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	Platinum 90 HMO 0/15 +Child Dental	
Covered Services	**2020**	**2021**
DEDUCTIBLES		
Annual Deductible	$0	$0
Out–of–Pocket Limit On Expenses	Individual $4,500 / Family $9,000	Individual $4,500 / Family $9,000
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	$15 Copay	$20 Copay
Specialist Visit	$30 Copay	$30 Copay
Acupuncture	$15 Copay	$20 Copay
Allergy Visit (Testing and Treatment)	$30 Copay	$30 Copay
Other Practitioner Office Visit	$15 Copay	$20 Copay
Outpatient Services	**Member Cost Share**	
Tests		
Laboratory Tests	$15 Copay	$20 Copay
X-Rays	$30 Copay	$30 Copay
Imaging (CT/PET scans, MRIs)	$75 Copay	$100 Copay
Outpatient Surgery		
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$100 Copay	$100 Copay
Physician/Surgeon Fees	$25 Copay	$25 Copay
Outpatient Visit	10% coinsurance	10% coinsurance
Hospitalization Services		
Facility Fee (e.g., Hospital Room)	$250 Per Day (Up To First 5 Days)	$250 Per Day (Up To First 5 Days)
Physician/Surgeon Fees	$0 Copay	$0 Copay

Benefit Comparison Chart	Platinum 90 HMO 0/15 +Child Dental	
Covered Services	**2020**	**2021**
Delivery and All Inpatient Services (Hospital Services)	$250 Per Day (Up To First 5 Days)	$250 per day (Up to the first Five Days)
Delivery and All Inpatient Services (Professional Services)	$0 Copay	$0 Copay
Emergency Health Coverage		
Emergency Room Services	$150 Copay	$150 Copay
Emergency Room Physician Fee	$0 Copay	$0 Copay
Urgent Care	$15 Copay	$20 Copay
Ambulance Services		
Medical Transportation (Including Emergency and Non-emergency)	$150 Copay	$150 Copay
Prescription Drug Coverage		
Tier 1:Generic Drugs (30-Day Supply)	$5 Copay	$5 Copay
Tier 1:Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$10 Copay	$10 Copay
Tier 2: Preferred Brand Drugs (30-Day Supply)	$15 Copay	$20 Copay
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$30 Copay	$40 Copay
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	$25 Copay	$30 Copay
Tier 3: Non-preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$50 Copay	$60 Copay
Tier 4: Specialty Drugs (30-Day Supply)	10% Coinsurance up to $250 per prescription	10% Coinsurance up to $250 per prescription
Medical Supplies/ Durable Medical Equipment		
Medical Supplies	10% Coinsurance	10% Coinsurance
Prosthetic Devices	10% Coinsurance	10% Coinsurance
Durable Medical Equipment (Outpatient)	10% Coinsurance	10% Coinsurance
Mental Health Services		
Mental/Behavioral Health Outpatient Office Visits	$15 Copay	$20 Copay
Mental/ Behavioral Health Other Outpatient Items and Services	$15 Copay	$20 Copay
Mental/Behavioral Health Inpatient Facility Fee	$250 Per Day (Up To First 5 Days)	$250 Per Day (Up To First 5 Days)
Mental/Behavioral Health Inpatient Professional Fee	$0 Copay	$0 Copay
Chemical Dependency Services		

Benefit Comparison Chart	Platinum 90 HMO 0/15 +Child Dental	
Covered Services	**2020**	**2021**
Substance Use Disorder Outpatient Office Visits	$15 Copay	$20 Copay
Substance Use Disorder Other Outpatient Items and Services	$15 Copay	$20 Copay
Substance Use Disorder Inpatient Facility Services	$250 Per Day (Up To First 5 Days)	$250 Per Day (Up To First 5 Days)
Substance Use Disorder Inpatient Professional Fee	$0 Copay	$0 Copay
Home Health Services		
Home Health Care	$20 copay	$20 copay
Rehabilitation Services	$15 copay	$20 copay
Habilitation Services	$15 copay	$20 copay
Skilled Nursing Care	$150 Per Day (Up to First Five Days)	$150 Per Day (Up to First Five Days)
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