KAISER PERMANENTE®

Plan Comparison[1]

2019–2020

	2019		2020	
	Silver 70 PPO 2000/45 + Child Dental		Silver 70 PPO 2250/50 + Child Dental	
FEATURES	Participating Provider Tier (in-network)	Non-Participating Provider Tier (out-of-network)	Participating Provider Tier (in-network)	Non-Participating Provider Tier (out-of-network)
PLAN DEDUCTIBLE				
Individual/Family (embedded)	$2,000/$4,000	$4,000/$8,000	$2,250/$4,500	$4,500/$9,000
OUT-OF-POCKET MAXIMUM				
Individual/Family (embedded)	$7,550/$15,100	$15,100/$30,200	$7,800/$15,600	$15,600/$31,200
IN THE MEDICAL OFFICE				
Primary care visits	$45	40% (after plan deductible)	$50	40% (after plan deductible)
Urgent care visits	$45	40% (after plan deductible)	$50	40% (after plan deductible)
Specialty office visits	$80	40% (after plan deductible)	$85	40% (after plan deductible)
Preventive exams, vaccines (immunizations)	$0	40%	$0	40%
Prenatal care	$0	40%	$0	40%
Postpartum care	$0	40%	$0	40%
Well-child preventive care visits	$0	40%	$0	40%
Allergy injections	20%	40% (after plan deductible)	20%	40% (after plan deductible)
Infertility services	50% (after plan deductible)	Not covered	50% (after plan deductible)	Not covered
Physical, occupational, and speech therapy	$45	40% (after plan deductible)	$50	40% (after plan deductible)
Most laboratory tests	$40	40% (after plan deductible)	$40	40% (after plan deductible)
Most X-rays and diagnostic testing	$75	40% (after plan deductible)	$85	40% (after plan deductible)
Most MRI/CT/PET scans	$300	40% (after plan deductible)	$300	40% (after plan deductible)
Outpatient surgery (per procedure)	20%	40% (after plan deductible)	20%	40% (after plan deductible)
EMERGENCY SERVICES				
Emergency Department visits (waived if admitted directly to hospital)	$350	$350	$400 (after plan deductible)	$400 (after plan deductible)
Ambulance	$250 (after plan deductible)	$250 (after plan deductible)	$250 (after plan deductible)	$250 (after plan deductible)
PRESCRIPTIONS				
Generic drugs	$15 (after $200 drug deductible) (up to a 30-day supply)		$17 (after $300 drug deductible) (up to a 30-day supply)	
Brand-name drugs	$55 (after $200 drug deductible) (up to a 30-day supply)		$65 (after $300 drug deductible) (up to a 30-day supply)	
Specialty drugs	20% per prescription up to $250 maximum (after $200 drug deductible) (up to a 30-day supply)		20% per prescription up to $250 maximum (after $300 drug deductible) (up to a 30-day supply)	
HOSPITAL CARE				
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	20% (after plan deductible)	40% (after plan deductible)	20% (after plan deductible)	40% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	20% (after plan deductible)	40% (after plan deductible)	20% (after plan deductible)	40% (after plan deductible)
MENTAL HEALTH SERVICES				
In the medical office	$45	40% (after plan deductible)	$50	40% (after plan deductible)
In the hospital	20% (after plan deductible)	40% (after plan deductible)	20% (after plan deductible)	40% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES				
In the medical office	$45	40% (after plan deductible)	$50	40% (after plan deductible)
In the hospital (detoxification only)	20% (after plan deductible)	40% (after plan deductible)	20% (after plan deductible)	40% (after plan deductible)
OTHER				
Televisits	$0	$0	$0	$0
Chiropractic and acupuncture	$45 per visit (acupuncture services only)	40% per visit (after plan deductible) (acupuncture services only)	$50 per visit (acupuncture services only)	40% per visit (after plan deductible) (acupuncture services only)
Certain durable medical equipment (DME)	20% (supplemental and base)	40% (after plan deductible) (supplemental and base)	20% (supplemental and base)	40% (after plan deductible) (supplemental and base)
Certain prosthetic and orthotic devices	20%	40% (after plan deductible)	20%	40% (after plan deductible)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year	20% (after plan deductible)	1 pair of eyeglasses or contact lenses per year	20% (after plan deductible)
Pediatric vision exam	$0	$0 (after plan deductible)	$0	$0 (after plan deductible)
Adult optical (eyewear)	Not covered	Not covered	Not covered	Not covered
Adult vision exam (for eye refraction)	$0	Not covered	$0	Not covered
Home health care (up to 100 visits per year)	$45	40% (after plan deductible)	$45	40% (after plan deductible)
Hospice care	$0	40% (after plan deductible)	$0	40% (after plan deductible)

[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*.