KAISER PERMANENTE

Benefit Summary Comparison Summary

Principal Benefits for Kaiser Permanente Traditional HMO Plan Year 2020/2021

Accumulation Period

The Accumulation Period for this plan is 1/1/20 through 12/31/21 (calendar year).

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

**For KP HSA-Qualified High Deductible Plan (HDHP) is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. For a complete explanation, please refer to the EOC.

	HMO														
Amounts Per Accumulation Period	**Self Only Coverage** (a Family of one Member)					**Family Coverage** Each Member in a Family of two or more Members					**Family Coverage** Entire Family of two or more Members				
	PLTNM 15	Gold 20	Silver 20	Bronze 40	Bronze HSA	PLTNM 15	Gold 20	Silver 20	Bronze 40	Bronze HSA	PLTNM 15	Gold 20	Silver 20	Bronze 40	Bronze HSA
Plan Out-of-Pocket Maximum	$1,500	$2,500	$3,000	$4,000	$5,600	$1,500	$2,500	$3,000	$4,000	$5,600	$3,000	$5,000	$6,000	$8,000	$11,200
Plan Deductible	None	None	$500	$1,500	$2,800	None	None	$500	$1,500	$2,800	None	None	$1,000	$3,000	$5,600
Drug Deductible	None	None	None	None	N/A	None	None	None	None	N/A	None	None	None	None	N/A

Professional Services (Plan Provider office visits)	**You Pay**				
	PLTNM 15	**Gold 20**	**Silver 20**	**Bronze 40**	**Bronze HSA**
Most Primary Care Visits and most Non-Physician Specialist Visits.....	$15 per visit	$20 per visit	$20 per visit (Plan Deductible doesn't apply)	$40 per visit (Plan Deductible doesn't apply)	$10 per visit after Plan Deductible
Most Physician Specialist Visits.....	$15 per visit	$20 per visit	$20 per visit (Plan Deductible doesn't apply)	$40 per visit (Plan Deductible doesn't apply)	$10 per visit after Plan Deductible
Routine physical maintenance exams, including well-woman exams	No charge	No charge	No charge (Plan Deductible doesn't apply)	No charge (Plan Deductible doesn't apply)	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge	No charge	No charge (Plan Deductible doesn't apply)	No charge (Plan Deductible doesn't apply)	No charge (Plan Deductible doesn't apply)
Family planning counseling and consultations.....	No charge	No charge	No charge (Plan Deductible doesn't apply)	No charge (Plan Deductible doesn't apply)	No charge (Plan Deductible doesn't apply)
Scheduled prenatal care exams	No charge	No charge	No charge (Plan Deductible doesn't apply)	No charge (Plan Deductible doesn't apply)	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	No charge	No charge	No charge (Plan Deductible doesn't apply)	No charge (Plan Deductible doesn't apply)	No charge (Plan Deductible doesn't apply)

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	PLTNM 15	Gold 20	Silver 20	Bronze 40	Bronze HSA
Urgent care consultations, evaluations, and treatment	$15 per visit	$20 per visit	$20 per visit (Plan Deductible doesn't apply)	$40 per visit (Plan Deductible doesn't apply)	$10 per visit after Plan Deductible
Most physical, occupational, and speech therapy	$15 per visit	$20 per visit	$20 per visit (Plan Deductible doesn't apply)	$40 per visit (Plan Deductible doesn't apply)	$10 per visit after Plan Deductible
Outpatient Services	**You Pay**				
Outpatient surgery and certain other outpatient procedures	$50 per procedure	$250 per procedure	10% Coinsurance after Plan Deductible	30% Coinsurance after Plan Deductible	20% Coinsurance after Plan Deductible
Allergy injections (including allergy serum)	$15 per visit	$15 per visit	No charge (Plan Deductible doesn't apply)	No charge (Plan Deductible doesn't apply)	$10 per visit after Plan Deductible
Most immunizations (including the vaccine)	No charge	No charge	No charge (Plan Deductible doesn't apply)	No charge (Plan Deductible doesn't apply)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	No charge	No charge	$10 per encounter (Plan Deductible doesn't apply)	$10 per encounter (Plan Deductible doesn't apply)	20% Coinsurance after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	N/A	N/A	No charge (Plan Deductible doesn't apply)	No charge (Plan Deductible doesn't apply)	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	N/A	$100 per procedure	10% Coinsurance up to a maximum of $50 per procedure (P.D. doesn't apply)	30% Coinsurance up to a maximum of $50 per procedure (P.D. doesn't apply)	N/A
Hospitalization Services	**You Pay**				
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$100 per admission	$500 per admission	10% Coinsurance after Plan Deductible	30% Coinsurance after Plan Deductible	20% Coinsurance after Plan Deductible
Emergency Health Coverage	**You Pay**				
Emergency Department visits	$100 per visit	$100 per visit	10% Coinsurance after Plan Deductible	30% Coinsurance after Plan Deductible	20% Coinsurance after Plan Deductible

Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services	**You Pay**				
Ambulance Services	$100 per trip	$100 per trip	$150 per trip (Plan Deductible doesn't apply)	$150 per trip (Plan Deductible doesn't apply)	20% Coinsurance after Plan Deductible
Presctiption Drug Coverage	**You Pay**				
Covered outpatient items in accord with our drug formulary guidelines:					
Most generic items at a Plan Pharmacy	$10 for up to a 30-day supply	$10 for up to a 30-day supply	$10 for up to a 30-day supply (Plan Deductible doesn't apply)	$10 for up to a 30-day supply (Plan Deductible doesn't apply)	$10 for up to a 30-day supply after Plan Deductible
Most generic refills through our mail-order service	$20 for up to a 100-day supply	$20 for up to a 100-day supply	$20 for up to a 100-day supply (Plan Deductible doesn't apply)	$20 for up to a 100-day supply (Plan Deductible doesn't apply)	$20 for up to a 100-day supply after Plan Deductible

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	PLTNM 15	Gold 20	Silver 20	Bronze 40	Bronze HSA
Most brand-name items at a Plan Pharmacy	$20 for up to a 30-day supply	$20 for up to a 30-day supply	$30 for up to a 30-day supply (Plan Deductible doesn't apply)	$30 for up to a 30-day supply (Plan Deductible doesn't apply)	$25 for up to a 30-day supply after Plan Deductible
Most brand-name refills through our mail-order service	$40 for up to a 100-day supply	$40 for up to a 100-day supply	$60 for up to a 100-day supply (Plan Deductible doesn't apply)	$60 for up to a 100-day supply (Plan Deductible doesn't apply)	$50 for up to a 100 day supply after Plan Deductible
Most specialty items at a Plan Pharmacy	20% Coinsurance (not to exceed $150) for up to a 30-day supply	20% Coinsurance (not to exceed $150) for up to a 30-day supply	20% Coinsurance (not to exceed $150) for up to a 30-day supply (Plan Deductible doesn't apply)	20% Coinsurance (not to exceed $150) for up to a 30-day supply (Plan Deductible doesn't apply)	30% Coinsurance (not to exceed $150) for up to a 30-day supply after Plan Deductible
Durable Medical Equipment (DME)	**You Pay**				
DME items as described in the *EOC*	No charge	20% Coinsurance	20% Coinsurance (Plan Deductible doesn't apply)	20% Coinsurance (Plan Deductible doesn't apply)	20% Coinsurance after Plan Deductible
Mental Health Services	**You Pay**				
Inpatient psychiatric hospitalization	$100 per admission	$500 per admission	10% Coinsurance after Plan Deductible	30% Coinsurance after Plan Deductible	20% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$15 per visit	$20 per visit	$20 per visit (Plan Deductable does not apply)	$40 per visit (Plan Deductable does not apply)	$10 per visit after Plan Deductible
Group outpatient mental health treatment	$7 per visit	$10 per visit	$10 per visit (Plan deductible doesn't apply)	$20 per visit (Plan Deductable does not apply)	$5 per visit after Plan Deductible
Substance Use Disorfer Treatment	**You Pay**				
Inpatient detoxification	$100 per admission	$500 per admission	10% Coinsurance after Plan Deductible	30% Coinsurance after Plan Deductible	20% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	$15 per visit	$20 per visit	$20 per visit (Plan Deductible doesn't apply)	$40 per visit (Plan Deductible doesn't apply)	$10 per visit after Plan Deductible
Group outpatient substance use disorder treatment	$7 per visit	$5 per visit	$5 per visit (Plan deductible doesn't apply)	$5 per visit (Plan deductible doesn't apply)	$5 per visit (Plan deductible doesn't apply)
Home Health Services	**You Pay**				
Home health care (up to 100 visits per Accumulation Period)	No charge	No charge	No charge (Plan Deductible doesn't apply)	No charge (Plan Deductible doesn't apply)	No Charge after Plan Deductible
Other	**You Pay**				
Skilled nursing facility care (up to 100 days per benefit period)	No charge	No charge	10% Coinsurance (Plan Deductible doesn't apply)	30% Coinsurance after Plan Deductible	20% Coinsurance after Plan Deductible

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(continued)

	You Pay				
	PLTNM 15	**Gold 20**	**Silver 20**	**Bronze 40**	**Bronze HSA**
Prosthetic and orthotic devices as described in the *EOC*	No charge	No charge	No charge (Plan Deductible doesn't apply)	No charge (Plan Deductible doesn't apply)	No charge after Plan Deductible
Diagnosis and treatment of infertility & artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC*	50% Coinsurance	50% Coinsurance	50% Coinsurance (Plan Deductible doesn't apply)	50% Coinsurance (Plan Deductible doesn't apply)	Not Covered
Assisted Reproductive Technology ("ART") Services.....	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Hospice care .....[illegible]	No charge[illegible]	No charge	No charge (Plan Deductible doesn't apply)	No charge (Plan Deductible doesn't apply)	No charge after Plan Deductible
Chiropractic and Acupuncture Benefit (30 visits per calendar year).....	$10 per visit	$10 per visit	$15 per visit	$15 per visit	N/A

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC* . Please note that we provide all benefits required by law (for example, diabetes testing supplies).