KAISER PERMANENTE®

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Plan Comparison[1]

2022–2023

	2022	2023
	Silver 70 HMO 2250/55* + Child Dental	**Silver 70 HMO 2500/55* + Child Dental**
FEATURES	**Deductible HMO Plan**	**Deductible HMO Plan**
PLAN DEDUCTIBLE Embedded	$2,250/$4,500	$2,500/$5,000
OUT-OF-POCKET MAXIMUM Embedded	$8,200/$16,400	$8,750/$17,500
IN THE MEDICAL OFFICE Primary care visits	$55	$55
Urgent care visits	$55	$55
Specialty office visits	$90	$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
Fertility services	Not covered	Not covered
Physical, occupational, and speech therapy	$55	$55
Most laboratory tests	$55	$55
Most X-rays and diagnostic testing	$90	$90
Most MRI/CT/PET scans	$300 (after plan deductible)	$300 (after plan deductible)
Outpatient surgery (per procedure)	30% (after plan deductible)	35% (after plan deductible)
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	30% (after plan deductible)	30% (after plan deductible)
Ambulance	30% (after plan deductible)	30% (after plan deductible)
PRESCRIPTIONS Generic drugs (up to a 30-day supply)	$17	$19
Brand-name drugs (up to a 30-day supply)	$80 (after $300 drug deductible)	$85 (after $370 drug deductible)
Specialty drugs (up to a 30-day supply)	30% per prescription up to $250 maximum (after $300 drug deductible)	30% per prescription up to $250 maximum (after $370 drug deductible)
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	30% (after plan deductible)	40% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	30% (after plan deductible)	40% (after plan deductible)
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$55	$0
Inpatient (in the hospital)	30% (after plan deductible)	40% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$55	$0
Inpatient (in the hospital) - detoxification only	30% (after plan deductible)	40% (after plan deductible)
OTHER Televisits	$0	$0
Acupuncture	$55 per visit for physician-referred acupuncture;	$55 per visit for physician-referred acupuncture
Certain durable medical equipment (DME) (supplemental and base)	30%	40%
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*.