KAISER PERMANENTE®

*ALSO AVAILABLE IN COVERED CALIFORNIA AND CALIFORNIA*CHOICE*

Plan Comparison[1]

2019–2020

	2019	2020
	Silver 70 HMO 1800/55* + Child Dental Alt	**Silver 70 HMO 1800/55* + Child Dental Alt**
FEATURES	**Deductible HMO Plan**	**Deductible HMO Plan**
PLAN DEDUCTIBLE		
Individual/Family	$1,800/$3,600 (embedded)	$1,800/$3,600 (embedded)
OUT-OF-POCKET MAXIMUM		
Individual/Family	$7,550/$15,100 (embedded)	$7,800/$15,600 (embedded)
IN THE MEDICAL OFFICE		
Primary care visits	$55	$55
Urgent care visits	$55	$55
Specialty office visits	$75	$75
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	$65	$65
Most laboratory tests	$50 (after plan deductible)	$25 (after plan deductible)
Most X-rays and diagnostic testing	$55 (after plan deductible)	$55 (after plan deductible)
Most MRI/CT/PET scans	$350 (after plan deductible)	$350 (after plan deductible)
Outpatient surgery (per procedure)	45% (after plan deductible)	45% (after plan deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital)	45% (after plan deductible)	45% (after plan deductible)
Ambulance	45% (after plan deductible)	45% (after plan deductible)
PRESCRIPTIONS		
Generic drugs	$30 (up to a 30-day supply)	$20 (up to a 30-day supply)
Brand-name drugs	$75 (after $350 drug deductible) (up to a 30-day supply)	$75 (after $350 drug deductible) (up to a 30-day supply)
Specialty drugs	20% per prescription up to $250 maximum (after $350 drug deductible) (up to a 30-day supply)	20% per prescription up to $250 maximum (after $350 drug deductible) (up to a 30-day supply)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	45% (after plan deductible)	45% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	45% (after plan deductible)	45% (after plan deductible)
MENTAL HEALTH SERVICES		
In the medical office	$55	$55
In the hospital	45% (after plan deductible)	45% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES		
In the medical office	$55	$55
In the hospital (detoxification only)	45% (after plan deductible)	45% (after plan deductible)
OTHER		
Televisits	$0	$0
Chiropractic and acupuncture	$15 per visit (20 combined visits per year)	$15 per visit (20 combined visits per year)
Certain durable medical equipment (DME)	45% (base only)	45% (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)	$0	$0
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*.