KAISER PERMANENTE®

Plan Comparison

2024–2025

	2024	2025
	SILVER 70 HMO 2300/65* + CHILD DENTAL ALT†	**SILVER 70 HMO 2300/65 PCP* + CHILD DENTAL ALT†**
FEATURES	**Deductible HMO Plan Member Pays**	**Deductible HMO Plan Member Pays**
PLAN DEDUCTIBLE Embedded	Individual $2,300 [1] / Family $4,600 [1]	Individual $2,300 [1] / Family $4,600 [1]
OUT-OF-POCKET MAXIMUM Embedded	Individual $8,750 [1, 2] / Family $17,500 [1, 2]	Individual $8,750 [1, 2] / Family $17,500 [1, 2]
IN THE MEDICAL OFFICE Primary care visits	$65	$65
Urgent care visits	$65	$65
Specialty office visits	$100	$100
Most laboratory tests	$30 [3]	$30 [3]
Most X-rays and diagnostic testing	$75 [3]	$75 [3]
Most MRI / CT / PET scans	$400 (after plan deductible) [3]	$400 (after plan deductible) [3]
Outpatient surgery (per procedure)	45% (after plan deductible)	45% (after plan deductible)
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	45% (after plan deductible)	45% (after plan deductible)
PRESCRIPTIONS (up to 30-day supply) Generic (Tier 1)	$20 [4, 6]	$20 [4, 6]
Brand-name (Tier 2)	$100 (after $500/$1,000 drug deductible) [4, 5, 6]	$100 (after $500/$1,000 drug deductible) [4, 5, 6]
Specialty drugs (Tier 4)	20% per prescription up to $250 maximum (after $500/$1,000 drug deductible) [4, 5, 6]	20% per prescription up to $250 maximum (after $500/$1,000 drug deductible) [4, 5, 6]
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	45% (after plan deductible)	45% (after plan deductible)
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$0	$0
Inpatient (in the hospital)	45% (after plan deductible)	45% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$0	$0
Inpatient (in the hospital) - detoxification only	45% (after plan deductible)	45% (after plan deductible)
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)	45% [7]	45% [7]

* 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.** 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.** 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 member 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. **6.** Mail order: Up to a 100-day supply of qualified prescriptions for the cost of a 60-day supply. **7.** Both base and supplemental DME are covered. 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*.