KAISER PERMANENTE®

Plan Comparison[1]

2020–2021

	2020		2021	
	Bronze 60 PPO 6300/65 + Child Dental		Bronze 60 PPO 6300/65 + 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)	$6,300/$12,600	$12,600/$25,200	$6,300/$12,600	$12,600/$25,200
OUT-OF-POCKET MAXIMUM				
Individual/Family (embedded)	$7,800/$15,600	$15,600/$31,200	$8,200/$16,400	$16,400/$32,800
IN THE MEDICAL OFFICE				
Primary care visits	$65 (after plan deductible)	100% (up to out-of-pocket maximum)	$65 (after plan deductible)	100% (up to out-of-pocket maximum)
Urgent care visits	$65 (after plan deductible)	100% (up to out-of-pocket maximum)	$65 (after plan deductible)	100% (up to out-of-pocket maximum)
Specialty office visits	$95 (after plan deductible)	100% (up to out-of-pocket maximum)	$95 (after plan deductible)	100% (up to out-of-pocket maximum)
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	$65 per visit	100% per visit (up to out-of-pocket maximum)	40% per visit	100% per visit (up to out-of-pocket maximum)
Infertility services	40% (after plan deductible)	Not covered	40% (after plan deductible)	Not covered
Physical, occupational, and speech therapy	$65	100% (up to out-of-pocket maximum)	$65	100% (up to out-of-pocket maximum)
Most laboratory tests	$40	100% (up to out-of-pocket maximum)	$40	100% (up to out-of-pocket maximum)
Most X-rays and diagnostic testing	40% (after plan deductible)	100% (up to out-of-pocket maximum)	40% (after plan deductible)	100% (up to out-of-pocket maximum)
Most MRI/CT/PET scans	40% (after plan deductible)	100% (up to out-of-pocket maximum)	40% (after plan deductible)	100% (up to out-of-pocket maximum)
Outpatient surgery (per procedure)	40% (after plan deductible)	100% (up to out-of-pocket maximum)	40% (after plan deductible)	100% (up to out-of-pocket maximum)
EMERGENCY SERVICES				
Emergency Department visits (waived if admitted directly to hospital)	40% (after plan deductible)	40% (up to out-of-pocket maximum)	40% (after plan deductible)	40% (up to out-of-pocket maximum)
Ambulance	40% (after plan deductible)	40% (up to out-of-pocket maximum)	40% (after plan deductible)	40% (up to out-of-pocket maximum)
PRESCRIPTIONS				
Generic drugs (up to a 30-day supply)	$18 (after $500 drug deductible)		$18 (after $500 drug deductible)	
Brand-name drugs (up to a 30-day supply)	40% per prescription up to $500 maximum (after $500 drug deductible)		40% per prescription up to $500 maximum (after $500 drug deductible)	
Specialty drugs (up to a 30-day supply	40% per prescription up to $500 maximum (after $500 drug deductible)		40% per prescription up to $500 maximum (after $500 drug deductible)	
HOSPITAL CARE				
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	40% (after plan deductible)	100% (up to out-of-pocket maximum)	40% (after plan deductible)	100% (up to out-of-pocket maximum)
Skilled nursing facility care (up to 100 days per benefit period)	40% (after plan deductible)	100% (up to out-of-pocket maximum)	40% (after plan deductible)	100% (up to out-of-pocket maximum)
MENTAL HEALTH SERVICES				
In the medical office	$65 (after plan deductible)	100% (up to out-of-pocket maximum)	$65 (after plan deductible)	100% (up to out-of-pocket maximum)
In the hospital	40% (after plan deductible)	100% (up to out-of-pocket maximum)	40% (after plan deductible)	100% (up to out-of-pocket maximum)
CHEMICAL DEPENDENCY SERVICES				
In the medical office	$65 (after plan deductible)	100% (up to out-of-pocket maximum)	$65 (after plan deductible)	100% (up to out-of-pocket maximum)
In the hospital (detoxification only)	40% (after plan deductible)	100% (up to out-of-pocket maximum)	40% (up to out-of-pocket maximum)	100% (up to out-of-pocket maximum)
OTHER				
Televisits	$0	$0	$0	$0
Chiropractic and acupuncture	$65 per visit (after plan deductible) (acupuncture services only)	100% per visit (up to out-of-pocket maximum) (acupuncture services only)	$65 per visit (after plan deductible) (acupuncture services only)	100% per visit (up to out-of-pocket maximum) (acupuncture services only)
Certain durable medical equipment (DME) (supplemental and base)	40% (after plan deductible)	100% (up to out-of-pocket maximum)	40% (after plan deductible)	100% (up to out-of-pocket maximum
Certain prosthetic and orthotic devices	40% (after plan deductible)	100% (up to out-of-pocket maximum)	40% (after plan deductible)	100% (up to out-of-pocket maximum)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year	100% (up to out-of-pocket maximum)	1 pair of eyeglasses or contact lenses per year	100% (up to out-of-pocket maximum)
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)	40% (after plan deductible)	100% (up to out-of-pocket maximum)	40% (after plan deductible)	100% (up to out-of-pocket maximum)
Hospice care	$0	100% (up to out-of-pocket maximum)	$0	100% (up to out-of-pocket maximum)

[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*.