

Plan Comparison¹

2022-2023

	2022	2023
	Gold 80 HDHP HMO 1600/15%* + Child Dental Alt	Gold 80 HDHP HMO 1600/15%* + Child Dental Alt
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 Embedded	Self-only - \$1,600 Individual - \$2,800 Family - \$3,200	Self-only - \$1,600 Individual - \$3,000 Family - \$3,200
OUT-OF-POCKET MAXIMUM Embedded	\$3,250/\$6,500	\$3,550/\$7,100
IN THE MEDICAL OFFICE		
Primary care visits	15% (after plan deductible)	15% (after plan deductible)
Urgent care visits	15% (after plan deductible)	15% (after plan deductible)
Specialty office visits	15% (after plan deductible)	15% (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	15% per visit (after plan deductible)	15% per visit (after plan deductible)
Fertility services	Not covered	Not covered
Physical, occupational, and speech therapy	15% (after plan deductible)	15% (after plan deductible)
Most laboratory tests	15% (after plan deductible)	15% (after plan deductible)
Most X-rays and diagnostic testing	15% (after plan deductible)	15% (after plan deductible)
Most MRI/CT/PET scans	15% (after plan deductible)	15% (after plan deductible)
Outpatient surgery (per procedure)	15% (after plan deductible)	15% (after plan deductible)
EMERGENCY SERVICES		
Emergency department visits (waived if admitted directly to hospital)	15% (after plan deductible)	15% (after plan deductible)
Ambulance	15% (after plan deductible)	15% (after plan deductible)
PRESCRIPTIONS		
Generic drugs (up to a 30-day supply)	\$15 (after plan deductible)	\$15 (after plan deductible)
Brand-name drugs (up to a 30-day supply)	\$45 (after plan deductible)	\$45 (after plan deductible)
Specialty drugs (up to a 30-day supply)	15% per prescription up to \$250 maximum (after plan deductible)	15% per prescription up to \$250 maximum (after plan deductible)
HOSPITAL INPATIENT CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	15% (after plan deductible)	15% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	15% (after plan deductible)	15% (after plan deductible)
MENTAL HEALTH SERVICES		
Outpatient (in the medical office)	15% (after plan deductible)	15% (after plan deductible)
Inpatient (in the hospital)	15% (after plan deductible)	15% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES		
Outpatient (in the medical office)	15% (after plan deductible)	15% (after plan deductible)
Inpatient (in the hospital) - detoxification only	15% (after plan deductible)	15% (after plan deductible)
OTHER		
Televisits	\$0 (after plan deductible)	\$0 (after plan deductible)
Acupuncture	15% per visit (after plan deductible) for physician-referred acupuncture	15% per visit (after plan deductible) for physician-referred acupuncture
Certain durable medical equipment (DME) (supplemental and base)	15% (after plan deductible)	15% (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)	15% (after plan deductible)	15% (after plan deductible)
Hospice care	\$0	\$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.