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	Opal 50 HMO Silver	
Covered Services	**2020**	**2021**
DEDUCTIBLES		
Annual Deductible	Individual $3,000/ Family $6,000 Drug: Individual $275 / Family $550	Medical: Individual $3,000/ Family $6,000 Drug: Individual $300 / Family $600
Out–of–Pocket Limit On Expenses	Individual $7,750 / Family $15,500	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	$50 Copay
Specialist Visit	$50 Copay	$50 Copay
Acupuncture	$50 Copay	$50 Copay
Allergy Visit (Testing and Treatment)	$50 Copay	$50 Copay
Other Practitioner Office Visit	$50 Copay	$50 Copay
Outpatient Services	**Member Cost Share**	
Tests		
Laboratory Tests	$25 Copay	$25 Copay
X-Rays	$75 Copay	$75 Copay
Imaging (CT/PET scans, MRIs)	$275 Copay	$275 Copay
Outpatient Surgery		
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$100 (Chinese Hospital) / $300 (Other Facilities) (After Deductible)	$300 (Chinese Hospital) / $750 (Other Facilities) (After Deductible)
Physician/Surgeon Fees	$0 Copay	$0 Copay
Outpatient Visit	$0 Copay	$0 Copay
Hospitalization Services		
Facility Fee (e.g., Hospital Room)	$250 Copay / Day	$250 Copay / Day

Benefit Comparison Chart	Opal 50 HMO Silver	
Covered Services	**2020**	**2021**
	(Chinese Hospital) $750 Copay / Day (Other Facilities) (Up to First 5 Days) (After Deductible)	(Chinese Hospital) $750 Copay / Day (Other Facilities) (Up to First 5 Days) (After Deductible)
Physician/Surgeon Fees	$0 Copay	$0 Copay
Delivery and All Inpatient Services (Hospital Services)	$250 copay per day (Up to the first 5 days) (After Deductible)	$250 copay per day (Up to the first 5 days) (After Deductible)
Delivery and All Inpatient Services (Professional Services)	$0 Copay	$0 Copay
Emergency Health Coverage		
Emergency Room Services	$300 Copay (After Deductible)	$300 Copay (After Deductible)
Emergency Room Physician Fee	$0 Copay	$0 Copay
Urgent Care	$50 Copay	$50 Copay
Ambulance Services		
Medical Transportation (Including Emergency and Non-emergency)	$100 copay (After Deductible)	$100 copay (After Deductible)
Prescription Drug Coverage		
Tier 1:Generic Drugs (30-Day Supply)	$15 Copay (After Drug Deductible)	$15 Copay (After Drug Deductible)
Tier 1:Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$30 Copay (After Drug Deductible)	$30 Copay
Tier 2: Preferred Brand Drugs (30-Day Supply)	$50 Copay (After Drug Deductible)	$50 Copay (After Drug Deductible)
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$100 Copay (After Drug Deductible)	$100 Copay (After Drug Deductible)
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	$70 Copay (After Drug Deductible)	$70 Copay (After Drug Deductible)
Tier 3: Non-preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$140 Copay (After Drug Deductible)	$140 Copay (After Drug Deductible)
Tier 4: Specialty Drugs (30-Day Supply)	20% Coinsurance Up to $250 Per Prescription (After Drug Deductible)	20% Coinsurance Up to $250 Per Prescription (After Drug Deductible)
Medical Supplies/ Durable Medical Equipment		
Medical Supplies	50% coinsurance (After Drug Deductible)	50% coinsurance (After Drug Deductible)
Prosthetic Devices	50% coinsurance (After Drug Deductible)	50% coinsurance (After Drug Deductible)
Durable Medical Equipment (Outpatient)	50% coinsurance (After Drug Deductible)	50% coinsurance (After Drug Deductible)

Benefit Comparison Chart	Opal 50 HMO Silver	
Covered Services	**2020**	**2021**
Mental Health Services		
Mental/Behavioral Health Outpatient Office Visits	$0 Copay	$50 Copay
Mental/ Behavioral Health Other Outpatient Items and Services	$0 Copay	$50 Copay
Mental/Behavioral Health Inpatient Facility Fee	$ 250 copay/day (Up to first 5 days) (After Deductible)	$250 copay/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	$50 Copay	$50 Copay
Substance Use Disorder Other Outpatient Items and Services	$0 Copay	$50 Copay
Substance Use Disorder Inpatient Facility Services	$250 copay/day (Up to first 5 days) (After Deductible)	$250 copay/day (Up to first 5 days) (After Deductible)
Substance Use Disorder Inpatient Professional Fee	$0 Copay	$0 Copay
Home Health Services		
Home Health Care	$0 copay (After Deductible)	$0 copay (After Deductible)
Rehabilitation Services	$50 Copay	$50 Copay
Habilitation Services	$50 Copay	$50 Copay
Skilled Nursing Care	1st 10 days at no charge; then $100 per day (After Deductible)	1st 10 days at no charge; then $100 per day (After Deductible)
Hospice Services	$0 copay (After Deductible)	$0 copay (After Deductible)
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