

Plan Comparison

2023-2024

2023

2024

	BRONZE 60 HDHP HMO 7000/0%* + CHILD DENTAL	BRONZE 60 HDHP HMO 7050/0%* + 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	Individual \$7,000 ¹ / Family \$14,000 ¹	Individual \$7,050 ¹ / Family \$14,100 ¹
OUT-OF-POCKET MAXIMUM Embedded	Individual \$7,000 ^{1,2} / Family \$14,000 ^{1,2}	Individual \$7,050 ^{1,2} / Family \$14,100 ^{1,2}
IN THE MEDICAL OFFICE		
Primary care visits	0% (after plan deductible)	0% (after plan deductible)
Urgent care visits	0% (after plan deductible)	0% (after plan deductible)
Specialty office visits	0% (after plan deductible)	0% (after plan deductible)
Most laboratory tests	0% (after plan deductible) ³	0% (after plan deductible) ³
Most X-rays and diagnostic testing	0% (after plan deductible) ³	0% (after plan deductible) ³
Most MRI / CT / PET scans	0% (after plan deductible) ³	0% (after plan deductible) ³
Outpatient surgery (per procedure)	0% (after plan deductible)	0% (after plan deductible)
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	0% (after plan deductible)	0% (after plan deductible)
PRESCRIPTIONS (up to 30-day supply)		
Generic (Tier 1)	0% (after plan deductible) ^{4,5}	0% (after plan deductible) ^{4,5}
Brand-name (Tier 2)	0% (after plan deductible) ^{4,5}	0% (after plan deductible) ^{4,5}
Specialty drugs (Tier 4)	0% per prescription (after plan deductible) ^{4,5}	0% per prescription (after plan deductible) ^{4,5}
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	0% (after plan deductible)	0% (after plan deductible)
MENTAL HEALTH SERVICES		
Outpatient (in the medical office)	0% (after plan deductible)	0% (after plan deductible)
Inpatient (in the hospital)	0% (after plan deductible)	0% (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	0% (after plan deductible)	0% (after plan deductible)
OTHER		
Virtual care	\$0 (after plan deductible) ⁶	\$0 (after plan deductible) ⁶
Chiropractic and acupuncture	0% per visit after deductible for physician-referred acupuncture only	0% per visit after deductible for physician-referred acupuncture only
Certain durable medical equipment (DME) (supplemental and base)	0% (after plan deductible) ⁷	0% (after plan deductible) 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.** 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.** 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*.