KAISER PERMANENTE®

Plan Comparison

2024–2025

	2024		2025	
	SILVER 70 PPO 2500/55 + Child Dental		SILVER 70 PPO 2500/55 PCP + Child Dental	
FEATURES	Participating Provider Tier (in-network) [1]	Non-Participating Provider Tier (out-of-network) [1]	Participating Provider Tier (in-network) [1]	Non-Participating Provider Tier (out-of-network) [1]
PLAN DEDUCTIBLE Embedded	Individual $2,500 [2] Family $5,000 [2]	Individual $5,000 [2] Family $10,000 [2]	Individual $2,500 [2] Family $5,000 [2]	Individual $5,000 [2] Family $10,000 [2]
OUT-OF-POCKET MAXIMUM Embedded	Individual $8,750 [2, 3] Family $17,500 [2, 3]	Individual $17,500 [2, 3] Family $35,000 [2, 3]	Individual $8,750 [2, 3] Family $17,500 [2, 3]	Individual $17,500 [2, 3] Family $35,000 [2, 3]
IN THE MEDICAL OFFICE Primary care visits	$55	40% (after plan deductible)	$55	40% (after plan deductible)
Urgent care visits	$55	40% (after plan deductible)	$55	40% (after plan deductible)
Specialty office visits	$90	40% (after plan deductible)	$90	40% (after plan deductible)
Most laboratory tests	$55	40% (after plan deductible)	$55	40% (after plan deductible)
Most X-rays and diagnostic testing	$90	40% (after plan deductible)	$90	40% (after plan deductible)
Most MRI / CT / PET scans	$300 (after plan deductible)	40% (after plan deductible)	$300 (after plan deductible)	40% (after plan deductible)
Outpatient surgery (per procedure)	35% (after plan deductible)	50% (after plan deductible)	35% (after plan deductible)	50% (after plan deductible)
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	35% (after plan deductible)	35% (after plan deductible)	35% (after plan deductible)	35% (after plan deductible)
PRESCRIPTIONS (up to 30-day supply) Generic (Tier 1)	$19 [4, 5, 7]	Not Covered	$19 [4, 5, 7]	Not Covered
Brand-name (Tier 2)	$85 [4,5,6,7] (after $300/$600 drug deductible)	Not Covered	$85 [4,5, 6, 7] (after $300/$600 drug deductible)	Not Covered
Specialty drugs (Tier 4)	30% per prescription up to $250 maximum (after $300/$600 drug deductible) [5, 6, 7]	Not Covered	30% per prescription up to $250 maximum (after $300/$600 drug deductible) [5, 6, 7]	Not Covered
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	35% (after plan deductible)	50% (after plan deductible)	35% (after plan deductible)	50% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	35% (after plan deductible)	50% (after plan deductible)	35% (after plan deductible)	50% (after plan deductible)
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$55	40% (after plan deductible)	$55	40% (after plan deductible)
Inpatient (in the hospital)	35% (after plan deductible)	50% (after plan deductible)	35% (after plan deductible)	50% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$55 per visit	40% (after plan deductible)	$55 per visit	40% (after plan deductible)
Inpatient (in the hospital) - detoxification only	35% (after plan deductible)	50% (after plan deductible)	35%	50% (after plan deductible)
OTHER Virtual care	$0	$0	$0	$0
Acupuncture (physician referred)	$55 per visit	40% (after plan deductible)	$55 per visit	40% (after plan deductible)
Certain durable medical equipment (DME) (supplemental and base)	35% [8, 9]	40% (after plan deductible) [8,9]	35% [8, 9]	40% (after plan deductible) [8, 9]

1. Payments are based upon the maximum allowable charge for covered services. Maximum allowable charge means the lesser of: the usual, customary, and reasonable charges; the negotiated rate; or the actual billed charges. The maximum allowable charge may be less than the amount actually billed by the provider. Covered persons may be responsible for payment of any amounts in excess of the maximum allowable charge for a covered service. **2.** 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. **3.** Covered charges incurred toward satisfaction of the out-of-pocket maximum at the non-participating provider tier won't accumulate toward satisfaction of the out-of-pocket maximum on the participating provider tier. Likewise, covered charges incurred toward satisfaction of the out-of-pocket maximum on the participating provider tier won't accumulate toward satisfaction of the out-of-pocket maximum on the non-participating provider tier. For a complete understanding of the out-of-pocket maximum, please refer to your *Certificate of Insurance*. **4.** Insured is responsible for paying the brand-name copay plus the difference in cost between the generic drug and the brand-name drug when the insured requests a brand-name drug and a generic version is available. **5.** Your plan has an open drug formulary; however, select prescription drugs may be excluded from coverage. Please refer to your KPIC *Certificate of Insurance* for a complete list of limitations and exclusions. Regardless of your provider, prescriptions must be filled at a MedImpact pharmacy. Please call MedImpact at 1-800-788-2949 for a participating pharmacy. **6.** 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. **7.** Mail order: Up to a 100-day supply of qualified prescriptions for the cost of a 60-day supply. **8.** Both base and supplemental DME are covered. Supplemental DME is limited to a combined maximum benefit of $2,000 per year for services from the participating providers and non-participating providers, excluding diabetic testing supplies and equipment. **9.** Diabetic equipment and supplies are limited to infusion set and syringe with needle for external insulin pumps, testing strips, lancets, skin barrier, adhesive remover wipes, ands transparent film. Coinsurance amounts are based on actual billed charges and aren't subject to the DME maximum limit of $2,000 per year.

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*.