

Plan Comparison *

2020-2021

2020

2021

	Gold 80 HRA HMO 2250/35 + Child Dental	Gold 80 HRA HMO 2250/35 + Child Dental
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)
PLAN DEDUCTIBLE		
Individual/Family (embedded)	\$2,250/\$4,500	\$2,250/\$4,500
OUT-OF-POCKET MAXIMUM		
Individual/Family (embedded)	\$7,800/\$15,600	\$7,800/\$15,600
IN THE MEDICAL OFFICE		
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 per visit (after plan deductible)	\$5 per visit (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)
EMERGENCY SERVICES		
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)
PRESCRIPTIONS		
Generic drugs (up to a 30-day supply)	\$15	\$15
Brand-name drugs (up to a 30-day supply)	\$30 (after \$100 drug deductible)	\$30 (after \$100 drug deductible)
Specialty drugs (up to a 30-day supply)	20% per prescription up to \$250 maximum (after \$100 drug deductible)	20% per prescription up to \$250 maximum (after \$100 drug deductible)
HOSPITAL CARE		
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)
MENTAL HEALTH SERVICES		
In the medical office	\$35	\$35
In the hospital	25% (after plan deductible)	25% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES		
In the medical office	\$35	\$35
In the hospital (detoxification only)	25% (after plan deductible)	25% (after plan deductible)
OTHER		
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) (supplemental and base)	50%	50%
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.