KAISER PERMANENTE®

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Plan Comparison[1]

2022–2023

	2022	2023
	Silver 70 HMO 1650/55* + Child Dental Alt	**Silver 70 HMO 1900/65* + Child Dental Alt**
FEATURES	**Deductible HMO Plan**	**Deductible HMO Plan**
PLAN DEDUCTIBLE Embedded	$1,650/$3,300	$1,900/$3,800
OUT-OF-POCKET MAXIMUM Embedded	$8,200/$16,400	$8,750/$17,500
IN THE MEDICAL OFFICE Primary care visits	$55	$65
Urgent care visits	$55	$65
Specialty office visits	$80	$100
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
Fertility services	Not covered	Not covered
Physical, occupational, and speech therapy	$65	$65
Most laboratory tests	$30	$30
Most X-rays and diagnostic testing	$75	$75
Most MRI/CT/PET scans	$350 (after plan deductible)	$400 (after plan deductible)
Outpatient surgery (per procedure)	40% (after plan deductible)	45% (after plan deductible)
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	40% (after plan deductible)	45% (after plan deductible)
Ambulance	40% (after plan deductible)	45% (after plan deductible)
PRESCRIPTIONS Generic drugs (up to a 30-day supply)	$20	$20
Brand-name drugs (up to a 30-day supply)	$75 (after $350 drug deductible)	$100
Specialty drugs (up to a 30-day supply)	20% per prescription up to $250 maximum (after $350 drug deductible)	20% per prescription up to $250 maximum (after plan deductible)
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	40% (after plan deductible)	45% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	40% (after plan deductible)	45% (after plan deductible)
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$55	$0
Inpatient (in the hospital)	40% (after plan deductible)	45% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$55	$0
Inpatient (in the hospital) - detoxification only	40% (after plan deductible)	45% (after plan deductible)
OTHER Televisits	$0	$0
Chiropractic and acupuncture	$15 per visit (self-referral; 20 combined visits per year)	$15 per visit (self-referral; 20 combined visits per year)
Certain durable medical equipment (DME) (supplemental and base)	40%	45%
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)	$0	$0
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*.