

Plan Comparison¹

2019-2020

	2019	2020
	Silver 70 HDHP HMO 2500/20%* + Child Dental	Silver 70 HDHP HMO 2500/20%* + Child Dental
FEATURES	HSA-qualified High Deductible Health Plan (HSA can be administered through Kaiser Permanente)	HSA-qualified High Deductible Health Plan (HSA can be administered through Kaiser Permanente)
PLAN DEDUCTIBLE		
Individual/Family	Self-only - \$2,500 Individual - \$2,700 Family - \$5,000 (embedded)	Self-only - \$2,500 Individual - \$2,800 Family - \$5,000 (embedded)
OUT-OF-POCKET MAXIMUM		
Individual/Family	\$6,650/\$13,300 (embedded)	\$6,850/\$13,700 (embedded)
IN THE MEDICAL OFFICE		
Primary care visits	20% (after plan deductible)	20% (after plan deductible)
Urgent care visits	20% (after plan deductible)	20% (after plan deductible)
Specialty office visits	20% (after plan deductible)	20% (after plan deductible)
Preventive exams, vaccines (immunizations)	\$0	\$0
Prenatal care	\$0	\$0
Postpartum care	\$0 (after plan deductible)	\$0 (after plan deductible)
Well-child preventive care visits	\$0	\$0
Allergy injections	20% (after plan deductible)	20% (after plan deductible)
Infertility services	Not covered	Not covered
Physical, occupational, and speech therapy	20% (after plan deductible)	20% (after plan deductible)
Most laboratory tests	20% (after plan deductible)	20% (after plan deductible)
Most X-rays and diagnostic testing	20% (after plan deductible)	20% (after plan deductible)
Most MRI/CT/PET scans	20% (after plan deductible)	20% (after plan deductible)
Outpatient surgery (per procedure)	20% (after plan deductible)	20% (after plan deductible)
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	20% (after plan deductible)	20% (after plan deductible)
Ambulance	20% (after plan deductible)	20% (after plan deductible)
PRESCRIPTIONS		
Generic drugs	20% per prescription up to \$250 maximum (after plan deductible) (up to a 30-day supply)	20% per prescription up to \$250 maximum (after plan deductible) (up to a 30-day supply)
Brand-name drugs	20% per prescription up to \$250 maximum (after plan deductible) (up to a 30-day supply)	20% per prescription up to \$250 maximum (after plan deductible) (up to a 30-day supply)
Specialty drugs	20% per prescription up to \$250 maximum (after plan deductible) (up to a 30-day supply)	20% per prescription up to \$250 maximum (after plan deductible) (up to a 30-day supply)
HOSPITAL CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	20% (after plan deductible)	20% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	20% (after plan deductible)	20% (after plan deductible)
MENTAL HEALTH SERVICES		
In the medical office	20% (after plan deductible)	20% (after plan deductible)
In the hospital	20% (after plan deductible)	20% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES		
In the medical office	20% (after plan deductible)	20% (after plan deductible)
In the hospital (detoxification only)	20% (after plan deductible)	20% (after plan deductible)
OTHER		
Televisits	\$0 (after plan deductible)	\$0 (after plan deductible)
Chiropractic and acupuncture	20% per visit (after plan deductible) for physician-referred acupuncture; chiropractic not covered	20% per visit (after plan deductible) for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME)	20% (after plan deductible) (base only)	20% (after plan deductible) (supplemental and base)
Certain prosthetic and orthotic devices	\$0 (after plan deductible)	\$0 (after plan deductible)
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)	20% (after plan deductible)	20% (after plan deductible)
Hospice care	\$0 (after plan deductible)	\$0 (after plan deductible)

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