KAISER PERMANENTE®

# Plan Comparison[1]

2020–2021

| | 2020 | | 2021 | |
|---|---|---|---|---|
| | Gold 80 PPO 250/25 + Child Dental | | Gold 80 PPO 350/25 + 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) | $250/$500 | $1,000/$2,000 | $350/$700 | $1,000/$2,000 |
| **OUT-OF-POCKET MAXIMUM** | | | | |
| Individual/Family (embedded) | $7,800/$15,600 | $15,600/$31,200 | $7,800/$15,600 | $15,600/$31,200 |
| **IN THE MEDICAL OFFICE** | | | | |
| Primary care visits | $25 | 40% (after plan deductible) | $25 | 40% (after plan deductible) |
| Urgent care visits | $25 | 40% (after plan deductible) | $25 | 40% (after plan deductible) |
| Specialty office visits | $50 | 40% (after plan deductible) | $50 | 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% per visit | 40% per visit (after plan deductible) | 20% per visit | 40% per visit (after plan deductible) |
| Infertility services | 50% | Not covered | 50% | Not covered |
| Physical, occupational, and speech therapy | $25 | 40% (after plan deductible) | $25 | 40% (after plan deductible) |
| Most laboratory tests | $25 | 40% (after plan deductible) | $25 | 40% (after plan deductible) |
| Most X-rays and diagnostic testing | $65 | 40% (after plan deductible) | $65 | 40% (after plan deductible) |
| Most MRI/CT/PET scans | 20% | 40% (after plan deductible) | 20% | 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) | $250 (after plan deductible) | $250 (after plan deductible) | 20% (after plan deductible) | 20% (after plan deductible) |
| Ambulance | $250 (after plan deductible) | $250 (after plan deductible) | 20% (after plan deductible) | 20% (after plan deductible) |
| **PRESCRIPTIONS** | | | | |
| Generic drugs (up to a 30-day supply) | $15 | | $15 | |
| Brand-name drugs (up to a 30-day supply) | $50 | | $50 | |
| Specialty drugs (up to a 30-day supply) | 20% per prescription up to $250 maximum | | 20% per prescription up to $250 maximum | |
| **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 | $25 | 40% (after plan deductible) | $25 | 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 | $25 | 40% (after plan deductible) | $25 | 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 | $25 per visit (acupuncture services only) | 40% per visit (after plan deductible) (acupuncture services only) | $25 per visit (acupuncture services only) | 40% per visit (after plan deductible) (acupuncture services only) |
| Certain durable medical equipment (DME) (supplemental and base) | 20% | 40% (after plan deductible) | 20% | 40% (after plan deductible) |
| 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) | 20% | 40% (after plan deductible) | 20% | 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*.