KAISER PERMANENTE®

Plan Comparison[1]

2022–2023

	2022		2023	
	Platinum 90 PPO 0/15 + Child Dental		Platinum 90 PPO 0/15 + 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	$0	Individual – $500 Family – $1,000	$0	Individual – $500 Family – $1,000
OUT-OF-POCKET MAXIMUM Embedded	Individual – $4,500 Family – $9,000	Individual – $9,000 Family – $18,000	Individual – $4,500 Family – $9,000	Individual – $9,000 Family – $18,000
IN THE MEDICAL OFFICE				
Primary care visits	$15	30% (after plan deductible)	$15	30% (after plan deductible)
Urgent care visits	$15	30% (after plan deductible)	$15	30% (after plan deductible)
Specialty office visits	$30	30% (after plan deductible)	$30	30% (after plan deductible)
Preventive exams, vaccines (immunizations)	$0	30%	$0	30%
Prenatal care	$0	30%	$0	30%
Postpartum care	$0	30%	$0	30%
Well-child preventive care visits	$0	30%	$0	30%
Allergy injections	10% per visit	30% per visit (after plan deductible)	10% per visit	30% per visit (after plan deductible)
Fertility services	50%	Not covered	50%	Not covered
Physical, occupational, and speech therapy	$15	30% (after plan deductible)	$15	30% (after plan deductible)
Most laboratory tests	$15	30% (after plan deductible)	$15	30% (after plan deductible)
Most X-rays and diagnostic testing	$30	30% (after plan deductible)	$30	30% (after plan deductible)
Most MRI/CT/PET scans	10%	30% (after plan deductible)	10%	30% (after plan deductible)
Outpatient surgery (per procedure)	10%	30% (after plan deductible)	10%	30% (after plan deductible)
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	$200	$200	$200	$200
Ambulance	$150	$150	$150	$150
PRESCRIPTIONS Generic drugs (up to a 30-day supply)	$10		$10	
Brand-name drugs (up to a 30-day supply)	$25		$25	
Specialty drugs (up to a 30-day supply)	10% per prescription up to $250 maximum		10% per prescription up to $250 maximum	
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	10%	30% (after plan deductible)	10%	30% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	10%	30% (after plan deductible)	10%	30% (after plan deductible)
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$15	30% (after plan deductible)	$15	30% (after plan deductible)
Inpatient (in the hospital)	10%	30% (after plan deductible)	10%	30% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$15	30% (after plan deductible)	$15	30% (after plan deductible)
Inpatient (in the hospital) - detoxification only	10%	30% (after plan deductible)	10%	30% (after plan deductible)
OTHER Televisits	$0	$0	$0	$0
Acupuncture	$15 per visit	30% per visit (after plan deductible)	$15 per visit	30% per visit (after plan deductible)
Certain durable medical equipment (DME) (supplemental and base)	10%	30% (after plan deductible)	10%	30% (after plan deductible)
Certain prosthetic and orthotic devices	10%	30% (after plan deductible)	10%	30% (after plan deductible)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year	10% (after plan deductible)	1 pair of eyeglasses or contact lenses per year	10% (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)	10%	30% (after plan deductible)	10%	30% (after plan deductible)
Hospice care	$0	30% (after plan deductible)	$0	30% (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*.