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	Gold 80 HMO 0/30 +Child Dental	
Covered Services	**2020**	**2021**
DEDUCTIBLES		
Annual Deductible	Medical: Individual $250/ Family $500 Drug: Individual $0/ Family $0	Medical: Individual $250/ Family $500 Drug: Individual $0/ Family $0
Out–of–Pocket Limit On Expenses	Individual $7,200/ Family $14,400	Individual $7,800/ Family $15,600
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	$35 Copay
Specialist Visit	$50 Copay	$55 Copay
Acupuncture	$25 Copay	$35 Copay
Allergy Visit (Testing and Treatment)	$50 Copay	$55 Copay
Other Practitioner Office Visit	$25 Copay	$35 Copay
Outpatient Services	**Member Cost Share**	
Tests		
Laboratory Tests	$25 Copay	$35 Copay
X-Rays	$65 Copay	$55 Copay
Imaging (CT/PET scans, MRIs)	$275 Copay	$250 Copay (After Deductible)
Outpatient Surgery		
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$300 Copay	$300 Copay (After Deductible)
Physician/Surgeon Fees	$40 Copay	$35 Copay
Outpatient Visit	20% Coinsurance	20% Coinsurance
Hospitalization Services		

Benefit Comparison Chart	Gold 80 HMO 0/30 +Child Dental	
Covered Services	**2020**	**2021**
Facility Fee (e.g., Hospital Room)	$600 Per Day (Up To First 5 Days) (After Deductible)	$600 Per Day (Up To First 5 Days) (After Deductible)
Physician/Surgeon Fees	$0 Copay	$0 Copay
Delivery and All Inpatient Services (Hospital Services)	$600 Per Day (Up To First 5 Days) (After Deductible)	$600 per day (Up to the first Five 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	$35 Copay
Ambulance Services		
Medical Transportation (Including Emergency and Non-emergency)	$250 Copay (After Deductible)	$250 Copay (After Deductible)
Prescription Drug Coverage		
Tier 1:Generic Drugs (30-Day Supply)	$15 Copay	$15 Copay
Tier 1:Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$30 Copay	$30 Copay
Tier 2: Preferred Brand Drugs (30-Day Supply)	$50 Copay	$40 Copay
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$100 Copay	$80 Copay
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	$80 Copay	$70 Copay
Tier 3: Non-preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$160 Copay	$140 Copay
Tier 4: Specialty Drugs (30-Day Supply)	20% Coinsurance up to $250 per Prescription	20% Coinsurance up to $250 per Prescription
Medical Supplies/ Durable Medical Equipment		
Medical Supplies	20% Coinsurance	20% Coinsurance
Prosthetic Devices	20% Coinsurance	20% Coinsurance
Durable Medical Equipment (Outpatient)	20% Coinsurance	20% Coinsurance
Mental Health Services		
Mental/Behavioral Health Outpatient Office Visits	$0 Copay	$0 Copay

Benefit Comparison Chart	Gold 80 HMO 0/30 +Child Dental	
Covered Services	**2020**	**2021**
Mental/ Behavioral Health Other Outpatient Items and Services	$25 Copay	$35 Copay
Mental/Behavioral Health Inpatient Facility Fee	$600 Per Day (Up To First 5 Days) (After Deductible)	$600 Per Day (Up To 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	$0 Copay
Substance Use Disorder Other Outpatient Items and Services	$25 Copay	$35 Copay
Substance Use Disorder Inpatient Facility Services	$600 Per Day (Up To First 5 Days) (After Deductible)	$600 Per Day (Up To First 5 Days) (After Deductible)
Substance Use Disorder Inpatient Professional Fee	$0 Copay	$0 Copay
Home Health Services		
Home Health Care	$30 Copay	$30 Copay
Rehabilitation Services	$25 Copay	$35 Copay
Habilitation Services	$25 Copay	$35 Copay
Skilled Nursing Care	$300 Per Day (Up to First Five Days) (After Deductible)	$300 Per Day (Up to First Five Days) (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