KAISER PERMANENTE®

Plan Comparison

2024–2025

	2024	2025
	GOLD 80 HDHP HMO 1750/15%* + CHILD DENTAL ALT†	**GOLD 80 HDHP HMO 1750/15% PCP* + CHILD DENTAL ALT†**
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 $1,750 [1,2] / Individual $3,200 [1,2] / Family $3,500 [1,2]	Self-only $1,750 [1,2] / Individual $3,300 [1,2] / Family $3,500 [1,2]
OUT-OF-POCKET MAXIMUM Embedded	Individual $3,700 [1,3] / Family $7,400 [1,3]	Individual $4,000 [1,3] / Family $8,000 [1,3]
IN THE MEDICAL OFFICE Primary care visits	15% (after plan deductible)	15% (after plan deductible)
Urgent care visits	15% (after plan deductible)	15% (after plan deductible)
Specialty office visits	15% (after plan deductible)	15% (after plan deductible)
Most laboratory tests	15% (after plan deductible) [4]	15% (after plan deductible) [4]
Most X-rays and diagnostic testing	15% (after plan deductible) [4]	15% (after plan deductible) [4]
Most MRI / CT / PET scans	15% (after plan deductible) [4]	15% (after plan deductible) [4]
Outpatient surgery (per procedure)	15% (after plan deductible)	15% (after plan deductible)
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	15% (after plan deductible)	15% (after plan deductible)
PRESCRIPTIONS (up to 30-day supply) Generic (Tier 1)	$15 (after plan deductible) [5,6]	$15 (after plan deductible) [5,6]
Brand-name (Tier 2)	$45 (after plan deductible) [5,6]	$45 (after plan deductible) [5,6]
Specialty drugs (Tier 4)	15% up to $250 maximum (after plan deductible) [5,6]	15% up to $250 maximum (after plan deductible) [5,6]
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	15% (after plan deductible)	15% (after plan deductible)
MENTAL HEALTH SERVICES Outpatient (in the medical office)	15% (after plan deductible)	15% (after plan deductible)
Inpatient (in the hospital)	15% (after plan deductible)	15% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	15% (after plan deductible)	15% (after plan deductible)
Inpatient (in the hospital) - detoxification only	15% (after plan deductible)	15% (after plan deductible)
OTHER Virtual care	$0 (after plan deductible) [7]	$0 (after plan deductible) [7]
Chiropractic and acupuncture	15% per visit after deductible for physician-referred acupuncture only	Not Covered
Certain durable medical equipment (DME) (supplemental and base)	15% [8]	15% [8]

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

† The abbreviation "ALT," in certain plan names, indicates Kaiser Permanente developed plans.

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.** Mail order: Up to a 100-day supply of qualified prescriptions for the cost of a 60-day supply. **7.** For HSA-qualified HDHP HMO members, all scheduled, non-preventive telehealth visits (phone and video). **8.** 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.*