

Plan Comparison

2024-2025

2024

2025

	SILVER 70 HDHP HMO 2850/25%* + CHILD DENTAL	SILVER 70 HDHP HMO 2850/25% PCP* + 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 \$2,850 ^{1,2} / Individual \$3,200 ^{1,2} / Family \$5,700 ^{1,2}	Self-only \$2,850 ^{1,2} / Individual \$3,300 ^{1,2} / Family \$5,700 ^{1,2}
OUT-OF-POCKET MAXIMUM Embedded	Individual \$7,500 ^{1,3} / Family \$15,000 ^{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*.