LACERA

Comparison of Medical Plans

2021

Effective July 1, 2021

Health Maintenance Organizations (HMOs) and Medicare Advantage Prescription Drug (MA-PD) HMOs

- **Kaiser Permanente – Colorado**
- **Kaiser Permanente – Georgia**
- **Kaiser Permanente – Hawaii**
- **Kaiser Permanente – Oregon**
- **Kaiser Permanente – Washington**

This chart represents a summary of benefits only. Additional benefit information is provided by each insurance carrier. This chart does not replace or modify the official documents, which legally govern each plan's operation.

The health plans and benefit designs available from the LACERA-administered options change when an enrolled member permanently moves outside the provider network area. Moving to a location outside the coverage area will impact your eligibility to be enrolled in the health plan, the benefit designs available and the rates you pay.

Note: The benefit levels contained in this booklet are subject to approval by the Centers for Medicare and Medicaid Services (CMS) and may be adjusted during the plan year.

BASIC (UNDER 65 OR OVER 65 WITHOUT MEDICARE COVERAGE) HMOs

	Kaiser Permanente – Colorado	Kaiser Permanente – Georgia	Kaiser Permanente – Hawaii	Kaiser Permanente – Oregon	Kaiser Permanente – Washington
Calendar Year Deductible/Copayment	None	None	None	None	None
Annual Maximum Out-of-Pocket Expenses (for most services)	Individual – $2,000 Family – $4,500	Individual – $2,000 Family – $4,000	Individual – $2,500 (including prescription drugs) Family (3 or more) – $7,500 (including prescription drugs)	Individual – $600 Family – $1,200	Individual – $1,500 Family – $3,000
Lifetime Maximum Benefits	None	None	Unlimited	None	Unlimited
Hospital Benefits					
Room and Board	$250 copay per admission	$250 copay per admission	$50/day	No charge	No charge
Surgical Services	Inpatient – no charge Outpatient – $50 copay	Inpatient – no charge Outpatient – $100 copay	Inpatient - no charge Outpatient - $15 copay	Inpatient – no charge Outpatient – $5 copay	Inpatient – no charge Outpatient – $10 copay
Hospital Services and Supplies	Durable medical equipment covered at 80%	Durable medical equipment covered at 80%	No charge	No charge	No charge
Hospital Admission Authorization Requirements	No authorization needed when referred by a Kaiser Permanente physician	Authorization required for hospital admissions	Authorization required by a Kaiser Permanente Medical Group physician	Authorization required by a Kaiser Permanente physician	Authorization required by a Kaiser Permanente physician
Nursing Benefits					
Skilled Nursing Facility Care	No charge; 100 days per period	$250 copay per admission; 100 days per year	No charge; 120 days per accumulated period	No charge; 100 days per year	No charge; 100 days per year
Private Duty Nurses	No charge if in service area only and referred by a network provider	No charge if authorized	Not covered	Not covered	Not covered
Home Health Care	No charge if authorized	No charge up to 120 visits per calendar year (private duty nursing excluded)	No charge if authorized	No charge if authorized; limited to 130 days	No charge up to 130 visits per calendar year
Hospice Care	No charge	No charge if authorized	No charge if authorized	No charge	No charge
Emergency Benefits					
Inpatient	$100 copay (waived if admitted)	$100 (waived if admitted)	$50/visit within service area; 20% copay outside of service area (waived if admitted)	$75 copay (waived if admitted)	$75 copay (waived if admitted)
Outpatient	$100 copay	$100 (waived if admitted)	$50/visit within service area; 20% copay outside of service area	$75 copay (waived if admitted)	$75 copay (waived if admitted)
Ambulance	20% copay; max. of $500 per trip	$100 copay	No charge	$75 copay	No Charge
Outpatient Benefits					
Doctor's Office Visits	$5 copay ($25 copay for after-hours care; $15 copay for specialist visit)	$15 copay	$15 copay	$5 copay	$10 copay
Preadmission Diagnostic X-ray and Lab Tests	Included in office visit copay	No charge	No charge	No charge	No charge
Routine Checkups					
– Adults	No charge	No charge	No charge	No charge	No charge
– Children Under 17	No charge	No charge	No charge	No charge	No charge
Immunizations	$5 copay; no charge if preventive	$15 copay; no charge if preventive	No charge	No charge for routine care	No charge
Outpatient Surgical Services	$50 copay	$100 copay	$15 copay	$5 copay	$10 copay
Physical Therapy	$250 copay inpatient; $5 copay outpatient; limited to 20 visits per year	$15 copay; limited to 20 visits per year	$15 copay	$5 copay; up to 20 visits per therapy, per calendar year	No charge inpatient, $10 copay outpatient; limited to 60 inpatient days/60 outpatient visits per calendar year (physical and speech therapy combined)
Speech Therapy	$250 copay inpatient; $5 copay outpatient; limited to 20 visits per year	$15 copay; limited to 20 visits per year	$15 copay	$5 copay; up to 20 visits per therapy, per calendar year	
Maternity	No charge	$15 copay for 1st visit; no charge thereafter	No charge (after confirmation of pregnancy)	Hospitalization – no charge; doctor's office visit – no charge	No charge inpatient; $10 copay outpatient; no charge for routine care
Prescription Drug Benefits					
Prescription Drugs	$10 copay for up to 60-day supply	$15 generic/$30 brand copay for up to 30-day supply at Kaiser Permanente; $25 generic/$40 brand copay for up to 30-day supply at Walgreens	$10 copay for up to 30-day supply	$5 copay for up to 30-day supply	$10 copay for up to 30-day supply, preferred generic and/or brand
Mental Health Benefits					
Inpatient	$250 per admission	$250 copay	$50/day*	No charge	No charge
Outpatient	$5 copay	$15 copay	$15 copay*	$5 copay	No charge
Substance Abuse Benefits					
Inpatient	$250 per admission	$250 copay per admission (detox only)	$50/day	No charge	No charge
Outpatient	$5 copay	$15 copay	$15 copay	$5 copay	No charge
Residential Day	$250/admission	Not covered	No charge	No charge	No charge
Vision/Hearing Care Benefits					
Eye Exams	$5 copay	$15 copay	$15 copay	$5 copay	$10 copay
Lenses	$150 (adults) or 50% (children) credit toward lenses, contact lenses or frames combined every 2 years	$100 credit toward lenses, contact lenses or frames combined every 2 years	Not covered	Not covered	Not covered
Frames			Not covered	Not covered	Not covered
Hearing Exam	$5 copay	$15 copay (if exam copay applies)	$15 copay	$5 copay	$10 copay
Hearing Aids	Not covered	Not covered	60% of applicable charges per ear, once every three years	Covered for children only	Not covered

*When prescribed by a physician, services for serious mental illness will be provided in accordance with state law.

RETIREE WITH MEDICARE MA-PD HMOs

	Kaiser Permanente – Colorado	Kaiser Permanente – Georgia	Kaiser Permanente – Hawaii	Kaiser Permanente – Oregon	Kaiser Permanente – Washington
Calendar Year Deductible/Copayment	None	None	None	None	None
Annual Maximum Out-of-Pocket Expenses (for most services)	Individual – $2,500	Individual – $2,000	Individual – $2,500	Individual – $600	Individual – $2,500
Lifetime Maximum Benefits	None	None	Unlimited	None	Unlimited
Hospital Benefits					
Room and Board	$250 copay per admission	$250 copay per admission	$50/day	No charge	No charge
Surgical Services	Inpatient – no charge Outpatient – $50 copay	Inpatient – no charge Outpatient – $100 copay	Inpatient – no charge Outpatient – $15 copay	Inpatient - no charge Outpatient – $5 copay	Inpatient – no charge Outpatient – $10 copay
Hospital Services and Supplies	Durable medical equipment covered at 80%	No charge	No charge	No charge	No Charge
Hospital Admission Authorization Requirements	No authorization needed when referred by a Kaiser Permanente physician	Authorization required for hospital admissions	Authorization required by a Kaiser Permanente Medical Group physician	Authorization required by a Kaiser Permanente physician	Authorization required by a Kaiser Permanente physician
Nursing Benefits					
Skilled Nursing Facility Care	No charge; 100 days per period	$250 copay per admission; 100 days per period	No charge for days 1-20; $50 copay per day for days 21-100 (per benefit period)	No charge; 100 days for Medicare benefits period	No charge; 100 days per Medicare benefit period
Private Duty Nurses	No charge in service area	No charge if authorized	Not covered	Not covered	Not covered
Home Health Care	No charge in service area	No charge, unlimited visits (private duty nursing excluded)	No charge if authorized	No charge; unlimited visits	No charge
Hospice Care	No charge (only home-based hospice care)	No charge	No charge if authorized	No charge	No charge
Emergency Benefits					
Inpatient	$50 copay (waived if admitted)	$50 copay (waived if admitted)	$50 copay (waived if admitted)	$50 copay (waived if admitted)	$75 copay (waived if admitted)
Outpatient	$50 copay	$50 copay (waived if admitted)	$50 per visit	$50 copay (waived if admitted)	$75 copay (waived if admitted)
Ambulance	20% copay; max. of $195 per trip	$100 copay	No charge	$50 copay	$0 – $150 per one-way trip
Outpatient Benefits					
Doctor's Office Visits	$5 copay ($15 copay for specialist visit)*	$15 copay	$15 copay	$5 copay	$10 copay
Preadmission Diagnostic X-ray and Lab Tests	Included in office visit copay	Copay varies	No charge	No charge	No charge
Routine Checkups	No charge	No charge	No charge	No charge	No charge; annual routine physical exam/ annual wellness visit covered once every 12 months
Immunizations	$5 copay; no charge if preventive	$15 copay; no charge if preventive	No charge	No charge	No charge
Outpatient Surgical Services	$50 copay	$100 copay	$15 copay	$5 copay	$10 copay
Physical Therapy	$250 copay inpatient; $5 copay outpatient	$15 copay outpatient	$15 copay	$5 copay; unlimited visits	$10 copay
Speech Therapy	$250 copay inpatient; $5 copay outpatient	$15 copay outpatient	$15 copay	$5 copay; unlimited visits	$10 copay
Maternity	No charge	No charge	No charge (after confirmation of pregnancy)	No charge	Covered at applicable cost shares
Prescription Drug Benefits					
Prescription Drugs	$10 copay for up to 60-day supply	$15 generic/$30 brand copay for up to 30-day supply at Kaiser Permanente; $25 generic/$40 brand copay for 30-day supply at Rite Aid or Walgreens	$10 copay for up to 30-day supply	$5 copay for a 30-day supply	$3 preferred generic/$40 preferred brand copay for up to 30-day supply
Mental Health Benefits					
Inpatient	$250 per admission	$250 per admission	$50/day**	No charge	No charge
Outpatient	$5 copay	$15 copay	$15 copay**	$5 copay	$10 copay
Substance Abuse Benefits					
Inpatient	$250 per admission	$250 per admission; detox and rehab	$50/day	No charge	No charge
Outpatient	$5 copay	$15 copay	$15 copay	$5 copay	No charge
Vision/Hearing Care Benefits					
Eye Exams	$5 copay	$15 copay	$15 copay	$5 copay	$10 copay; one routine exam per calendar year
Lenses	$150 credit toward lenses, contact lenses or frames combined every 2 years	$100 credit toward lenses and/or frames combined every 2 years	Not covered	$150 credit toward the purchase of lenses, frames, and/or contact lenses every 24 months	$250 combined allowance per calendar year
Frames			Not covered		
Hearing Exam	$5 copay	$15 copay	$15 copay	$5 copay (adults/children)	$10 copay
Hearing Aids	Not covered	Not covered	60% of applicable charges per ear, once every three years	Not covered	$1,000 combined allowance per calendar year

*All office-administered prescription drugs covered by Medicare Part B (except preventive immunizations and diagnostic drugs) will be subject to 20% coinsurance. This coinsurance will apply to the annual maximum out-of-pocket expenses.

**When prescribed by a physician, services for serious mental illness will be provided in accordance with state law.

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