

## Plan Comparison<sup>1</sup>

2022-2023

2022

2023

	<b>Gold 80 HMO 1000/40* + Child Dental Alt</b>	<b>Gold 80 HMO 1000/40* + Child Dental Alt</b>
FEATURES	Deductible HMO Plan	Deductible HMO Plan
<b>PLAN DEDUCTIBLE</b> Embedded	Individual – \$1,000 <sup>10</sup> Family – \$2,000 <sup>10</sup>	Individual – \$1,000 <sup>10</sup> Family – \$2,000 <sup>10</sup>
<b>OUT-OF-POCKET MAXIMUM</b> Embedded	Individual – \$7,800 <sup>1,10</sup> Family – \$15,600 <sup>1,10</sup>	Individual – \$7,800 <sup>1,10</sup> Family – \$15,600 <sup>1,10</sup>
<b>IN THE MEDICAL OFFICE</b>		
Primary care visits	\$40	\$40
Urgent care visits	\$40	\$40
Specialty office visits	\$60	\$60
Preventive exams, vaccines (immunizations)	\$0 <sup>12</sup>	\$0 <sup>12</sup>
Prenatal care	\$0 <sup>3</sup>	\$0 <sup>3</sup>
Postpartum care	\$0 <sup>3</sup>	\$0 <sup>3</sup>
Well-child preventive care visits	\$0 <sup>23</sup>	\$0 <sup>23</sup>
Allergy injections	\$5 per visit	\$5 per visit
Fertility services	Not covered <sup>17</sup>	Not covered <sup>17</sup>
Physical, occupational, and speech therapy	\$40	\$40
Most laboratory tests	\$30	\$30
Most X-rays and diagnostic testing	\$60	\$60
Most MRI/CT/PET scans	\$350 (after plan deductible)	\$350 (after plan deductible)
Outpatient surgery (per procedure)	\$350	\$350
<b>EMERGENCY SERVICES</b>		
Emergency department visits (waived if admitted directly to hospital)	\$350	\$350
Ambulance	\$350	\$350
<b>PRESCRIPTIONS</b>		
Generic drugs (up to a 30-day supply)	\$20 <sup>24</sup>	\$20 <sup>24</sup>
Brand-name drugs (up to a 30-day supply)	\$50 (after \$250 drug deductible) <sup>24</sup>	\$50 (after \$250 drug deductible) <sup>24</sup>
Specialty drugs (up to a 30-day supply)	20% per prescription up to \$250 maximum (after \$250 drug deductible) <sup>24</sup>	20% per prescription up to \$250 maximum (after \$250 drug deductible) <sup>24</sup>
<b>HOSPITAL INPATIENT CARE</b>		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	\$600 per day up to 5 days per admission (after plan deductible) <sup>26</sup>	\$600 per day up to 5 days per admission (after plan deductible) <sup>26</sup>
Skilled nursing facility care (up to 100 days per benefit period)	\$300 per day up to 5 days per admission (after plan deductible) <sup>26</sup>	\$300 per day up to 5 days per admission (after plan deductible) <sup>26</sup>
<b>MENTAL HEALTH SERVICES</b>		
Outpatient (in the medical office)	\$40	\$40
Inpatient (in the hospital)	\$600 per day up to 5 days per admission (after plan deductible) <sup>26</sup>	\$600 per day up to 5 days per admission (after plan deductible) <sup>26</sup>
<b>SUBSTANCE USE DISORDER SERVICES</b>		
Outpatient (in the medical office)	\$40	\$40
Inpatient (in the hospital) - detoxification only	\$600 per day up to 5 days per admission (after plan deductible) <sup>26</sup>	\$600 per day up to 5 days per admission (after plan deductible) <sup>26</sup>
<b>OTHER</b>		
Televisits	\$0	\$0
Chiropractic and acupuncture	\$15 per visit (self-referral; 20 combined visits per year)	\$15 per visit (self-referral; 20 combined visits per year)
Certain durable medical equipment (DME) (supplemental and base)	20% <sup>5,6,27</sup>	20% <sup>5,6,27</sup>
Certain prosthetic and orthotic devices	\$0	\$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year <sup>7</sup>	1 pair of eyeglasses or contact lenses per year <sup>7</sup>
Pediatric vision exam	\$0	\$0
Adult optical (eyewear)	Not covered <sup>8</sup>	Not covered <sup>8</sup>
Adult vision exam (for eye refraction)	\$0	\$0
Home health care (up to 100 visits per year)	\$0	\$0
Hospice care	\$0	\$0

<sup>1</sup>This is a benefit comparison only. The changes have been highlighted. For limitations, exclusions, or exceptions, refer to the plan highlights or your EOC.