KAISER PERMANENTE®

*ALSO AVAILABLE IN COVERED CALIFORNIA AND CALIFORNIA*CHOICE*

Plan Comparison[1]

2019–2020

	2019	2020
	Gold 80 HMO 0/30* + Child Dental	**Gold 80 HMO 250/25* + Child Dental**
FEATURES	Copay HMO Plan	Deductible HMO Plan
PLAN DEDUCTIBLE		
Individual/Family	$0/$0	$250/$500
OUT-OF-POCKET MAXIMUM		
Individual/Family	$7,200/$14,400 (embedded)	$7,800/$15,600 (embedded)
IN THE MEDICAL OFFICE		
Primary care visits	$30	$25
Urgent care visits	$30	$25
Specialty office visits	$55	$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	$5
Infertility services	Not covered	Not covered
Physical, occupational, and speech therapy	$30	$25
Most laboratory tests	$35	$25
Most X-rays and diagnostic testing	$55	$65
Most MRI/CT/PET scans	$275	$275
Outpatient surgery (per procedure)	$340	$340
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	$325	$250 (after plan deductible)
Ambulance	$250	$250 (after plan deductible)
PRESCRIPTIONS		
Generic drugs	$15 (up to a 30-day supply)	$15 (up to a 30-day supply)
Brand-name drugs	$55 (up to a 30-day supply)	$50 (up to a 30-day supply)
Specialty drugs	20% per prescription up to $250 maximum (up to a 30-day supply)	20% per prescription up to $250 maximum (up to a 30-day supply)
HOSPITAL CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$600 per day up to 5 days per admission	$600 per day up to 5 days per admission (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	$300 per day up to 5 days per admission	$300 per day up to 5 days per admission (after plan deductible)
MENTAL HEALTH SERVICES		
In the medical office	$30	$25
In the hospital	$600 per day up to 5 days per admission	$600 per day up to 5 days per admission (after plan deductible)
CHEMICAL DEPENDENCY SERVICES		
In the medical office	$30	$25
In the hospital (detoxification only)	$600 per day up to 5 days per admission	$600 per day up to 5 days per admission (after plan deductible)
OTHER		
Televisits	$0	$0
Chiropractic and acupuncture	$30 per visit for physician-referred acupuncture; chiropractic not covered	$25 per visit for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME)	20% (base only)	20% (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)	$30 per visit	$30 per visit
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*.