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	Silver 70 HMO 2000/45 +Child Dental	
Covered Services	**2020**	**2021**
DEDUCTIBLES		
Annual Deductible	Medical: Individual $2,250 / Family $4,500 Drug: Individual $300/ Family $600	Medical: Individual $2,250 / Family $4,500 Drug: Individual $300/ Family $600
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	$50 Copay	$55 Copay
Specialist Visit	$85 Copay	$90 Copay
Acupuncture	$50 Copay	$55 Copay
Allergy Visit (Testing and Treatment)	$85 Copay	$90 Copay
Other Practitioner Office Visit	$50 Copay	$55 Copay
Outpatient Services	**Member Cost Share**	
Tests		
Laboratory Tests	$40 Copay	$55 Copay
X-Rays	$85 Copay	$90 Copay
Imaging (CT/PET scans, MRIs)	$300 Copay	$300 Copay (After Deductible)
Outpatient Surgery		
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	20% Coinsurance	30% Coinsurance (After Deductible)
Physician/Surgeon Fees	20% Coinsurance	30% Coinsurance
Outpatient Visit	20% Coinsurance	30% Coinsurance
Hospitalization Services		

Benefit Comparison Chart	Silver 70 HMO 2000/45 +Child Dental	
Covered Services	**2020**	**2021**
Facility Fee (e.g., Hospital Room)	20% Coinsurance (After Deductible)	30% Coinsurance (After Deductible)
Physician/Surgeon Fees	20% Coinsurance	30% Coinsurance
Delivery and All Inpatient Services (Hospital Services)	20% Coinsurance (After Deductible)	30% Coinsurance (After Deductible)
Delivery and All Inpatient Services (Professional Services)	20% Coinsurance	30% Coinsurance
Emergency Health Coverage		
Emergency Room Services	$400 Copay (After Deductible)	30% Coinsurance (After Deductible)
Emergency Room Physician Fee	$0 Copay	$0 Copay
Urgent Care	$50 Copay	$55 Copay
Ambulance Services		
Medical Transportation (Including Emergency and Non-emergency)	$250 Copay (After Deductible)	30% Coinsurance (After Deductible)
Prescription Drug Coverage		
Tier 1:Generic Drugs (30-Day Supply)	$ 17 Copay (After Drug Deductible)	$ 17 Copay
Tier 1:Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$34 Copay (After Drug Deductible)	$34 Copay
Tier 2: Preferred Brand Drugs (30-Day Supply)	$ 65 Copay (After Drug Deductible)	$80 Copay (After Drug Deductible)
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$130 Copay (After Drug Deductible)	$160 Copay (After Drug Deductible)
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	$90 Copay (After Drug Deductible)	$110 Copay (After Drug Deductible)
Tier 3: Non-preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$180 Copay (After Drug Deductible)	$220 Copay (After Drug Deductible)
Tier 4: Specialty Drugs (30-Day Supply)	20% Coinsurance Up to $250 Per Prescription (After Drug Deductible)	30% coinsurance up to $250 per prescription (After Drug Deductible)
Medical Supplies/ Durable Medical Equipment		
Medical Supplies	20% Coinsurance	30% Coinsurance
Prosthetic Devices	20% Coinsurance	30% Coinsurance
Durable Medical Equipment (Outpatient)	20% Coinsurance	30% Coinsurance
Mental Health Services		
Mental/Behavioral Health Outpatient Office Visits	$50 Copay	$0 Copay

Benefit Comparison Chart	Silver 70 HMO 2000/45 +Child Dental	
Covered Services	**2020**	**2021**
Mental/ Behavioral Health Other Outpatient Items and Services	$0 Copay	$55 Copay
Mental/Behavioral Health Inpatient Facility Fee	20% Coinsurance (After Deductible)	30% Coinsurance (After Deductible)
Mental/Behavioral Health Inpatient Professional Fee	20% Coinsurance	30% Coinsurance
Chemical Dependency Services		
Substance Use Disorder Outpatient Office Visits	$50 Copay	$0 Copay
Substance Use Disorder Other Outpatient Items and Services	$0 Copay	$55 Copay
Substance Use Disorder Inpatient Facility Services	20% Coinsurance (After Deductible)	30% Coinsurance (After Deductible)
Substance Use Disorder Inpatient Professional Fee	20% Coinsurance	30% Coinsurance
Home Health Services		
Home Health Care	$45 Copay	$45 Copay
Rehabilitation Services	$50 Copay	$55 Copay
Habilitation Services	$50 copay	$55 Copay
Skilled Nursing Care	20% Coinsurance (After Deductible)	30% 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