes Education	$0 Copay	$0 Copay
Primary Care Visit to Treat an Injury or Illness	$25 Copay	$30 Copay
Specialist Visit	$25 Copay	$30 Copay
Acupuncture	$25 Copay	$30 Copay
Allergy Visit (Testing and Treatment)	$25 Copay	$30 Copay
Other Practitioner Office Visit	$25 Copay	$30 Copay
Outpatient Services	**Member Cost Share**	
Tests		
Laboratory Tests	$25 Copay	$25 Copay
X-Rays	$25 Copay	$25 Copay
Imaging (CT/PET scans, MRIs)	$250 Copay	$250 Copay
Outpatient Surgery		
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$250 (Chinese Hospital) / $750 (Other Contracted	$250 (Chinese Hospital) / $750 (Other Contracted

Benefit Comparison Chart	Opal 25 HMO Gold	
Covered Services	**2020**	**2021**
	Facilities) (After Deductible)	Facilities) (After Deductible)
Physician/Surgeon Fees	$0 Copay	$0 Copay
Outpatient Visit	$0 Copay	$0 Copay
Hospitalization Services		
Facility Fee (e.g., Hospital Room)	$250 Copay/Day (Chinese Hospital) $ 750 Copay/Day (Other Facilities) (Up to the first 5 days) (After Deductible)	$250 Copay/Day (Chinese Hospital) $ 750 Copay/Day (Other Facilities) (Up to the first 5 days) (After Deductible)
Physician/Surgeon Fees	$0 Copay	$0 Copay
Delivery and All Inpatient Services (Hospital Services)	$250 copay per day (Up to the first 5 days) (After Deductible)	$250 copay per day (Up to the first 5 days) (After Deductible)
Delivery and All Inpatient Services (Professional Services)	$0 Copay	$0 Copay
Emergency Health Coverage		
Emergency Room Services	$250 Copay (After Deductible)	$250 Copay (After Deductible)
Emergency Room Physician Fee	$0 Copay	$0 Copay
Urgent Care	$25 Copay	$25 Copay
Ambulance Services		
Medical Transportation (Including Emergency and Non-emergency)	$100 copay (After Deductible)	$100 copay (After Deductible)
Prescription Drug Coverage		
Tier 1:Generic Drugs (30-Day Supply)	$10 Copay	$10 Copay
Tier 1:Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$20 Copay	$20 Copay
Tier 2: Preferred Brand Drugs (30-Day Supply)	$30 Copay (After Drug Deductible)	$30 Copay (After Drug Deductible)
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$60 Copay (After Drug Deductible)	$60 Copay (After Drug Deductible)
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	$60 Copay (After Drug Deductible)	$60 Copay (After Drug Deductible)
Tier 3: Non-preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$120 Copay (After Drug Deductible)	$120 Copay (After Drug Deductible)
Tier 4: Specialty Drugs (30-Day Supply)	20% Coinsurance Up to $250 Per Prescription (After Drug Deductible)	20% Coinsurance Up to $250 Per Prescription (After Drug Deductible)
Medical Supplies/ Durable Medical Equipment		

Benefit Comparison Chart	Opal 25 HMO Gold	
Covered Services	**2020**	**2021**
Medical Supplies	20% coinsurance (After Deductible)	20% coinsurance (After Deductible)
Prosthetic Devices	20% coinsurance (After Deductible)	20% coinsurance (After Deductible)
Durable Medical Equipment (Outpatient)	20% coinsurance (After Deductible)	20% coinsurance (After Deductible)
Mental Health Services		
Mental/Behavioral Health Outpatient Office Visits	$0 Copay	$30 Copay
Mental/ Behavioral Health Other Outpatient Items and Services	$0 Copay	$30 Copay (After Deductible)
Mental/Behavioral Health Inpatient Facility Fee	$250 copay/day (Up to the first 5 days)	$250 copay/day (Up to the first 5 days) (After Deductible)
Mental/Behavioral Health Inpatient Professional Fee	$0 Copay	$0 Copay
Chemical Dependency Services		
Substance Use Disorder Outpatient Office Visits	$0 Copay	$30 Copay
Substance Use Disorder Other Outpatient Items and Services	$0 Copay	$30 Copay (After Deductible)
Substance Use Disorder Inpatient Facility Services	$250 copay/day (Up to the first 5 days) (After Deductible)	$250 copay/day (Up to the first 5 days) (After Deductible)
Substance Use Disorder Inpatient Professional Fee	$0 Copay	$0 Copay
Home Health Services		
Home Health Care	$0 copay (After Deductible)	$0 copay (After Deductible)
Rehabilitation Services	$25 Copay	$25 Copay
Habilitation Services	$25 Copay	$25 Copay
Skilled Nursing Care	1st 10 days at no charge; then $100 per day (After Deductible)	1st 10 days at no charge; then $100 per day (After Deductible)
Hospice Services	$0 copay (After Deductible)	$0 copay (After Deductible)
Pediatric Vision and Dental (Included in Plan)		
Pediatric Vision (Ages 0-18) Administered by VSP		
Eye Exam Including Refraction and Dilation Per Year	$0 Copay	$0 Copay
1 Pair of Glasses Per Year (or Contact Lenses in Lieu of Glasses) Calendar Year	$0 Copay	$0 Copay
Pediatric Dental (Ages 0-18)		

Benefit Comparison Chart	Opal 25 HMO Gold	
Covered Services	**2020**	**2021**
Administered by Delta Dental		
Child Dental Diagnostic and Preventive Services	See Delta Dental EOC	See Delta Dental EOC