KAISER PERMANENTE®

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# Plan Comparison[1]

2022–2023

| | 2022 | 2023 |
|---|---|---|
| | **Bronze 60 HDHP HMO 7000/0* + Child Dental** | **Bronze 60 HDHP HMO 7000/0* + Child Dental** |
| **FEATURES** | **HSA-qualified High Deductible Health Plan (HSA can be administered through Kaiser Permanente)** | **HSA-qualified High Deductible Health Plan (HSA can be administered through Kaiser Permanente)** |
| **PLAN DEDUCTIBLE** Embedded | $7,000/$14,000 | $7,000/$14,000 |
| **OUT-OF-POCKET MAXIMUM** Embedded | $7,000/$14,000 | $7,000/$14,000 |
| **IN THE MEDICAL OFFICE** Primary care visits | $0 (after plan deductible) | $0 (after plan deductible) |
| Urgent care visits | $0 (after plan deductible) | $0 (after plan deductible) |
| Specialty office visits | $0 (after plan deductible) | $0 (after plan deductible) |
| Preventive exams, vaccines (immunizations) | $0 | $0 |
| Prenatal care | $0 | $0 |
| Postpartum care | $0 (after plan deductible) | $0 (after plan deductible) |
| Well-child preventive care visits | $0 | $0 |
| Allergy injections | $0 per visit (after plan deductible) | $0 per visit (after plan deductible) |
| Fertility services | Not covered | Not covered |
| Physical, occupational, and speech therapy | $0 (after plan deductible) | $0 (after plan deductible) |
| Most laboratory tests | $0 (after plan deductible) | $0 (after plan deductible) |
| Most X-rays and diagnostic testing | $0 (after plan deductible) | $0 (after plan deductible) |
| Most MRI/CT/PET scans | $0 (after plan deductible) | $0 (after plan deductible) |
| Outpatient surgery (per procedure) | $0 (after plan deductible) | $0 (after plan deductible) |
| **EMERGENCY SERVICES** Emergency department visits (waived if admitted directly to hospital) | $0 (after plan deductible) | $0 (after plan deductible) |
| Ambulance | $0 (after plan deductible) | $0 (after plan deductible) |
| **PRESCRIPTIONS** Generic drugs (up to a 30-day supply) | $0 (after plan deductible) | $0 (after plan deductible) |
| Brand-name drugs (up to a 30-day supply) | $0 (after plan deductible) | $0 (after plan deductible) |
| Specialty drugs (up to a 30-day supply) | $0 (after plan deductible) | $0 (after plan deductible) |
| **HOSPITAL INPATIENT CARE** Physicians' services, room and board, tests, medications, supplies, therapies, birth services | $0 (after plan deductible) | $0 (after plan deductible) |
| Skilled nursing facility care (up to 100 days per benefit period) | $0 (after plan deductible) | $0 (after plan deductible) |
| **MENTAL HEALTH SERVICES** Outpatient (in the medical office) | $0 (after plan deductible) | $0 (after plan deductible) |
| Inpatient (in the hospital) | $0 (after plan deductible) | $0 (after plan deductible) |
| **SUBSTANCE USE DISORDER SERVICES** Outpatient (in the medical office) | $0 (after plan deductible) | $0 (after plan deductible) |
| Inpatient (in the hospital) - detoxification only | $0 (after plan deductible) | $0 (after plan deductible) |
| **OTHER** Televisits | $0 (after plan deductible) | $0 (after plan deductible) |
| Acupuncture | $0 per visit (after plan deductible) for physician-referred acupuncture | $0 per visit (after plan deductible) for physician-referred acupuncture |
| Certain durable medical equipment (DME) (supplemental and base) | $0 (after plan deductible) | $0 (after plan deductible) |
| Certain prosthetic and orthotic devices | $0 (after plan deductible) | $0 (after plan deductible) |
| 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 (after plan deductible) | $0 (after plan deductible) |
| Hospice care | $0 (after plan deductible) | $0 (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*.