KAISER PERMANENTE®

Plan Comparison*

2020–2021

	2020	2021
	Gold 80 HRA HMO 2250/35 + Child Dental	**Gold 80 HRA HMO 2250/35 + Child Dental**
FEATURES	**Deductible HMO with HRA Plan (HRA can be administered through Kaiser Permanente)**	**Deductible HMO with HRA Plan (HRA can be administered through Kaiser Permanente)**
PLAN DEDUCTIBLE		
Individual/Family (embedded)	$2,250/$4,500	$2,250/$4,500
OUT-OF-POCKET MAXIMUM		
Individual/Family (embedded)	$7,800/$15,600	$7,800/$15,600
IN THE MEDICAL OFFICE		
Primary care visits	$35	$35
Urgent care visits	$35	$35
Specialty office visits	$50	$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 per visit (after plan deductible)	$5 per visit (after plan deductible)
Infertility services	Not covered	Not covered
Physical, occupational, and speech therapy	$35 (after plan deductible)	$35 (after plan deductible)
Most laboratory tests	25% (after plan deductible)	25% (after plan deductible)
Most X-rays and diagnostic testing	25% (after plan deductible)	25% (after plan deductible)
Most MRI/CT/PET scans	25% (after plan deductible)	25% (after plan deductible)
Outpatient surgery (per procedure)	25% (after plan deductible)	25% (after plan deductible)
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	25% (after plan deductible)	25% (after plan deductible)
Ambulance	25% (after plan deductible)	25% (after plan deductible)
PRESCRIPTIONS		
Generic drugs (up to a 30-day supply)	$15	$15
Brand-name drugs (up to a 30-day supply)	$30 (after $100 drug deductible)	$30 (after $100 drug deductible)
Specialty drugs (up to a 30-day supply)	20% per prescription up to $250 maximum (after $100 drug deductible)	20% per prescription up to $250 maximum (after $100 drug deductible)
HOSPITAL CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	25% (after plan deductible)	25% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	25% (after plan deductible)	25% (after plan deductible)
MENTAL HEALTH SERVICES		
In the medical office	$35	$35
In the hospital	25% (after plan deductible)	25% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES		
In the medical office	$35	$35
In the hospital (detoxification only)	25% (after plan deductible)	25% (after plan deductible)
OTHER		
Televisits	$0	$0
Chiropractic and acupuncture	$35 per visit for physician-referred acupuncture; chiropractic not covered	$35 per visit for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (supplemental and base)	50%	50%
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

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