Health Plan Comparison Highlights for 2021

	Health Savings Plan (HSP)		MissionCare Plan (MCP)	
	Mission Health Partners (MHP)	**In-Network**	**Mission Health Partners (MHP)**	**In-Network**
Deductible (Single/Employee +1/Family)	$1,500 / $3,000		$1,000 / $1,250 / $2,000	
Max OOP (Single/Employee +1/Family)	$7,000 / $14,000		$6,550 / $13,100	
Account Contribution (Single / Family)	HSA: $250 / $500		N/A	
Coinsurance	20% after deductible	30% after deductible	25% after deductible	
Preventive Care (you pay)	$0		$0	
PCP Office Visit (you pay)	20% after deductible		$35 copay	
Spec Office Visit (you pay)	20% after deductible		$50 copay	25% after deductible
Urgent Care (you pay)	20% after deductible		$50 copay	
Emergency Room (you pay)	20% after deductible if true emergency 30% after deductible if non-emergency		$200 copay if emergency (copay waived if admitted) $300 copay if non-emergency	
Hospital Expenses (Outpatient) (you pay)	20% after deductible	30% after deductible	$225 copay Mission Hospitals 25% after deductible other MHP & In-Network	
Hospital Expenses (Inpatient) (you pay)	20% after deductible	30% after deductible	$600 copay	25% after deductible
X-Ray / Imaging Basic (you pay)	20% after deductible	30% after deductible	$20 copay	25% after deductible
X-Ray / Imaging Complex (you pay)	20% after deductible	30% after deductible	$100 copay	25% after deductible
Lab (Facility) (you pay)	20% after deductible	30% after deductible	$0	25% after deductible

Out-of-Network benefits are only covered for emergency room, urgent care, and gap exceptions. Refer to plan information posted on MissionAndMe.com.

Prescription Benefits Comparison Highlights for 2021

	Health Savings Plan (HSP)		MissionCare Plan (MCP)	
	Mission Network	**Optum Network**	**Mission Network**	**Optum Network**
Deductible	Health Plan Deductible		$0	$200 / $400
Generic (you pay)	$0 after Deductible (Ded)		$0	
Brand Preferred (you pay)	30% after deductible	40% after deductible	$40 co-pay	$60 co-pay after Ded
Brand Non-Preferred (you pay)	50% after Deductible		$500/$1,000 Ded, then 50% with min $100 & max $200	$500/$1,000 Ded, then 60% with min $100 & max $300
Insulin, Hypoglycemics, Non-Insulin Injectables and supplies (you pay)	$25 co-pay $60 co-pay (Mission Mail) No Ded if preventive	$25 co-pay No Deductible if preventive	$25 co-pay $60 co-pay (Mission Mail)	$25 co-pay after Deductible
Specialty (you pay)	30% after Deductible	Not covered	10% with min $75 and max $150	Not covered
Mail Generic (90 day) (you pay)	0% after Deductible	Not covered	$0	Not covered
Mail Brand Pref (90 day) (you pay)	30% after Deductible	Not covered	$80 co-pay	Not covered
Mail Brand Non-Preferred (90 day) (you pay)	50% after Deductible	Not covered	$500/$1,000 Ded then 50% with min $200 and max $400	Not covered

If a brand drug is chosen when a generic drug is available, you must pay the brand drug copay and the difference in cost between the brand drug and the generic drug.