KAISER PERMANENTE®

*ALSO AVAILABLE IN COVERED CALIFORNIA AND CALIFORNIACHOICE®

Plan Comparison[1]

2020–2021

	2020	2021
	Silver 70 HMO 2250/50* + Child Dental	**Silver 70 HMO 2250/55* + Child Dental**
FEATURES	**Deductible HMO Plan**	**Deductible HMO Plan**
PLAN DEDUCTIBLE		
Individual/Family (embedded)	$2,250/$4,500	$2,250/$4,500
OUT-OF-POCKET MAXIMUM		
Individual/Family (embedded)	$7,800/$15,600	$8,200/$16,400
IN THE MEDICAL OFFICE		
Primary care visits	$50	$55
Urgent care visits	$50	$55
Specialty office visits	$85	$90
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	$5 per visit
Infertility services	Not covered	Not covered
Physical, occupational, and speech therapy	$50	$55
Most laboratory tests	$40	$55
Most X-rays and diagnostic testing	$85	$90
Most MRI/CT/PET scans	$300	$300 (after plan deductible)
Outpatient surgery (per procedure)	20%	30% (after plan deductible)
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	$400 (after plan deductible)	30% (after plan deductible)
Ambulance	$250 (after plan deductible)	30% (after plan deductible)
PRESCRIPTIONS		
Generic drugs (up to a 30-day supply)	$17 (after $300 drug deductible)	$17
Brand-name drugs (up to a 30-day supply)	$65 (after $300 drug deductible)	$80 (after $300 drug deductible)
Specialty drugs (up to a 30-day supply)	20% per prescription up to $250 maximum (after $300 drug deductible)	30% per prescription up to $250 maximum (after $300 drug deductible)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	20% (after plan deductible)	30% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	20% (after plan deductible)	30% (after plan deductible)
MENTAL HEALTH SERVICES		
In the medical office	$50	$55
In the hospital	20% (after plan deductible)	30% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES		
In the medical office	$50	$55
In the hospital (detoxification only)	20% (after plan deductible)	30% (after plan deductible)
OTHER		
Televisits	$0	$0
Chiropractic and acupuncture	$50 per visit for physician-referred acupuncture; chiropractic not covered	$55 per visit for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (supplemental and base)	20%	30%
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)	$45 per day	$45 per day
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*.