KAISER PERMANENTE®

*ALSO AVAILABLE IN COVERED CALIFORNIA AND CALIFORNIA*CHOICE*

Plan Comparison[1]

2019–2020

	2019	2020
	Bronze 60 HMO 6300/75* + Child Dental	**Bronze 60 HMO 6300/65* + Child Dental**
FEATURES	**Deductible HMO Plan**	**Deductible HMO Plan**
PLAN DEDUCTIBLE Individual/Family	$6,300/$12,600 (embedded)	$6,300/$12,600 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	$7,550/$15,100 (embedded)	$7,800/$15,600 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$75 (after plan deductible)	$65 (after plan deductible)
Urgent care visits	$75 (after plan deductible)	$65 (after plan deductible)
Specialty office visits	$105 (after plan deductible)	$95 (after plan deductible)
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	$75	$65
Most laboratory tests	$40	$40
Most X-rays and diagnostic testing	100% (up to out-of-pocket maximum)	40% (after plan deductible)
Most MRI/CT/PET scans	100% (up to out-of-pocket maximum)	40% (after plan deductible)
Outpatient surgery (per procedure)	100% (up to out-of-pocket maximum)	40% (after plan deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital)	100% (up to out-of-pocket maximum)	40% (after plan deductible)
Ambulance	100% (up to out-of-pocket maximum)	40% (after plan deductible)
PRESCRIPTIONS Generic drugs	100% per prescription up to $500 maximum (after $500 drug deductible) (up to a 30-day supply)	$18 (after $500 drug deductible) (up to a 30-day supply)
Brand-name drugs	100% per prescription up to $500 maximum (after $500 drug deductible) (up to a 30-day supply)	40% up to $500 maximum (after $500 drug deductible) (up to a 30-day supply)
Specialty drugs	100% per prescription up to $500 maximum (after $500 drug deductible) (up to a 30-day supply)	40% up to $500 maximum (after $500 drug deductible) (up to a 30-day supply)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	100% (up to out-of-pocket maximum)	40% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	100% (up to out-of-pocket maximum)	40% (after plan deductible)
MENTAL HEALTH SERVICES In the medical office	$75 (after plan deductible)	$65 (after plan deductible)
In the hospital	100% (up to out-of-pocket maximum)	40% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES In the medical office	$75 (after plan deductible)	$65 (after plan deductible)
In the hospital (detoxification only)	100% (up to out-of-pocket maximum)	40% (after plan deductible)
OTHER		
Televisits	$0	$0
Chiropractic and acupuncture	$75 per visit (after plan deductible) for physician-referred acupuncture; chiropractic not covered	$65 per visit (after plan deductible) for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME)	100% (up to out-of-pocket maximum) (base only)	40% (after plan deductible) (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)	100% (up to out-of-pocket maximum)	40% (after plan deductible)
Hospice care	$0	$0

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