KAISER PERMANENTE®

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Plan Comparison[1]

2022–2023

	2022	2023
	Silver 70 HMO 2600/55* + Child Dental Alt	**Silver 70 HMO 2800/65* + Child Dental Alt**
FEATURES	**Deductible HMO Plan**	**Deductible HMO Plan**
PLAN DEDUCTIBLE Embedded	Individual - $2,600[10] Family - $5,200[10]	Individual - $2,800[10] Family - $5,600[10]
OUT-OF-POCKET MAXIMUM Embedded	Individual - $8,200[1,10] Family - $16,400[1,10]	Individual - $8,750[1,10] Family - $17,500[1,10]
IN THE MEDICAL OFFICE Primary care visits	$55	$65
Urgent care visits	$55	$65
Specialty office visits	$80	$100
Preventive exams, vaccines (immunizations)	$0[12]	$0[12]
Prenatal care	$0[3]	$0[3]
Postpartum care	$0[3]	$0[3]
Well-child preventive care visits	$0[23]	$0[23]
Allergy injections	$5 per visit	$5 per visit
Fertility services	Not covered[17]	Not covered[17]
Physical, occupational, and speech therapy	$65	$65
Most laboratory tests	$30 (after plan deductible)	$30 (after plan deductible)
Most X-rays and diagnostic testing	$75 (after plan deductible)	$75 (after plan deductible)
Most MRI/CT/PET scans	$350 (after plan deductible)	$400 (after plan deductible)
Outpatient surgery (per procedure)	45% (after plan deductible)	45% (after plan deductible)
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	45% (after plan deductible)	45% (after plan deductible)
Ambulance	45% (after plan deductible)	45% (after plan deductible)
PRESCRIPTIONS Generic drugs (up to a 30-day supply)	$20[24]	$20[24]
Brand-name drugs (up to a 30-day supply)	$75 (after plan deductible)[24]	$100 (after plan deductible)[24]
Specialty drugs (up to a 30-day supply)	45% per prescription up to $250 maximum (after plan deductible)[24]	45% per prescription up to $250 maximum (after plan deductible)[24]
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	45% (after plan deductible)	45% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	45% (after plan deductible)	45% (after plan deductible)
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$55	$0
Inpatient (in the hospital)	45% (after plan deductible)	45% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$55	$0
Inpatient (in the hospital) - detoxification only	45% (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)	45%[5,6,27]	45%[5,6,27]
Certain prosthetic and orthotic devices	$0	$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[7]	1 pair of eyeglasses or contact lenses per year[7]
Pediatric vision exam	$0	$0
Adult optical (eyewear)	Not covered[8]	Not covered[8]
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*.