

## Plan Comparison

2023-2024

2023

2024

	<b>GOLD 80 HDHP HMO 1600/15%* + CHILD DENTAL ALT†</b>	<b>GOLD 80 HDHP HMO 1750/15%* + CHILD DENTAL ALT†</b>
<b>FEATURES</b>	<b>HSA-qualified High Deductible Health Plan (HSA can be administered through Kaiser Permanente)</b>	<b>HSA-qualified High Deductible Health Plan (HSA can be administered through Kaiser Permanente)</b>
<b>PLAN DEDUCTIBLE</b> Embedded	Self-only \$1,600 <sup>1,2</sup> / Individual \$3,000 <sup>1,2</sup> / Family \$3,200 <sup>1,2</sup>	Self-only \$1,750 <sup>1,2</sup> / Individual \$3,200 <sup>1,2</sup> / Family \$3,500 <sup>1,2</sup>
<b>OUT-OF-POCKET MAXIMUM</b> Embedded	Individual \$3,550 <sup>1,3</sup> / Family \$3,500 <sup>1,3</sup>	Individual \$3,700 <sup>1,3</sup> / Family \$7,400 <sup>1,3</sup>
<b>IN THE MEDICAL OFFICE</b>		
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) <sup>4</sup>	15% (after plan deductible) <sup>4</sup>
Most X-rays and diagnostic testing	15% (after plan deductible) <sup>4</sup>	15% (after plan deductible) <sup>4</sup>
Most MRI / CT / PET scans	15% (after plan deductible) <sup>4</sup>	15% (after plan deductible) <sup>4</sup>
Outpatient surgery (per procedure)	15% (after plan deductible)	15% (after plan deductible)
<b>EMERGENCY SERVICES</b> Emergency department visits (waived if admitted directly to hospital)	15% (after plan deductible)	15% (after plan deductible)
<b>PRESCRIPTIONS</b> (up to 30-day supply) Generic (Tier 1)	\$15 (after plan deductible) <sup>5,6</sup>	\$15 (after plan deductible) <sup>5,6</sup>
Brand-name (Tier 2)	\$45 (after plan deductible) <sup>5,6</sup>	\$45 (after plan deductible) <sup>5,6</sup>
Specialty drugs (Tier 4)	15% up to \$250 maximum (after plan deductible) <sup>5,6</sup>	15% up to \$250 maximum (after plan deductible) <sup>5,6</sup>
<b>HOSPITAL INPATIENT CARE</b> Physicians' services, room and board, tests, medications, supplies, therapies, birth services	15% (after plan deductible)	15% (after plan deductible)
<b>MENTAL HEALTH SERVICES</b> 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)
<b>SUBSTANCE USE DISORDER SERVICES</b> 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)
<b>OTHER</b> Virtual care	\$0 (after plan deductible) <sup>7</sup>	\$0 (after plan deductible) <sup>7</sup>
Chiropractic and acupuncture	15% per visit after deductible for physician-referred acupuncture only	15% per visit after deductible for physician-referred acupuncture only
Certain durable medical equipment (DME) (supplemental and base)	15% <sup>8</sup>	15% <sup>8</sup>

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

† The abbreviation "ALT," in certain plan names, designates Kaiser Permanente developed plans that are different from the standard plans and are available through Covered California for Small Business.

**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](https://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 KFP *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*.