

Plan Comparison¹

2020-2021

	2020	2021
	Bronze 60 HDHP HMO 6900/0* + Child Dental	Bronze 60 HDHP HMO 7000/0* + 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 (embedded)	\$6,900/\$13,800	\$7,000/\$14,000
OUT-OF-POCKET MAXIMUM		
Individual/Family (embedded)	\$6,900/\$13,800	\$7,000/\$14,000
IN THE MEDICAL OFFICE		
Primary care visits	\$0 (after plan deductible)	\$0 (after plan deductible)
Urgent care visits	\$0 (after plan deductible)	\$0 (after plan deductible)
Specialty office visits	\$0 (after plan deductible)	\$0 (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	\$0 per visit (after plan deductible)	\$0 per visit (after plan deductible)
Infertility services	Not covered	Not covered
Physical, occupational, and speech therapy	\$0 (after plan deductible)	\$0 (after plan deductible)
Most laboratory tests	\$0 (after plan deductible)	\$0 (after plan deductible)
Most X-rays and diagnostic testing	\$0 (after plan deductible)	\$0 (after plan deductible)
Most MRI/CT/PET scans	\$0 (after plan deductible)	\$0
Outpatient surgery (per procedure)	\$0 (after plan deductible)	\$0 (after plan deductible)
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	\$0 (after plan deductible)	\$0 (after plan deductible)
Ambulance	\$0 (after plan deductible)	\$0 (after plan deductible)
PRESCRIPTIONS		
Generic drugs (up to a 30-day supply)	\$0 (after plan deductible)	\$0 per prescription up to \$500 maximum
Brand-name drugs (up to a 30-day supply)	\$0 (after plan deductible)	\$0 per prescription up to \$500 maximum
Specialty drugs (up to a 30-day supply)	\$0 (after plan deductible)	\$0 per prescription up to \$500 maximum
HOSPITAL CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	\$0 (after plan deductible)	\$0 (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	\$0 (after plan deductible)	\$0 (after plan deductible)
MENTAL HEALTH SERVICES		
In the medical office	\$0 (after plan deductible)	\$0 (after plan deductible)
In the hospital	\$0 (after plan deductible)	\$0 (after plan deductible)
CHEMICAL DEPENDENCY SERVICES		
In the medical office	\$0 (after plan deductible)	\$0 (after plan deductible)
In the hospital (detoxification only)	\$0 (after plan deductible)	\$0 (after plan deductible)
OTHER		
Televisits	\$0 (after plan deductible)	\$0 (after plan deductible)
Chiropractic and acupuncture	\$0 per visit (after plan deductible) for physician-referred acupuncture; chiropractic not covered	\$0 per visit (after plan deductible) for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (supplemental and base)	\$0 (after plan deductible)	\$0 (after plan deductible)
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)	\$0 (after plan deductible)	\$0 (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.