
2020 Health Plans
Individual & Family
Cost Sharing
Details

All 2020 Health Plans Cover The Same Sevices

Preventive - Primary Care -Urgent Care
Specialists - Emergency - Labs
Imaging - Tests
Prescription Drug Coverage

California Rating & Plan Regions
Color Coded by County

All Health Plans Include Preventive Services at No Cost

Physicals,
Cancer Screenings,
Immunizations, and more...

2020 Patient-Centered Benefit Designs and Medical Cost Shares

Benefits in blue are NOT subject to a deductible. Benefits in blue with a white corner are subject to a deductible after the first three visits.

Coverage Category	Minimum Coverage	Bronze	Silver	Gold	Platinum
Percent of cost coverage	Covers 0% until out-of-pocket maximum is met	Covers 60% average annual cost	Covers 70% average annual cost	Covers 80% average annual cost	Covers 90% average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	N/A	N/A	N/A
Annual Wellness Exam	$0	$0	$0	$0	$0
Primary Care Vist	After first 3 non-preventive visits, full cost per instance until out-of-pocket maximum is met	$65*	$40	$30	$15
Urgent Care		$65*	$40	$30	$15
Specialist Visit	Full cost per service until out-of-pocket maximum is met	$95*	$80	$65	$30
Emergency Room Facility		40% after deductible is met	$400	$350	$150
Laboratory Tests		$40	$40	$40	$15
X-Rays and Diagnostics		40% after deductible is met	$85	$75	$30
Imaging			$325	$275 copay or 20% coinsurance***	$75 copay or 10% coinsurance***
Tier 1 (Generic Drugs)	Full cost per script until out-of-pocket maximum is met	$18**	$16**	$15 or less	$5 or less
Tier 2 (Preferred Drugs)		40% up to $500 after drug deductible is met	$60**	$55 or less	$15 or less
Tier 3 (Non-preferred Drugs)			$90**	$80 or less	$25 or less

Bronze 60

3 Visit Copayment Limit
- Primary Care $65
- Urgent Care $65
- Specialist $95

Additional Visits
- Full Negotiated Rate

Lab Tests
$40
Not Subject To Deductible

Deductibles	Individual	Family
Medical	$6,300	$12,600
Pharmacy	$500	$1,000

Coinsurance After Deductible

Medical	40%
Pharmacy	40%

Maximum Out-of-Pocket

Individual	$7,800
Family	$15,600

Kaiser Permanente 2019 Sample Fee List*

NORTHERN CALIFORNIA

What's the Sample Fee List?

The Sample Fee List is one of many resources we offer to help you better understand and manage your health care costs. It shows the estimated amount Kaiser Permanente members would be charged for certain professional services.† It doesn't include costs for hospital services, facility fees, or other kinds of services.

When reviewing the list, keep in mind that the amount you're actually charged may be different depending on the care you get, the type of facility you visit, your plan details, and whether you've reached your deductible. Some services may also require additional services that have extra costs – like an earwax cleaning ordered by your doctor during a hearing evaluation.

How can I use the list?

The Sample Fee List can help you:

- Choose the right Kaiser Permanente deductible HMO plan during open enrollment
- Estimate what you'll pay for services before you reach your deductible
- Identify services that may be preventive care services, which are covered at no cost or at a copay (for a full list, visit **kp.org/prevention**)
- Estimate how much to contribute to any flexible spending account (FSA) or health savings account (HSA) connected to your plan, based on the services you expect to receive

	CT Scans	
70450	Head CT scan	$501
70486	Sinus CT scan	$693
71250	Chest CT scan	$638
71260	Chest CT scan, including dye	$798
74176	Abdomen/pelvis CT without contrast	$690
74177	Abdomen/pelvic CT scan, including dye	$1,046
	MRIs (Without Contrast)	
70551	Brain MRI without dye	$1,315
70553	Brain MRI with and without dye	$1,716
72148	Lumbar Spine MRI	$1,147
73721	Knee MRI	$843
	Pregnancy and Prenatal Tests	
59025	Fetal non-stress test	$140
76801	Pregnancy ultrasound, first trimester	$384
76805	Pregnancy ultrasound, after first trimester	$450
76815	Obstetric ultrasound, limited	$274
76816	Obstetric ultrasound, after first trimester	$360
76817	Obstetric ultrasound, transvaginal	$310

Sutter Health Plus
Your Health Plan

Bronze 60

3 Visit Copayment Limit

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- Urgent Care $65
- Specialist $95

Additional Visits

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- Primary Care $65
- Urgent Care $65
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Additional Visits

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Lab Tests
$40
Not Subject To Deductible

Deductibles	Individual	Family
Medical	$6,300	$12,600
Pharmacy	$500	$1,000

Coinsurance After Deductible

Medical	40%
Pharmacy	40%

Maximum Out-of-Pocket

Individual	$7,800
Family	$15,600

Bronze 60

Services* Subject to the Medical Deductible

- Ambulance
- Dialysis
- Diabetic supplies
- Diagnostic imaging
- Doctor, Specialist, Urgent Care after 3 visit limit
- Durable Medical Equipment
- Emergency Services
- Home Health/Skilled Nursing
- In-Patient Hospitalization
- Mental Health In-Patient
- Out-Patient Surgery
- PKU product formula, food
- Rehabilitative Therapy

*Not All Services Listed

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Deductibles	Individual	Family
Medical	$6,300	$12,600
Pharmacy	$500	$1,000

Coinsurance After Deductible

Medical	40%
Pharmacy	40%

Maximum Out-of-Pocket

Individual	$7,800
Family	$15,600

Bronze - Silver - Gold - Platinum

EPO - HSP - HMO - PPO

Emergency Room Treatment

for life threatening illness or accident

Always Treated As In-Network Anywhere in U.S.A

Bronze 60

Pharmacy Deductible = $500 Individual/ $1,000 Family

Tier 1 Generics = $18/ 30-day Supply

Tier 2 - 4 = 40% Coinsurance

Maximum $500/ 30-day Supply

Bronze 60

Maximum Out-of-Pocket Amount

Total of All:
- **Copayments services and drugs**
- **Medical & Pharmacy Deductibles**
- **Coinsurance for services & drugs**

$7,800 Individual
or
$15,600 Family

Bronze 60

3 Visit Copayment Limit

- Primary Care $65
- Urgent Care $65
- Specialist $95

Additional Visits

- Full Negotiated Rate

Lab Tests
$40
Not Subject To Deductible

Deductibles	Individual	Family
Medical	$6,300	$12,600
Pharmacy	$500	$1,000

Coinsurance After Deductible

Medical	40%
Pharmacy	40%

Maximum Out-of-Pocket

Individual	$7,800
Family	$15,600

Silver 70

Copayments & Coinsurance
Not Subject to Deductible

Deductibles	Individual	Family
Medical	$4,000	$8,000
Pharmacy	$300	$600

Coinsurance

Medical	20%
Pharmacy	20%

Maximum Out-of-Pocket
Individual $7,800
Family $15,600

Silver 70

Copayment Services

Not Subject to Medical Deductible

Ambulance	**$250***	**PCP Office Visit**	**$40**
Emergency Room	**$400****	**Specialist Visit**	**$80**
Imaging: MRI	**$325**	**Urgent Care**	**$40**
Laboratory Test	**$40**	**X-rays, Diagnostic Tests**	**$85**

**** Off-Exchange Silver Plans $5 higher***

***** Copayment waived if admited, then subject to Medical Deductible***

Silver 70

20% Coinsurance Services *

Not Subject to Medical Deductible

Ambulatory Out-Patient Surgeries
Chemotherapy
Diabetic Equipment & Supplies
Dialysis
Radiation Therapy

****Not a complete list***

Silver 70

Medical Deductible $4,000/$8,000 Individual/Family

Medical Deductible Services*

- Bariatric Surgery
- In-Patient Hospitalization
- Skilled Nursing Facility
- Transplant Services

20% Coinsurance After Deductible

Other services may be subject to Medical Deductible

Silver 70

Pharmacy Deductible $300/$600 Individual/Family

Copayments After Deductible

Generic Drugs Tier 1	**$16**
Preferred Drugs Tier 2	**$60**
Non-Preferred Drugs Tier 3	**$90**
Specialty Drugs Tier 4	**20%***

$250 maximum cost for 30-day supply

Silver 70

Copayments & Coinsurance
Not Subject to Deductible

Deductibles	Individual	Family
Medical	$4,000	$8,000
Pharmacy	$300	$600

Coinsurance
Medical 20%
Pharmacy 20%

Maximum Out-of-Pocket
Individual $7,800
Family $15,600

Silver

73 - 87 - 94

Cost Sharing Reductions

Lower
Deductibles
Copayments
Coinsurance
Maximum Out-of-Pocket

Gold 80 **Platinum 90**

NO Medical or Pharmacy Deductibles

Same Copayment Services as Silver Plans

At Lower Dollar Amounts

Coinsurance

Gold 20% **Platinum 10%**

Maximum Out-of-Pocket Amount

Gold $7,800/$15,600 **Platinum $4,500/$9,000**

Individual/Family

Bronze 60

High Deductible Health Plans (HDHP)

- Health Savings Account Compliant
- Single Deductible for both Medical & Pharmacy
- No Services or Drugs at set Copayment
- Deductible = Maximum Out-of-Pocket Amount

Deductible/Maximum Out-of-Pocket Amount

$6,900 Individual $13,800 Family

Off-Exchange Health Plans

- Cover All Services as On-Exchange Plans
- Cost-Sharing: Copayments, Coinsurance, Deductible, Max. Out-of-Pocket Different
- HDHP may include Coinsurance After Deductible, Before Max O-o-P is Met

Review Health Plan Documents

- **Summary of Benefits & Coverage**
- **Evidence of Coverage**
- **Member Agreements**

oscar

An Exclusive Provider Organization (EPO) Plan

2020 Subscriber Agreement and Combined Evidence of Coverage and Disclosure Form

Western Health Advantage

PLAN COMPARISON

FOR INDIVIDUALS AND FAMILIES

Effective **1.1.20**

Kevin Knauss

Education Before Enrollment

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COVERED CALIFORNIA

Certified *Insurance Agent*