KAISER PERMANENTE®

Plan Comparison

2023–2024

	2023	2024
	BRONZE 60 HMO 6300/65* + CHILD DENTAL	**BRONZE 60 HMO 6300/60* + CHILD DENTAL**
FEATURES	**Deductible HMO Plan Member Pays**	**Deductible HMO Plan Member Pays**
PLAN DEDUCTIBLE Embedded	Individual $6,300 [1] / Family $12,600 [1]	Individual $6,300 [1] / Family $12,600 [1]
OUT-OF-POCKET MAXIMUM Embedded	Individual $8,600 [1,2] / Family $17,200 [1,2]	Individual $9,100 [1,2] / Family $18,200 [1,2]
IN THE MEDICAL OFFICE Primary care visits	$65 (after plan deductible) [3]	$60 (after plan deductible) [3]
Urgent care visits	$65 (after plan deductible) [3]	$60 (after plan deductible) [3]
Specialty office visits	$95 (after plan deductible) [3]	$95 (after plan deductible) [3]
Most laboratory tests	$40 [4]	$40 [4]
Most X-rays and diagnostic testing	40% (after plan deductible) [4]	40% (after plan deductible) [4]
Most MRI / CT / PET scans	40% (after plan deductible) [4]	40% (after plan deductible) [4]
Outpatient surgery (per procedure)	40% (after plan deductible)	40% (after plan deductible)
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	40% (after plan deductible)	40% (after plan deductible)
PRESCRIPTIONS (up to 30-day supply) Generic (Tier 1)	$18 (after $500/$1,000 drug deductible) [5,6]	$17 (after $500/$1,000 drug deductible) [5,6]
Brand-name (Tier 2)	40% per prescription up to $500 maximum (after $500/$1,000 drug deductible) [5,6]	40% per prescription up to $500 maximum (after $500/$1,000 drug deductible) [5,6]
Specialty drugs (Tier 4)	40% per prescription up to $500 maximum (after $500/$1,000 drug deductible) [5,6]	40% per prescription up to $500 maximum (after $500/$1,000 drug deductible) [5,6]
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	40% (after plan deductible)	40% (after plan deductible)
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$0 [3]	$0 [3]
Inpatient (in the hospital)	40% (after plan deductible)	40% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$0 [3]	$0 [3]
Inpatient (in the hospital) - detoxification only	40% (after plan deductible)	40% (after plan deductible)
OTHER Virtual care	$0	$0
Chiropractic and acupuncture	$65 per visit for physician-referred acupuncture only	$60 per visit for physician-referred acupuncture only
Certain durable medical equipment (DME) (supplemental and base)	40% (after plan deductible) [7]	40% (after plan deductible) [7]

* The plan is also offered at Covered California for Small Business and CaliforniaChoice®.

1. This plan has an embedded deductible and out-of-pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual deductible or out-of-pocket maximum (depending on the benefit), or when the family deductible or out-of-pocket maximum is satisfied. Individual family members aren't subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of-pocket maximum is met. **2.** Out-of-pocket maximum is the maximum amount an individual or family will pay for certain services in a year. **3.** Deductible is waived for first 3 visits combined for non-preventive primary care, specialty care, other practitioner care, urgent care, and mental/behavioral health and substance use disorder outpatient services. **4.** Laboratory and diagnostic test, x-rays and MRI/CT/PET scans related to preventive services are no charge. **5.** Prescription drugs are covered in accordance with our formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copays. For information on our formulary, including the drugs on the specialty tier, go to kp.org/formulary or call our Member Service Contact Center. **6.** This plan has a drug deductible of $500 per individual and $1,000 for family for prescription costs and out-of-pocket maximum. Each family m ember will begin paying copays or coinsurance after meeting his or her individual drug deductible or out-of-pocket maximum (depending on the benefit), or when the family deductible is satisfied. Individual family members aren't subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of-pocket maximum is met. **7.** Both base and supplemental DME are covered (after plan deductible). Supplemental DME is limited to a combined maximum benefit of $2,000 per year for services (after plan deductible). Refer to the *Evidence of Coverage* for information on what's included in your DME benefit.

This is a summary of benefits only and is subject to change. The KFHP *Evidence of Coverage* and the KPIC *Certificate of Insurance* contain a complete explanation of benefits, exclusions, and limitations. The information provided isn't intended to describe all the benefits included in each plan, nor is it designed to serve as the *Evidence of Coverage* or *Certificate of Insurance*.