KAISER PERMANENTE®

*ALSO AVAILABLE IN COVERED CALIFORNIA AND CALIFORNIACHOICE®

Plan Comparison[1]

2020–2021

	2020	2021
	Bronze 60 HDHP HMO 6900/0* + Child Dental	**Bronze 60 HDHP HMO 7000/0* + Child Dental**
FEATURES	**HSA-qualified High Deductible Health Plan (HSA can be administered through Kaiser Permanente)**	**HSA-qualified High Deductible Health Plan (HSA can be administered through Kaiser Permanente)**
PLAN DEDUCTIBLE		
Individual/Family (embedded)	$6,900/$13,800	$7,000/$14,000
OUT-OF-POCKET MAXIMUM		
Individual/Family (embedded)	$6,900/$13,800	$7,000/$14,000
IN THE MEDICAL OFFICE		
Primary care visits	$0 (after plan deductible)	$0 (after plan deductible)
Urgent care visits	$0 (after plan deductible)	$0 (after plan deductible)
Specialty office visits	$0 (after plan deductible)	$0 (after plan deductible)
Preventive exams, vaccines (immunizations)	$0	$0
Prenatal care	$0	$0
Postpartum care	$0 (after plan deductible)	$0 (after plan deductible)
Well-child preventive care visits	$0	$0
Allergy injections	$0 per visit (after plan deductible)	$0 per visit (after plan deductible)
Infertility services	Not covered	Not covered
Physical, occupational, and speech therapy	$0 (after plan deductible)	$0 (after plan deductible)
Most laboratory tests	$0 (after plan deductible)	$0 (after plan deductible)
Most X-rays and diagnostic testing	$0 (after plan deductible)	$0 (after plan deductible)
Most MRI/CT/PET scans	$0 (after plan deductible)	$0
Outpatient surgery (per procedure)	$0 (after plan deductible)	$0 (after plan deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital)	$0 (after plan deductible)	$0 (after plan deductible)
Ambulance	$0 (after plan deductible)	$0 (after plan deductible)
PRESCRIPTIONS Generic drugs (up to a 30-day supply)	$0 (after plan deductible)	$0 per prescription up to $500 maximum
Brand-name drugs (up to a 30-day supply)	$0 (after plan deductible)	$0 per prescription up to $500 maximum
Specialty drugs (up to a 30-day supply)	$0 (after plan deductible)	$0 per prescription up to $500 maximum
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$0 (after plan deductible)	$0 (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	$0 (after plan deductible)	$0 (after plan deductible)
MENTAL HEALTH SERVICES		
In the medical office	$0 (after plan deductible)	$0 (after plan deductible)
In the hospital	$0 (after plan deductible)	$0 (after plan deductible)
CHEMICAL DEPENDENCY SERVICES		
In the medical office	$0 (after plan deductible)	$0 (after plan deductible)
In the hospital (detoxification only)	$0 (after plan deductible)	$0 (after plan deductible)
OTHER		
Televisits	$0 (after plan deductible)	$0 (after plan deductible)
Chiropractic and acupuncture	$0 per visit (after plan deductible) for physician-referred acupuncture; chiropractic not covered	$0 per visit (after plan deductible) for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (supplemental and base)	$0 (after plan deductible)	$0 (after plan deductible)
Certain prosthetic and orthotic devices	$0 (after plan deductible)	$0 (after plan deductible)
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 (after plan deductible)	$0 (after plan deductible)
Hospice care	$0 (after plan deductible)	$0 (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*.