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	Bronze 60 HMO 6300/75 +Child Dental	
Covered Services	**2020**	**2021**
DEDUCTIBLES		
Annual Deductible	Medical: Individual $6,300/ Family $12,600 Drug: Individual $500/ Family $1,000	Medical: Individual $6,300/ Family $12,600 Drug: Individual $500/ Family $1,000
Out–of–Pocket Limit On Expenses	Individual $7,800/ Family $15,600	Individual $8,200/ Family $16,400
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	$65 Copay (Deductible Applies after 1st 3 non-preventive visits)	$65 Copay (Deductible Applies after 1st 3 non-preventive visits)
Specialist Visit	$95 Copay (Deductible Applies after 1st 3 non-preventive visits)	$95 Copay (Deductible Applies after 1st 3 non-preventive visits)
Acupuncture	$65 Copay (Deductible Applies after 1st 3 non-preventive visits)	$65 Copay (Deductible Applies after 1st 3 non-preventive visits)
Allergy Visit (Testing and Treatment)	$95 Copay (Deductible Applies after 1st 3 non-preventive visits)	$95 Copay (Deductible Applies after 1st 3 non-preventive visits)
Other Practitioner Office Visit	$65 Copay	$65 Copay (Deductible Applies after

Benefit Comparison Chart	Bronze 60 HMO 6300/75 +Child Dental	
Covered Services	**2020**	**2021**
	(Deductible Applies after 1st 3 non-preventive visits)	1st 3 non-preventive visits)
Outpatient Services	Member Cost Share	
Tests		
Laboratory Tests	$40 copay	$40 copay
X-Rays	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Imaging (CT/PET scans, MRIs)	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Outpatient Surgery		
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Physician/Surgeon Fees	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Outpatient Visit	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Hospitalization Services		
Facility Fee (e.g., Hospital Room)	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Physician/Surgeon Fees	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Delivery and All Inpatient Services (Hospital Services)	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Delivery and All Inpatient Services (Professional Services)	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Emergency Health Coverage		
Emergency Room Services	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Emergency Room Physician Fee	$0 Copay	$0 Copay
Urgent Care	$65 Copay, (Deductible Applies after 1st 3 non-preventive visits)	$65 Copay, (Deductible Applies after 1st 3 non-preventive visits)
Ambulance Services		
Medical Transportation (Including Emergency and Non-emergency)	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Prescription Drug Coverage		
Tier 1:Generic Drugs (30-Day Supply)	$18 Copay (After Drug Deductible)	$18 Copay (After Drug Deductible)
Tier 1:Generic Drugs (90-Day Supply)	$36 Copay	$36 Copay

Benefit Comparison Chart	Bronze 60 HMO 6300/75 +Child Dental	
Covered Services	**2020**	**2021**
Chinese Hospital Pharmacy, or Mail Order	(After Drug Deductible)	(After Drug Deductible)
Tier 2: Preferred Brand Drugs (30-Day Supply)	40% Coinsurance up to $500 per prescription (After Drug Deductible)	40% Coinsurance up to $500 per prescription (After Drug Deductible)
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	40% Coinsurance up to $1500 per prescrioption (After Drug Deductible)	40% Coinsurance up to $1500 per prescription (After Drug Deductible)
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	40% Coinsurance up to $500 per prescription (After Drug Deductible)	40% Coinsurance up to $500 per prescription (After Drug Deductible)
Tier 3: Non-preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	40% Coinsurance up to $1500 per prescrioption (After Drug Deductible)	40% Coinsurance up to $1500 per prescription (After Drug Deductible)
Tier 4: Specialty Drugs (30-Day Supply)	40% Coinsurance up to $500 per prescription (After Drug Deductible)	40% Coinsurance up to $500 per prescription (After Drug Deductible)
Medical Supplies/ Durable Medical Equipment		
Medical Supplies	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Prosthetic Devices	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Durable Medical Equipment (Outpatient)	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Mental Health Services		
Mental/Behavioral Health Outpatient Office Visits	$0 Copay	$0 Copay
Mental/ Behavioral Health Other Outpatient Items and Services	40% coinsurance, maximum $65 Copay (After Deductible)	40% coinsurance, maximum $65 Copay (After Deductible)
Mental/Behavioral Health Inpatient Facility Fee	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Mental/Behavioral Health Inpatient Professional Fee	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Chemical Dependency Services		
Substance Use Disorder Outpatient Office Visits	$0 Copay	$0 Copay
Substance Use Disorder Other Outpatient Items and Services	40% coinsurance, maximum $65 Copay (After Deductible)	40% coinsurance, maximum $65 Copay (After Deductible)
Substance Use Disorder Inpatient	40% Coinsurance	40% Coinsurance

Benefit Comparison Chart	Bronze 60 HMO 6300/75 +Child Dental	
Covered Services	**2020**	**2021**
Facility Services	(After Deductible)	(After Deductible)
Substance Use Disorder Inpatient Professional Fee	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Home Health Services		
Home Health Care	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Rehabilitation Services	$65 copay	$65 copay
Habilitation Services	$65 copay	$65 copay
Skilled Nursing Care	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)
Hospice Services	$0 Copay	$0 Copay
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) Administered by Delta Dental		
Child Dental Diagnostic and Preventive Services	See Delta Dental EOC	See Delta Dental EOC