KAISER PERMANENTE®

# Plan Comparison

2023–2024

| | 2023 | 2024 |
|---|---|---|
| | **SILVER 70 HDHP HMO 2700/25%* + CHILD DENTAL** | **SILVER 70 HDHP HMO 2850/25%* + 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** Embedded | Self-only $2,700 [1,2] / Individual $3,000 [1,2] / Family $5,400 [1,2] | Self-only $2,850 [1,2] / Individual $3,200 [1,2] / Family $5,700 [1,2] |
| **OUT-OF-POCKET MAXIMUM** Embedded | Individual $7,200 [1,3] / Family $14,400 [1,3] | Individual $7,500 [1,3] / Family $15,000 [1,3] |
| **IN THE MEDICAL OFFICE** Primary care visits | 25% (after plan deductible) | 25% (after plan deductible) |
| Urgent care visits | 25% (after plan deductible) | 25% (after plan deductible) |
| Specialty office visits | 25% (after plan deductible) | 25% (after plan deductible) |
| Most laboratory tests | 25% (after plan deductible) [4] | 25% (after plan deductible) [4] |
| Most X-rays and diagnostic testing | 25% (after plan deductible) [4] | 25% (after plan deductible) [4] |
| Most MRI / CT / PET scans | 25% (after plan deductible) [4] | 25% (after plan deductible) [4] |
| Outpatient surgery (per procedure) | 25% (after plan deductible) | 25% (after plan deductible) |
| **EMERGENCY SERVICES** Emergency department visits (waived if admitted directly to hospital) | 25% (after plan deductible) | 25% (after plan deductible) |
| **PRESCRIPTIONS** (up to 30-day supply) Generic (Tier 1) | 25% per prescription up to $250 maximum (after plan deductible) [5] | 25% per prescription up to $250 maximum (after plan deductible) [5] |
| Brand-name (Tier 2) | 25% per prescription up to $250 maximum (after plan deductible) [5] | 25% per prescription up to $250 maximum (after plan deductible) [5] |
| Specialty drugs (Tier 4) | 25% per prescription up to $250 maximum (after plan deductible) [5] | 25% per prescription up to $250 maximum (after plan deductible) [5] |
| **HOSPITAL INPATIENT CARE** Physicians' services, room and board, tests, medications, supplies, therapies, birth services | 25% (after plan deductible) | 25% (after plan deductible) |
| **MENTAL HEALTH SERVICES** Outpatient (in the medical office) | $0 (after plan deductible) | $0 (after plan deductible) |
| Inpatient (in the hospital) | 25% (after plan deductible) | 25% (after plan deductible) |
| **SUBSTANCE USE DISORDER SERVICES** Outpatient (in the medical office) | $0 (after plan deductible) | $0 (after plan deductible) |
| Inpatient (in the hospital) - detoxification only | 25% (after plan deductible) | 25% (after plan deductible) |
| **OTHER** Virtual care | $0 (after plan deductible) [6] | $0 (after plan deductible) [6] |
| Chiropractic and acupuncture | 25% per visit after deductible for physician-referred acupuncture only | 25% per visit after deductible for physician-referred acupuncture only |
| Certain durable medical equipment (DME) (supplemental and base) | 25% [7] | 25% [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.** Self-only: a family of 1 member. Individual: each member in a family of 2 or more members. Family: entire family of 2 or more members. **3.** Out-of-pocket maximum is the maximum amount an individual or family will pay for all covered services in a year. **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.** For HSA-qualified HDHP HMO members, all scheduled, non-preventive telehealth visits (phone and video). **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*.