

## Plan Comparison \*

2019-2020

2019

2020

	<b>Gold 80 HRA HMO 2250/35 + Child Dental</b>	<b>Gold 80 HRA HMO 2250/35 + Child Dental</b>
FEATURES	Deductible HMO with HRA Plan (HRA can be administered through Kaiser Permanente)	Deductible HMO with HRA Plan (HRA can be administered through Kaiser Permanente)
<b>PLAN DEDUCTIBLE</b>		
Individual/Family	\$2,250/\$4,500 (embedded)	\$2,250/\$4,500 (embedded)
<b>OUT-OF-POCKET MAXIMUM</b>		
Individual/Family	\$7,550/\$15,100 (embedded)	\$7,800/\$15,600 (embedded)
<b>IN THE MEDICAL OFFICE</b>		
Primary care visits	\$35	\$35
Urgent care visits	\$35	\$35
Specialty office visits	\$50	\$50
Preventive exams, vaccines (immunizations)	\$0	\$0
Prenatal care	\$0	\$0
Postpartum care	\$0	\$0
Well-child preventive care visits	\$0	\$0
Allergy injections	\$5 (after plan deductible)	\$5 (after plan deductible)
Infertility services	Not covered	Not covered
Physical, occupational, and speech therapy	\$35 (after plan deductible)	\$35 (after plan deductible)
Most laboratory tests	25% (after plan deductible)	25% (after plan deductible)
Most X-rays and diagnostic testing	25% (after plan deductible)	25% (after plan deductible)
Most MRI/CT/PET scans	25% (after plan deductible)	25% (after plan deductible)
Outpatient surgery (per procedure)	25% (after plan deductible)	25% (after plan deductible)
<b>EMERGENCY SERVICES</b>		
Emergency Department visits (waived if admitted directly to hospital)	25% (after plan deductible)	25% (after plan deductible)
Ambulance	25% (after plan deductible)	25% (after plan deductible)
<b>PRESCRIPTIONS</b>		
Generic drugs	\$15 (up to a 30-day supply)	\$15 (up to a 30-day supply)
Brand-name drugs	\$30 (up to a 30-day supply)	\$30 (after \$100 drug deductible) (up to a 30-day supply)
Specialty drugs	20% per prescription up to \$250 maximum (up to a 30-day supply)	20% per prescription up to \$250 maximum (after \$100 drug deductible) (up to a 30-day supply)
<b>HOSPITAL CARE</b>		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	25% (after plan deductible)	25% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	25% (after plan deductible)	25% (after plan deductible)
<b>MENTAL HEALTH SERVICES</b>		
In the medical office	\$35	\$35
In the hospital	25% (after plan deductible)	25% (after plan deductible)
<b>CHEMICAL DEPENDENCY SERVICES</b>		
In the medical office	\$35	\$35
In the hospital (detoxification only)	25% (after plan deductible)	25% (after plan deductible)
<b>OTHER</b>		
Televisits	\$0	\$0
Chiropractic and acupuncture	\$35 per visit for physician-referred acupuncture; chiropractic not covered	\$35 per visit for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME)	50% (base only)	50% (supplemental and base)
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)	Not covered	Not covered
Adult vision exam (for eye refraction)	\$0	\$0
Home health care (up to 100 visits per year)	\$0	\$0
Hospice care	\$0	\$0

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