

## Plan Comparison

2024-2025

### 2024 - DISCONTINUED PLAN

### 2025

	BRONZE 60 HMO 5400/60* + CHILD DENTAL	BRONZE 60 HMO 5800/60 PCP* + CHILD DENTAL
FEATURES	Deductible HMO Plan Member Pays	Deductible HMO Plan Member Pays
<b>PLAN DEDUCTIBLE</b> Embedded	Individual \$5,400 <sup>1</sup> / Family \$10,800 <sup>1</sup>	Individual \$5,800 <sup>1</sup> / Family \$11,600 <sup>1</sup>
<b>OUT-OF-POCKET MAXIMUM</b> Embedded	Individual \$8,300 <sup>1,2</sup> / Family \$17,200 <sup>1,2</sup>	Individual \$8,850 <sup>1,2</sup> / Family \$17,700 <sup>1,2</sup>
<b>IN THE MEDICAL OFFICE</b>		
Primary care visits	\$60 (after plan deductible)	\$60 (after plan deductible)
Urgent care visits	\$60 (after plan deductible)	\$60 (after plan deductible)
Specialty office visits	\$80 (after plan deductible)	\$95 (after plan deductible) <sup>3</sup>
Most laboratory tests	\$30 (after plan deductible) <sup>4</sup>	\$40 (after plan deductible) <sup>4</sup>
Most X-rays and diagnostic testing	50% (after plan deductible) <sup>4</sup>	40% (after plan deductible) <sup>4</sup>
Most MRI / CT / PET scans	50% (after plan deductible) <sup>4</sup>	40% (after plan deductible) <sup>4</sup>
Outpatient surgery (per procedure)	50% (after plan deductible)	40% (after plan deductible)
<b>EMERGENCY SERVICES</b> Emergency department visits (waived if admitted directly to hospital)	50% (after plan deductible)	40% (after plan deductible)
<b>PRESCRIPTIONS</b> (up to 30-day supply) Generic (Tier 1)	\$20 <sup>5,6</sup>	\$19 <sup>5,6</sup>
Brand-name (Tier 2)	50% per prescription up to \$500 maximum (after plan deductible) <sup>5,6</sup>	40% per prescription up to \$500 maximum (after \$450/\$900 drug deductible) <sup>5,6,7</sup>
Specialty drugs (Tier 4)	50% per prescription up to \$500 maximum (after plan deductible) <sup>5,6</sup>	40% per prescription up to \$500 maximum (after \$450/\$900 drug deductible) <sup>5,6,7</sup>
<b>HOSPITAL INPATIENT CARE</b>		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	50% (after plan deductible)	40% (after plan deductible)
<b>MENTAL HEALTH SERVICES</b>		
Outpatient (in the medical office)	\$0 (after plan deductible)	\$0 (after plan deductible)
Inpatient (in the hospital)	50% (after plan deductible)	40% (after plan deductible)
<b>SUBSTANCE USE DISORDER SERVICES</b>		
Outpatient (in the medical office)	\$0 (after plan deductible)	\$0 (after plan deductible)
Inpatient (in the hospital) - detoxification only	50% (after plan deductible)	40% (after plan deductible)
<b>OTHER</b>		
Virtual care	\$0	\$0
Chiropractic and acupuncture	\$15 per visit (self-referral; 20 combined visits per year)	\$60 per visit for physician-referred acupuncture only
Certain durable medical equipment (DME) (supplemental and base)	50% (after plan deductible) <sup>8</sup>	40% (after plan deductible to \$2,000 max.) <sup>8</sup>

\* 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.** The plan deductible doesn't apply to your first three visits for specialty care as described in the EOC. **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.** This plan has a drug deductible of \$450 per individual and \$900 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. **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 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*.