KAISER PERMANENTE®

Plan Comparison[1]

2022–2023

	2022		2023	
	Gold 80 PPO 350/25 + 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 Embedded	$350/$700	$1,000/$2,000	$350/$700	$1,000/$2,000
OUT-OF-POCKET MAXIMUM 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)
Fertility 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)	20% (after plan deductible)	20% (after plan deductible)	20% (after plan deductible)	20% (after plan deductible)
Ambulance	20% (after plan deductible)	20% (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 INPATIENT 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 Outpatient (in the medical office)	$25	40% (after plan deductible)	$25	40% (after plan deductible)
Inpatient (in the hospital)	20% (after plan deductible)	40% (after plan deductible)	20% (after plan deductible)	40% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$25	40% (after plan deductible)	$25	40% (after plan deductible)
Inpatient (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
Acupuncture	$25 per visit	40% per visit (after plan deductible)	$25 per visit	40% per visit (after plan deductible)
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*.