Plan Comparison[1]

2022–2023

	2022	2023
	Platinum 90 HMO 0/10* + Child Dental Alt	**Platinum 90 HMO 0/10* + Child Dental Alt**
FEATURES	**Copay HMO Plan**	**Copay HMO Plan**
PLAN DEDUCTIBLE Embedded	$0	$0
OUT-OF-POCKET MAXIMUM Embedded	$3,000/$6,000	$3,000/$6,000
IN THE MEDICAL OFFICE Primary care visits	$10	$10
Urgent care visits	$10	$10
Specialty office visits	$20	$20
Preventive exams, vaccines (immunizations)	$0	$0
Prenatal care	$0	$0
Postpartum care	$0	$0
Well-child preventive care visits	$0	$0
Allergy injections	$5 per visit	$5 per visit
Fertility services	Not covered	Not covered
Physical, occupational, and speech therapy	$10	$10
Most laboratory tests	$20	$20
Most X-rays and diagnostic testing	$40	$40
Most MRI/CT/PET scans	$150	$150
Outpatient surgery (per procedure)	$300	$300
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	$200	$200
Ambulance	$150	$150
PRESCRIPTIONS Generic drugs (up to a 30-day supply)	$5	$5
Brand-name drugs (up to a 30-day supply)	$15	$15
Specialty drugs (up to a 30-day supply)	10% per prescription up to $250 maximum	10% per prescription up to $250 maximum
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$500 per admission	$500 per admission
Skilled nursing facility care (up to 100 days per benefit period)	$250 per admission	$250 per admission
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$10	$10
Inpatient (in the hospital)	$500 per admission	$500 per admission
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$10	$10
Inpatient (in the hospital) - detoxification only	$500 per admission	$500 per admission
OTHER 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)	10%	10%
Certain prosthetic and orthotic devices	$0	$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year	1 pair of eyeglasses or contact lenses per year
Pediatric vision exam	$0	$0
Adult optical (eyewear)	$175 allowance	$175 allowance
Adult vision exam (for eye refraction)	$0	$0
Home health care (up to 100 visits per year)	$0	$0
Hospice care	$0	$0

[1]This is a benefit comparison only. The changes have been highlighted. For limitations, exclusions, or exceptions, refer to the plan highlights or your *EOC*.