

Plan Comparison

2024-2025

	2024	2025
	PLATINUM 90 HMO 0/10* + CHILD DENTAL ALT†	PLATINUM 90 HMO 0/10 PCP* + CHILD DENTAL ALT†
FEATURES	Copay HMO Plan Member Pays	Copay HMO Plan Member Pays
PLAN DEDUCTIBLE Embedded	\$0	\$0
OUT-OF-POCKET MAXIMUM Embedded	Individual \$3,000 ^{1,2} / Family \$6,000 ^{1,2}	Individual \$3,000 ^{1,2} / Family \$6,000 ^{1,2}
IN THE MEDICAL OFFICE		
Primary care visits	\$10	\$10
Urgent care visits	\$10	\$10
Specialty office visits	\$20	\$20
Most laboratory tests	\$20 ³	\$20 ³
Most X-rays and diagnostic testing	\$40 ³	\$40 ³
Most MRI / CT / PET scans	\$150 ³	\$150 ³
Outpatient surgery (per procedure)	\$300	\$300
EMERGENCY SERVICES		
Emergency department visits (waived if admitted directly to hospital)	\$200	\$200
PRESCRIPTIONS (up to 30-day supply)		
Generic (Tier 1)	\$5 ^{4,5}	\$5 ^{4,5}
Brand-name (Tier 2)	\$15 ^{4,5}	\$15 ^{4,5}
Specialty drugs (Tier 4)	10% per prescription up to \$250 maximum ^{4,5}	10% per prescription up to \$250 maximum ^{4,5}
HOSPITAL INPATIENT CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	\$500 per admission	\$500 per admission
MENTAL HEALTH SERVICES		
Outpatient (in the medical office)	\$10	\$10
Inpatient (in the hospital)	\$500 per admission	\$500 per admission
SUBSTANCE USE DISORDER SERVICES		
Outpatient (in the medical office)	\$10	\$10
Inpatient (in the hospital) - detoxification only	\$500 per admission	\$500 per admission
OTHER		
Virtual care	\$0	\$0
Chiropractic and acupuncture	\$15 per visit (self-referral; 20 combined visits per year)	\$15 per visit (self-referral; 20 combined visits per year)
Certain durable medical equipment (DME) (supplemental and base)	10% ⁶	10% ⁶

* 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 out-of-pocket maximum. 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.** Laboratory and diagnostic test, x-rays and MRI/CT/PET scans related to preventive services are no charge. **4.** 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. **5.** Mail order: Up to a 100-day supply of qualified prescriptions for the cost of a 60-day supply. **6.** Both base and supplemental DME are covered. Supplemental DME is limited to a combined maximum benefit of \$2,000 per year for services. 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*.