

Plan Comparison

2023-2024

2023

2024

	SILVER 70 HMO 2500/55* + CHILD DENTAL	SILVER 70 HMO 2500/55* + CHILD DENTAL
FEATURES	Deductible HMO Plan Member Pays	Deductible HMO Plan Member Pays
PLAN DEDUCTIBLE Embedded	Individual \$2,500 ¹ / Family \$5,000 ¹	Individual \$2,500 ¹ / Family \$5,000 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	\$55	\$55
Urgent care visits	\$55	\$55
Specialty office visits	\$90	\$90
Most laboratory tests	\$55 ³	\$55 ³
Most X-rays and diagnostic testing	\$90 ³	\$90 ³
Most MRI / CT / PET scans	\$300 (after plan deductible) ³	\$300 (after plan deductible) ³
Outpatient surgery (per procedure)	35% (after plan deductible)	35% (after plan deductible)
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	30% (after plan deductible)	35% (after plan deductible)
PRESCRIPTIONS (up to 30-day supply) Generic (Tier 1)	\$19 ^{4,6}	\$19 ^{4,6}
Brand-name (Tier 2)	\$85 (after \$370/\$740 drug deductible) ^{4,5,6}	\$85 (after \$300/\$600 drug deductible) ^{4,5,6}
Specialty drugs (Tier 4)	30% per prescription (after \$370/\$740 drug deductible) ^{4,5,6}	30% per prescription (after \$300/\$600 drug deductible) ^{4,5,6}
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	40% (after plan deductible)	35% (after plan deductible)
MENTAL HEALTH SERVICES Outpatient (in the medical office)	\$0	\$0
Inpatient (in the hospital)	40% (after plan deductible)	35% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	\$0	\$0
Inpatient (in the hospital) - detoxification only	40% (after plan deductible)	35% (after plan deductible)
OTHER Virtual care	\$0	\$0
Chiropractic and acupuncture	\$55 per visit for physician-referred acupuncture only	\$55 per visit for physician-referred acupuncture only
Certain durable medical equipment (DME) (supplemental and base)	40% ⁷	35% 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.** This plan has a drug deductible of \$300 per individual and \$600 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 KHP *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*.