KAISER PERMANENTE®

Plan Comparison

2024–2025

	2024	2025
	GOLD 80 HMO 0/35* + CHILD DENTAL ALT†	**GOLD 80 HMO 0/35 PCP* + CHILD DENTAL ALT†**
FEATURES	**Copay HMO Plan Member Pays**	**Copay HMO Plan Member Pays**
PLAN DEDUCTIBLE Embedded	$0	$0
OUT-OF-POCKET MAXIMUM Embedded	Individual $7,700 [1, 2] / Family $15,400 [1, 2]	Individual $7,700 [1, 2] / Family $15,400 [1, 2]
IN THE MEDICAL OFFICE Primary care visits	$35	$35
Urgent care visits	$35	$35
Specialty office visits	$60	$60
Most laboratory tests	$30 [3]	$30 [3]
Most X-rays and diagnostic testing	$40 [3]	$40 [3]
Most MRI / CT / PET scans	$250 [3]	$250 [3]
Outpatient surgery (per procedure)	$320	$320
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	$350	$350
PRESCRIPTIONS (up to 30-day supply) Generic (Tier 1)	$15 [4, 5]	$15 [4, 5]
Brand-name (Tier 2)	$50 [4, 5]	$50 [4, 5]
Specialty drugs (Tier 4)	20% per prescription up to $250 maximum [4, 5]	20% per prescription up to $250 maximum [4, 5]
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$600 per day up to 5 days per admission [6]	$600 per day up to 5 days per admission [6]
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$35	$35
Inpatient (in the hospital)	$600 per day up to 5 days per admission [6]	$600 per day up to 5 days per admission [6]
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$35	$35
Inpatient (in the hospital) - detoxification only	$600 per day up to 5 days per admission [6]	$600 per day up to 5 days per admission [6]
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)	20% [7]	20% [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. Out-of-pocket maximum is the maximum amount an individual or family will pay for certain services in a year. **2.** This plan has an embedded out-of-pocket maximum. 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. **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.** After the 5 days, additional days for the same admission are covered at no charge. **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*.