2027 Plans and Products

CALIFORNIA HEALTH PLANS

Complete Suite plan comparison chart

Use this overview of our Complete Suite portfolio to easily explore a wide range of Kaiser Permanente plans. This interactive tool also enables you to get quick side-by-side comparisons of the different plans we have to offer.

Compare. Select. Administer. It's that easy.

With Complete Suite, we've done the work for you. We've compiled our most popular standard mid-market plans in this interactive plan comparison chart, which allows you to easily compare plan benefits. And with a single request, you can get binding quotes for up to 1,000 members.

This plan comparison chart provides details of our Complete Suite medical plans. Supplemental benefits can be added. Visit our Complete Suite page on **business.kp.org** to see the full list of options that can be paired with our Complete Suite medical plans. Or simply contact your Kaiser Permanente account representative for a quote.

NEW IN THE 2027 COMPLETE SUITE PORTFOLIO

Leaner plan options: We've expanded our Complete Suite portfolio with 6 new plan options that deliver greater affordability and quality coverage at a lower cost. These new additions to our portfolio include 2 HMO plans, 3 deductible HMO plans, and 1 HDHP plan.

Kaiser Permanente Plus™ plans:* The new KP Plus plans give your employees more choices to meet their health care needs at a lower cost than traditional PPO plans. In addition to high-quality care in the Kaiser Permanente network, they can also get care from out-of-network providers for a limited number of doctor visits, outpatient medical services, and prescription fills and refills.

Additional supplemental benefits: We've added 2 new combined chiropractic and acupuncture plans to our Complete Suite portfolio, now available to pair with all HMO, deductible HMO, and POS plan options within the suite.

*Kaiser Permanente Plus is a limited point-of-service (POS) plan with coverage for certain outpatient services and prescriptions from out-of-network providers as described in the *Evidence of Coverage*.

How to compare plans

With our Complete Suite interactive plan comparison chart, you can choose up to 3 plans at a time and get as many comparisons as you'd like.

To get a comparison:

1. Click the **Overview** tab at the top of the page.
2. Check the box next to each plan you'd like to compare, then click the **Compare plans** button at the top-right corner of the page.
3. To remove a plan from your comparison, click the checked box to clear it. To remove all plans selected, click the **Reset** button at the bottom of the page.

You can also get more detailed information about each plan type by clicking the tabs at the top of the page – **HMO, DHMO** (deductible HMO), **HDHP** (high deductible health plan), **POS/PPO** (point-of-service, preferred provider organization), or **KP Plus. Kaiser Permanente Everyday Care** and **Virtual Complete** plan information are included in the DHMO tab. To go back to the plan comparison page at any time, simply click the **Overview** tab at the top-left corner of the page.

How to use this interactive PDF to compare plans

1. Download the interactive PDF to your desktop.
2. Open the PDF with Adobe Reader.

The plan summary highlights the most frequently asked-about benefits and is for illustration purposes only. For a complete description, please refer to the appropriate *Evidence of Coverage* or *Certificate of Insurance* booklet, or contact your broker or Kaiser Permanente account manager.

Information may have changed since date of publication.

→ **READY TO CONNECT?**

Check out our 2027 plans and request a quote from your Kaiser Permanente account representative today.

The HMO tier of the point-of-service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC) underwrites the participating and nonparticipating provider tiers of the POS plan and the PPO plan. KPIC is a subsidiary of KFHP.

2027 Complete Suite plans

Select the plans that you want to compare. You can choose up to 3 at a time.

Plans selected:

HMO | DHMO | HDHP | POS/PPO

Compare plans

HMO plan families NCAL/SCAL plan ID – primary care office visit/hospital inpatient/out-of-pocket maximum		
HMO High[1, 2]	HMO Mid[1, 2]	HMO Low[1, 2]
19353/19354 – $10/$0/$2,000	**19383/19384 –** $20/$500/$3,000	**19403/19404 –** $20/$500/$3,500
19357/19358 – $15/$0/$2,000	**19387/19388 –** $30/$500/$3,000	**19407/19408 –** $20/$500/$3,500
19427/19428 – $20/$250/$2,000	**19391/19392 –** $20/$500/$3,000	**19411/19412 –** $30/$500/$3,500
19431/19432 – $15/$250/$2,000	**19395/19396 –** $25/$500/$3,000	**19415/19416 –** $30/$500/$3,500
19367/19368 – $25/$250/$2,000	**19399/19400 –** $30/$500/$3,000	**19419/19420 –** $40/$750/$3,500
19371/19372 – $20/$500/$2,000		**19423/19424 –** $30/$750/$3,500
19375/19376 – $25/$500/$2,000		**21363/21364 –** $40/$750/$4,000
19379/19380 – $30/$500/$2,000		**21367/21368 –** $50/$1,000/$5,000
		16072/16073[3] – $35/20%/$4,000
		16033/16035[3] – $40/30%/$4,000

Reset

Clear all plans selected

1. HMO Low/Mid/High plans—HMO High, Mid, and Low designations are driven by the plans' out-of-pocket maximum levels. High plans offer the lowest out-of-pocket maximums. Low plans offer the highest out-of-pocket maximums. **2.** Traditional HMO—pay a simple copay for most covered services. **3.** Coinsurance HMO—pay office visit copays; coinsurance for most other services.

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2027 Complete Suite plans

Select the plans that you want to compare. You can choose up to 3 at a time.

Plans selected:

HMO | DHMO | HDHP | POS/PPO

Compare plans

Deductible HMO (DHMO) plan families NCAL/SCAL plan ID – deductible/primary care office visit/hospital inpatient	
Deductible HMO HO[1]	**Deductible HMO XD[2]**
19433/19434 – $250/$20/10%	**19461/19462 –** $250/$20/10%
19437/19438 – $500/$30/15%	**19465/19466 –** $500/$30/20%
19441/19442 – $750/$30/20%	**19469/19470 –** $750/$30/20%
19445/19446 – $1,000/$30/20%	**19473/19474 –** $1,000/$30/20%
19449/19450 – $1,500/$30/20%	**19477/19478 –** $1,000/$30/30%
17678/17679 – $2,000/$30/20%	**19481/19482 –** $2,000/$30/20%
19453/19454 – $1,500/$40/30%	**19485/19486 –** $1,500/$30/20%
19457/19458 – $2,500/$30/20%	**19489/19490 –** $1,500/$40/30%
21371/21372 – $3,500/$50/30%	**19493/19494 –** $2,500/$40/30%
	19497/19498 – $3,000/$40/30%
	19501/19502 – $3,500/$40/30%
	13868/13869 – $4,000/$40/30%

Reset

Clear all plans selected

1. Deductible HMO HO – Most services are covered at a copay or coinsurance. A deductible applies to hospital services, such as inpatient hospital, outpatient surgery, and emergency room services. **2.** Deductible HMO XD – provider office visits and pharmacy are covered at a copay or coinsurance. A deductible applies to most other services.

2027 Complete Suite plans

Select the plans that you want to compare. You can choose up to 3 at a time.

Plans selected:

HMO | DHMO | HDHP | POS/PPO

Compare plans

Deductible HMO (DHMO) plan families NCAL/SCAL plan ID – deductible/primary care office visit/hospital inpatient		
Kaiser Permanente Everyday Care	**Virtual Complete**	**Deductible HMO CDO***
19536/19537 – $2,000/$0/$0	**16019/16020 –** $1,500/$30/20%	**19505/19506 –** $1,000/$20/20%
19540/19541 – $3,000/$0/$0	**13770/13771 –** $2,000/$30/20%	**19509/19510 –** $1,500/$20/20%
19546/19547 – $4,000/$0/$0	**13778/13779 –** $3,000/$40/30%	**19513/19514 –** $2,000/$20/20%
19551/19552 – $2,000/$10/$0		**19517/19518 –** $2,500/$20/20%
19555/19556 – $3,000/$10/$0		**19521/19522 –** $3,000/30%/30%
19560/19561 – $4,000/$10/$0		**19525/19526 –** $3,500/30%/30%
19564/19565 – $5,000/$10/$0		**19529/19530 –** $4,000/30%/30%
19568/19569 – $6,000/$10/$0		**13860/13861 –** $5,000/$50/30%
		13858/13859 – $5,500/$50/40%
		21375/21376 – $6,500/$50/40%

Reset

Clear all plans selected

*Deductible HMO CDO – preventive care is covered at no cost. A deductible applies to most services, including pharmacy.

2027 Complete Suite plans

Select the plans that you want to compare. You can choose up to 3 at a time.

Plans selected:

HMO | DHMO | HDHP | POS/PPO

Compare plans

High Deductible Health Plan (HDHP) NCAL/SCAL plan ID – deductible/primary care office visit/hospital inpatient
HSA-qualified HDHP HMO[1]
TBD – $1,750/10%/10%[2]
TBD – $1,750/$20/$250[2]
TBD – $2,000/$30/$250[2]
TBD – $3,500/$0/$0[2]
TBD – $2,500/$30/$250[2]
TBD – $3,500/$30/30%[2]
14670/14671 – $3,500/$30/30%
14674/14675 – $4,500/$40/40%
13854/13855 – $4,500/40%/40%
13850/13851 – $5,500/$50/40%
21380/21381 – $6,500/$50/40%

Reset

Clear all plans selected

1. HSA-qualified HDHP HMO – all services, except preventive services, are subject to a deductible. **2.** Plan designs are subject to change. Once IRS rules for 2027 HDHPs are available, plan designs may need to change to align with HDHP requirements.

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2027 Complete Suite plans

Select the plans that you want to compare. You can choose up to 3 at a time.

Plans selected: ☐

HMO | DHMO | HDHP | **POS/PPO**

Compare plans

POS/PPO plans NCAL/SCAL plan ID – deductible by tier; office visit by tier	
POS	**POS XA[1]**
☐ **17209/17210 –** $0/$1,000/$2,000; $30/$50/50%	☐ **19587/19588 –** $1,500/$2,500/$6,000; $40/$60/50%
☐ **17213/17214 –** $0/$2,000/$4,000; $30/30%/50%	☐ **19595/19596 –** $2,000/$3,000/$8,000; $40/$60/50%
☐ **19572/19573 –** $0/$2,500/$5,000; $40/$60/50%	☐ **19591/19592 –** $2,500/$4,000/$10,000; $30/$50/50%
☐ **17845/17846 –** $250/$500/$1,000; $20/$40/40%	☐ **19603/19604 –** $2,500/$4,000/$10,000; $20/$40/50%
☐ **17847/17848 –** $500/$1,000/$2,000;$30/$50/50%	☐ **19599/19600 –** $3,500/$5,500/$14,000; $40/$60/50%
☐ **17849/17850 –** $750/$1,500/$3,000;$30/30%/50%	☐ **19607/19608 –** $4,000/$6,000/$16,000; 30%/40%/50%
☐ **17851/17852 –** $1,000/$2,000/$4,000;$30/30%/50%	☐ **19611/19612 –** $6,000/$9,000/$24,000; $30/$50/50%
☐ **19575/19576 –** $1,000/$2,000/$4,000; $30/$50/50%	
POS XA HDHP[2]	**PPO**
☐ **19615/19616 –** $3,500/$5,500/$14,000; $30/$50/50%	☐ **10229/10230 –** $500/$1,000; $20/40%
	☐ **17611/17612 –** $1,000/$2,000; $30/40%
	☐ **17615/17616 –** $1,500/$3,000; $40/50%
	☐ **17619/17620 –** $2,000/$4,000; $30/40%
	☐ **17623/17624 –** $3,000/$6,000; $40/50%
	☐ **19581/19582–** $3,500/$7,000; $40/50%

Reset

Clear all plans selected

1. Payments made toward the satisfaction of the deductible or out-of-pocket maximum in the HMO tier or participating provider tier will cross accumulate and apply to the deductible or out-of-pocket maximum in both tiers. **2.** Payments made toward the satisfaction of the deductible or out-of-pocket maximum in the HMO tier or participating provider tier will cross accumulate and apply to the deductible or out-of-pocket maximum in both tiers. All services, except preventive services, are subject to a deductible.

The HMO tier of the point-of-service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP), while the participating provider and nonparticipating provider tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP.

Compare plans   Plans selected:

Complete Suite category	HMO			
	HMO High[1]	HMO High[1]	HMO High[1]	HMO High[1]
NCAL/SCAL plan ID	19353/19354	19357/19358	19427/19428	19431/19432
Plan deductible (individual/family)	None	None	None	None
Out-of-pocket maximum (individual/family)	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000
Telehealth[2]	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary/specialty care visit	$10/$20	$15/$25	$20/$30	$15/$25
Hospital inpatient (per admission)	No charge	No charge	$250	$250
Outpatient surgery (per procedure)	$100	$100	$100	$100
Emergency care	$200	$200	$200	$200
Prescription drugs				
Generic	$10	$10	$10	$10
Brand	$30	$30	$30	$30
Specialty	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250
Emergency ambulance services (per trip)	$50	$50	$50	$50
Urgent care	$10	$15	$20	$15
CT/PET/MRI (per procedure)	No charge	No charge	$100	$100
Lab/X-ray (per encounter)	No charge	No charge	$10	$10
Durable medical equipment	20%	20%	20%	20%
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Prosthetics and orthotics	No charge	No charge	No charge	No charge

1. Traditional HMO—pay a simple copay for most covered services. **2.** Telehealth—telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	HMO		
	HMO High[1]	HMO High[1]	HMO High[1]
NCAL/SCAL plan ID	19367/19368	19371/19372	19375/19376
Plan deductible (individual/family)	None	None	None
Out-of-pocket maximum (individual/family)	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000
Telehealth[2]	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge
Primary/specialty care visit	$25/$35	$20/$30	$25/$35
Hospital inpatient (per admission)	$250	$500	$500
Outpatient surgery (per procedure)	$100	$150	$150
Emergency care	$200	$200	$200
Prescription drugs			
Generic	$15	$15	$15
Brand	$35	$35	$35
Specialty	20%, not to exceed $250	30%, not to exceed $250	30%, not to exceed $250
Emergency ambulance services (per trip)	$50	$100	$100
Urgent care	$25	$20	$25
CT/PET/MRI (per procedure)	$100	$100	$100
Lab/X-ray (per encounter)	$10	$10	$10
Durable medical equipment	20%	20%	20%
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge
Prosthetics and orthotics	No charge	No charge	No charge

1. Traditional HMO—pay a simple copay for most covered services. **2.** Telehealth—telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	HMO		
	HMO High[1]	HMO Mid[1]	HMO Mid[1]
NCAL/SCAL plan ID	19379/19380	19383/19384	19387/19388
Plan deductible (individual/family)	None	None	None
Out-of-pocket maximum (individual/family)	$2,000/$4,000	$3,000/$6,000	$3,000/$6,000
Telehealth[2]	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge
Primary/specialty care visit	$30/$40	$20/$30	$30/$40
Hospital inpatient (per admission)	$500	$500	$500
Outpatient surgery (per procedure)	$150	$150	$150
Emergency care	$200	$250	$250
Prescription drugs			
Generic	$15	$15	$15
Brand	$35	$35	$35
Specialty	30%, not to exceed $250	30%, not to exceed $250	30%, not to exceed $250
Emergency ambulance services (per trip)	$100	$100	$100
Urgent care	$30	$20	$30
CT/PET/MRI (per procedure)	$100	$100	$100
Lab/X-ray (per encounter)	$10	$10	$10
Durable medical equipment	20%	20%	20%
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge
Prosthetics and orthotics	No charge	No charge	No charge

1. Traditional HMO—pay a simple copay for most covered services. **2.** Telehealth—telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans | Plans selected:

Complete Suite category	HMO			
	HMO Mid[1]	HMO Mid[1]	HMO Mid[1]	HMO Low[1]
NCAL/SCAL plan ID	19391/19392	19395/19396	19399/19400	19403/19404
Plan deductible (individual/family)	None	None	None	None
Out-of-pocket maximum (individual/family)	$3,000/$6,000	$3,000/$6,000	$3,000/$6,000	$3,500/$7,000
Telehealth[2]	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary/specialty care visit	$20/$30	$25/$35	$30/$40	$20/$40
Hospital inpatient (per admission)	$500	$500	$500	$500 per day up to $1,500
Outpatient surgery (per procedure)	$250	$250	$250	$250
Emergency care	$250	$250	$250	$350
Prescription drugs				
Generic	$15	$15	$15	$15
Brand	$35	$35	$35	$35
Specialty	30%, not to exceed $250	30%, not to exceed $250	30%, not to exceed $250	20%, not to exceed $250
Emergency ambulance services (per trip)	$100	$100	$100	$100
Urgent care	$20	$25	$30	$20
CT/PET/MRI (per procedure)	$100	$100	$100	$100
Lab/X-ray (per encounter)	$10	$10	$10	$10
Durable medical equipment	20%	20%	20%	50%
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Prosthetics and orthotics	No charge	No charge	No charge	No charge

1. Traditional HMO—pay a simple copay for most covered services. **2.** Telehealth—telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans   Plans selected:

Complete Suite category	HMO			
	HMO Low[1]	HMO Low[1]	HMO Low[1]	HMO Low[1]
NCAL/SCAL plan ID	19407/19408	19411/19412	19415/19416	19419/19420
Plan deductible (individual/family)	None	None	None	None
Out-of-pocket maximum (individual/family)	$3,500/$7,000	$3,500/$7,000	$3,500/$7,000	$3,500/$7,000
Telehealth[2]	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary/specialty care visit	$20/$40	$30/$40	$30/$40	$40/$50
Hospital inpatient (per admission)	$500 per day up to $1,500	$500 per day up to $1,500	$500 per day	$750 per day up to $2,250
Outpatient surgery (per procedure)	$400	$400	$400	$500
Emergency care	$350	$350	$350	$350
Prescription drugs				
Generic	$15	$15	$15	$15
Brand	$35	$35	$35	$35
Specialty	30%, not to exceed $250	30%, not to exceed $250	30%, not to exceed $250	30%, not to exceed $250
Emergency ambulance services (per trip)	$150	$150	$150	$150
Urgent care	$20	$30	$30	$40
CT/PET/MRI (per procedure)	$100	$100	$100	$100
Lab/X-ray (per encounter)	$10	$10	$10	$10
Durable medical equipment	50%	50%	50%	50%
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Prosthetics and orthotics	No charge	No charge	No charge	No charge

1. Traditional HMO—pay a simple copay for most covered services. **2.** Telehealth—telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	HMO		
	HMO Low[1]	HMO Low[1]	HMO Low[1]
NCAL/SCAL plan ID	19423/19424	21363/21364	21367/21368
Plan deductible (individual/family)	None	None	None
Out-of-pocket maximum (individual/family)	$3,500/$7,000	$4,000/$8,000	$5,000/$10,000
Telehealth[2]	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge
Primary/specialty care visit	$30/$50	$40/$60	$50/$75
Hospital inpatient (per admission)	$750 per day up to $2,250	$750 per day up to $2,250	$1,000 per day up to $3,000
Outpatient surgery (per procedure)	$500	$600	$750
Emergency care	$350	$450	$500
Prescription drugs			
Generic	$15	$15	$15
Brand	$35	$40	$50
Specialty	30%, not to exceed $250	$250	$250
Emergency ambulance services (per trip)	$150	$250	$350
Urgent care	$30	$40	$50
CT/PET/MRI (per procedure)	$100	$250	$500
Lab/X-ray (per encounter)	$10	$15/$20	$25/$30
Durable medical equipment	50%	50%	50%
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge
Prosthetics and orthotics	No charge	No charge	No charge

1. Traditional HMO – pay a simple copay for most covered services. **2.** Telehealth – telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans   Plans selected:

Complete Suite category	HMO	
	HMO Low (Coinsurance)[1]	HMO Low (Coinsurance)[1]
NCAL/SCAL plan ID	16072/16073	16033/16035
Plan deductible (individual/family)	None	None
Out-of-pocket maximum (individual/family)	$4,000/$8,000	$4,000/$8,000
Telehealth[2]	No charge	No charge
Preventive care	No charge	No charge
Primary/specialty care visit	$35/$50	$40/$50
Hospital inpatient (per admission)	20%	30%
Outpatient surgery (per procedure)	20%	30%
Emergency care	20%	30%
Prescription drugs		
Generic	$15	$15
Brand	$40	$40
Specialty	20%, not to exceed $250	30%, not to exceed $250
Emergency ambulance services (per trip)	20%, not to exceed $150	30%, not to exceed $150
Urgent care	$35	$40
CT/PET/MRI (per procedure)	20%, not to exceed $150	30%, not to exceed $150
Lab/X-ray (per encounter)	$15	$15
Durable medical equipment	50%	50%
Fertility services	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge
Prosthetics and orthotics	No charge	No charge

1. Traditional HMO—pay a simple copay for most covered services. **2.** Telehealth—telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans   Plans selected:

Complete Suite category	DHMO		
	Deductible HMO HO[1]	Deductible HMO HO[1]	Deductible HMO HO[1]
NCAL/SCAL plan ID	19433/19434	19437/19438	19441/19442
Plan deductible (individual/family)	$250/$500	$500/$1,000	$750/$1,500
Out-of-pocket maximum (individual/family)	$3,000/$6,000	$3,000/$6,000	$3,000/$6,000
Telehealth[2]	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge
Primary/specialty care visit	$20/$30	$30/$40	$30/$40
Hospital inpatient (per admission)	10% after deductible	15% after deductible	20% after deductible
Outpatient surgery (per procedure)	10% after deductible	15% after deductible	20% after deductible
Emergency care	10% after deductible	15% after deductible	20% after deductible
Prescription drugs			
Generic	$10	$15	$15
Brand	$30	$35	$35
Specialty	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250
Emergency ambulance services (per trip)	10%, not to exceed $150	15%, not to exceed $150	20%, not to exceed $150
Urgent care	$20	$30	$30
CT/PET/MRI (per procedure)	10%, not to exceed $150	15%, not to exceed $150	20%, not to exceed $150
Lab/X-ray (per encounter)	$15	$15	$15
Durable medical equipment	20%	20%	20%
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge
Prosthetics and orthotics	No charge	No charge	No charge

1. Deductible HMO HO—most services are covered at a copay or coinsurance. A deductible applies to hospital services, such as inpatient hospital, outpatient surgery, and emergency room services. **2.** Telehealth—telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	DHMO		
	Deductible HMO HO[1]	Deductible HMO HO[1]	Deductible HMO HO[1]
NCAL/SCAL plan ID	19445/19446	19449/19450	17678/17679
Plan deductible (individual/family)	$1,000/$2,000	$1,500/$3,000	$2,000/$4,000
Out-of-pocket maximum (individual/family)	$3,000/$6,000	$4,000/$8,000	$4,500/$9,000
Telehealth[2]	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge
Primary/specialty care visit	$30/$40	$30/$40	$30/$40
Hospital inpatient (per admission)	20% after deductible	20% after deductible	20% after deductible
Outpatient surgery (per procedure)	20% after deductible	20% after deductible	20% after deductible
Emergency care	20% after deductible	20% after deductible	20% after deductible
Prescription drugs			
Generic	$15	$15	$10
Brand	$35	$35	$30
Specialty	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250
Emergency ambulance services (per trip)	20%, not to exceed $150	20%, not to exceed $150	20%, not to exceed $150
Urgent care	$30	$30	$30
CT/PET/MRI (per procedure)	20%, not to exceed $150	20%, not to exceed $150	20%, not to exceed $150
Lab/X-ray (per encounter)	$15	$15	$10
Durable medical equipment	20%	20%	20%
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge
Prosthetics and orthotics	No charge	No charge	No charge

1. Deductible HMO HO—most services are covered at a copay or coinsurance. A deductible applies to hospital services, such as inpatient hospital, outpatient surgery, and emergency room services. **2.** Telehealth—telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans   Plans selected:

Complete Suite category	DHMO		
	Deductible HMO HO[1]	Deductible HMO HO[1]	Deductible HMO HO[1]
NCAL/SCAL plan ID	19453/19454	19457/19458	21371/21372
Plan deductible (individual/family)	$1,500/$3,000	$2,500/$5,000	$3,500/$7,000
Out-of-pocket maximum (individual/family)	$4,000/$8,000	$6,000/$12,000	$7,000/$14,000
Telehealth[2]	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge
Primary/specialty care visit	$40/$50	$30/$40	$50/$75
Hospital inpatient (per admission)	30% after deductible	20% after deductible	30% after deductible
Outpatient surgery (per procedure)	30% after deductible	20% after deductible	30% after deductible
Emergency care	30% after deductible	20% after deductible	30% after deductible
Prescription drugs			
Generic	$15	$15	$15
Brand	$35	$35	$50
Specialty	20%, not to exceed $250	20%, not to exceed $250	$250
Emergency ambulance services (per trip)	30%, not to exceed $150	20%, not to exceed $150	30%, not to exceed $350
Urgent care	$40	$30	$50
CT/PET/MRI (per procedure)	30%, not to exceed $150	20%, not to exceed $150	30% not to exceed $500
Lab/X-ray (per encounter)	$15	$15	$25/$30
Durable medical equipment	20%	20%	20%
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge
Prosthetics and orthotics	No charge	No charge	No charge

1. Deductible HMO HO—most services are covered at a copay or coinsurance. A deductible applies to hospital services, such as inpatient hospital, outpatient surgery, and emergency room services. **2.** Telehealth—telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	DHMO			
	Deductible HMO XD[1]	Deductible HMO XD[1]	Deductible HMO XD[1]	Deductible HMO XD[1]
NCAL/SCAL plan ID	19461/19462	19465/19466	19469/19470	19473/19474
Plan deductible (individual/family)	$250/$500	$500/$1,000	$750/$1,500	$1,000/$2,000
Out-of-pocket maximum (individual/family)	$3,000/$6,000	$3,000/$6,000	$3,000/$6,000	$3,000/$6,000
Telehealth[2]	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary/specialty care visit	$20/$30	$30/$40	$30/$40	$30/$40
Hospital inpatient (per admission)	10% after deductible	20% after deductible	20% after deductible	20% after deductible
Outpatient surgery (per procedure)	10% after deductible	20% after deductible	20% after deductible	20% after deductible
Emergency care	10% after deductible	20% after deductible	20% after deductible	20% after deductible
Prescription drugs				
Generic	$10	$15	$15	$15
Brand	$30	$35	$35	$35
Specialty	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250
Emergency ambulance services (per trip)	10% after deductible, not to exceed $150	20% after deductible, not to exceed $150	20% after deductible, not to exceed $150	20% after deductible, not to exceed $150
Urgent care	$20	$30	$30	$30
CT/PET/MRI (per procedure)	10% after deductible, not to exceed $150	20% after deductible, not to exceed $150	20% after deductible, not to exceed $150	20% after deductible, not to exceed $150
Lab/X-ray (per encounter)	$15 after deductible	$15 after deductible	$15 after deductible	$15 after deductible
Durable medical equipment	20%	20%	20%	20%
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Prosthetics and orthotics	No charge	No charge	No charge	No charge

1. Deductible HMO XD—provider office visits and pharmacy are covered at a copay or coinsurance. A deductible applies to most other services.
2. Telehealth—telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	DHMO			
	Deductible HMO XD[1]	Deductible HMO XD[1]	Deductible HMO XD[1]	Deductible HMO XD[1]
NCAL/SCAL plan ID	19477/19478	19481/19482	19485/19486	19489/19490
Plan deductible (individual/family)	$1,000/$2,000	$2,000/$4,000	$1,500/$3,000	$1,500/$3,000
Out-of-pocket maximum (individual/family)	$4,000/$8,000	$4,000/$8,000	$4,000/$8,000	$4,000/$8,000
Telehealth[2]	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary/specialty care visit	$30/$40	$30/$40	$30/$40	$40/$50
Hospital inpatient (per admission)	30% after deductible	20% after deductible	20% after deductible	30% after deductible
Outpatient surgery (per procedure)	30% after deductible	20% after deductible	20% after deductible	30% after deductible
Emergency care	30% after deductible	20% after deductible	20% after deductible	30% after deductible
Prescription drugs				
Generic	$15	$15	$15	$15
Brand	$35	$35	$35	$35
Specialty	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250
Emergency ambulance services (per trip)	30% after deductible, not to exceed $150	20% after deductible, not to exceed $150	20% after deductible, not to exceed $150	30% after deductible, not to exceed $150
Urgent care	$30	$30	$30	$40
CT/PET/MRI (per procedure)	30% after deductible, not to exceed $150	20% after deductible, not to exceed $150	20% after deductible, not to exceed $150	30% after deductible, not to exceed $150
Lab/X-ray (per encounter)	$15 after deductible	$15 after deductible	$15 after deductible	$15 after deductible
Durable medical equipment	20%	20%	20%	20%
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Prosthetics and orthotics	No charge	No charge	No charge	No charge

1. Deductible HMO XD—provider office visits and pharmacy are covered at a copay or coinsurance. A deductible applies to most other services.
2. Telehealth—telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	DHMO			
	Deductible HMO XD[1]	Deductible HMO XD[1]	Deductible HMO XD[1]	Deductible HMO XD[1]
NCAL/SCAL plan ID	19493/19494	19497/19498	19501/19502	13868/13869
Plan deductible (individual/family)	$2,500/$5,000	$3,000/$6,000	$3,500/$7,000	$4,000/$8,000
Out-of-pocket maximum (individual/family)	$6,000/$12,000	$6,000/$12,000	$6,500/$13,000	$7,000/$14,000
Telehealth[2]	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary/specialty care visit	$40/$50	$40/$50	$40/$50	$40/$50
Hospital inpatient (per admission)	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Outpatient surgery (per procedure)	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Emergency care	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Prescription drugs				
Generic	$15	$15	$15	$15
Brand	$35	$35	$30	$40
Specialty	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250	30%, not to exceed $250
Emergency ambulance services (per trip)	30% after deductible, not to exceed $150	30% after deductible, not to exceed $150	30% after deductible, not to exceed $150	30% after deductible, not to exceed $150
Urgent care	$40	$40	$40	$40
CT/PET/MRI (per procedure)	30% after deductible, not to exceed $150	30% after deductible, not to exceed $150	30% after deductible, not to exceed $150	30% after deductible, not to exceed $150
Lab/X-ray (per encounter)	$15 after deductible	$15 after deductible	$15 after deductible	$15 after deductible
Durable medical equipment	20%	20%	20%	30%
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Prosthetics and orthotics	No charge	No charge	No charge	No charge

1. Deductible HMO XD – provider office visits and pharmacy are covered at a copay or coinsurance. A deductible applies to most other services.
2. Telehealth – telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	DHMO			
	Kaiser Permanente Everyday Care	Kaiser Permanente Everyday Care	Kaiser Permanente Everyday Care	Kaiser Permanente Everyday Care
NCAL/SCAL plan ID	19536/19537	19540/19541	19546/19547	19551/19552
Plan deductible (individual/family)	$2,000/$4,000	$3,000/$6,000	$4,000/$8,000	$2,000/$4,000
Out-of-pocket maximum (individual/family)	$2,000/$4,000	$3,000/$6,000	$4,000/$8,000	$2,000/$4,000
Telehealth*	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary/specialty care visit	$0	$0	$0	$10
Hospital inpatient (per admission)	$0 after deductible	$0 after deductible	$0 after deductible	$0 after deductible
Outpatient surgery (per procedure)	$0 after deductible	$0 after deductible	$0 after deductible	$0 after deductible
Emergency care	$500	$500	$500	$500
Prescription drugs				
Generic	$0	$0	$0	$10
Brand	$50	$50	$50	$50
Specialty	$250	$250	$250	$250
Emergency ambulance services (per trip)	$500	$500	$500	$500
Urgent care	$0	$0	$0	$10
CT/PET/MRI (per procedure)	$500	$500	$500	$500
Lab/X-ray (per encounter)	Lab: $0 X-ray: $50	Lab: $0 X-ray: $50	Lab: $0 X-ray: $50	Lab: $10 X-ray: $50
Durable medical equipment	50%	50%	50%	50%
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Prosthetics and orthotics	No charge	No charge	No charge	No charge

*Telehealth – telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans   Plans selected:

Complete Suite category	DHMO			
	Kaiser Permanente Everyday Care	Kaiser Permanente Everyday Care	Kaiser Permanente Everyday Care	Kaiser Permanente Everyday Care
NCAL/SCAL plan ID	19555/19556	19560/19561	19564/19565	19568/19569
Plan deductible (individual/family)	$3,000/$6,000	$4,000/$8,000	$5,000/$10,000	$6,000/$12,000
Out-of-pocket maximum (individual/family)	$3,000/$6,000	$4,000/$8,000	$5,000/$10,000	$6,000/$12,000
Telehealth*	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary/specialty care visit	$10	$10	$10	$10
Hospital inpatient (per admission)	$0 after deductible	$0 after deductible	$0 after deductible	$0 after deductible
Outpatient surgery (per procedure)	$0 after deductible	$0 after deductible	$0 after deductible	$0 after deductible
Emergency care	$500	$500	$500	$500
Prescription drugs				
Generic	$10	$10	$10	$10
Brand	$50	$50	$50	$50
Specialty	$250	$250	$250	$250
Emergency ambulance services (per trip)	$500	$500	$500	$500
Urgent care	$10	$10	$10	$10
CT/PET/MRI (per procedure)	$500	$500	$500	$500
Lab/X-ray (per encounter)	Lab: $10 X-ray: $50	Lab: $10 X-ray: $50	Lab: $10 X-ray: $50	Lab: $10 X-ray: $50
Durable medical equipment	50%	50%	50%	50%
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Prosthetics and orthotics	No charge	No charge	No charge	No charge

*Telehealth – telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans   Plans selected:

Complete Suite category	DHMO		
	Virtual Complete	Virtual Complete	Virtual Complete
NCAL/SCAL plan ID	16019/16020	13770/13771	13778/13779
Plan deductible (individual/family)	$1,500/$3,000	$2,000/$4,000	$3,000/$6,000
Out-of-pocket maximum (individual/family)	$4,500/$9,000	$5,000/$10,000	$6,000/$12,000
Telehealth[1]	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge
Primary/specialty care visit	$30 after deductible[2]	$30 after deductible[2]	$40 after deductible[2]
Hospital inpatient (per admission)	20% after deductible	20% after deductible	30% after deductible
Outpatient surgery (per procedure)	20% after deductible	20% after deductible	30% after deductible
Emergency care	20% after deductible	20% after deductible	30% after deductible
Prescription drugs			
Generic	$15	$15	$15
Brand	$30 after deductible	$30 after deductible	$40 after deductible
Specialty	20% after deductible, not to exceed $250	20% after deductible, not to exceed $250	30% after deductible, not to exceed $250
Emergency ambulance services (per trip)	20% after deductible	20% after deductible	30% after deductible
Urgent care	$30 after deductible[2]	$30 after deductible[2]	$40 after deductible[2]
CT/PET/MRI (per procedure)	20% after deductible	20% after deductible	30% after deductible
Lab/X-ray (per encounter)	Lab: $15 X-ray: 20% after deductible	Lab: $15 X-ray: 20% after deductible	Lab: $15 X-ray: 30% after deductible
Durable medical equipment	20%	20%	30%
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge
Prosthetics and orthotics	No charge	No charge	No charge

1. Telehealth – telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers. **2.** Plan deductible doesn't apply to the first 3 visits combined for primary care, urgent care, mental health, and substance use disorder treatment.

Compare plans Plans selected:

Complete Suite category	DHMO		
	Deductible HMO CDO[1]	Deductible HMO CDO[1]	Deductible HMO CDO[1]
NCAL/SCAL plan ID	19505/19506	19509/19510	19513/19514
Plan deductible (individual/family)	$1,000/$2,000	$1,500/$3,000	$2,000/$4,000
Out-of-pocket maximum (individual/family)	$2,000/$4,000	$3,000/$6,000	$4,000/$8,000
Telehealth[2]	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge
Primary/specialty care visit	$20 after deductible	$20 after deductible	$20 after deductible
Hospital inpatient (per admission)	20% after deductible	20% after deductible	20% after deductible
Outpatient surgery (per procedure)	20% after deductible	20% after deductible	20% after deductible
Emergency care	20% after deductible	20% after deductible	20% after deductible
Prescription drugs			
Generic	$15	$15	$10
Brand	$30	$30	$30
Specialty	20% after deductible, not to exceed $250	20% after deductible, not to exceed $250	20% after deductible, not to exceed $250
Emergency ambulance services (per trip)	20% after deductible, not to exceed $150	20% after deductible, not to exceed $150	20% after deductible, not to exceed $150
Urgent care	$20 after deductible	$20 after deductible	$20 after deductible
CT/PET/MRI (per procedure)	20% after deductible, not to exceed $150	20% after deductible, not to exceed $150	20% after deductible, not to exceed $150
Lab/X-ray (per encounter)	$15 after deductible	$15 after deductible	$10 after deductible
Durable medical equipment	20%	20%	20%
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge
Prosthetics and orthotics	No charge	No charge	No charge

1. Deductible HMO CDO – preventive care is covered at no cost. A deductible applies to most services, including pharmacy. **2.** Telehealth – telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	DHMO			
	Deductible HMO CDO[1]	Deductible HMO CDO[1]	Deductible HMO CDO[1]	Deductible HMO CDO[1]
NCAL/SCAL plan ID	19517/19518	19521/19522	19525/19526	19529/19530
Plan deductible (individual/family)	$2,500/$5,000	$3,000/$6,000	$3,500/$7,000	$4,000/$8,000
Out-of-pocket maximum (individual/family)	$5,000/$10,000	$6,000/$12,000	$6,500/$13,000	$7,000/$14,000
Telehealth[2]	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary/specialty care visit	$20 after deductible	30% after deductible	30% after deductible	30% after deductible
Hospital inpatient (per admission)	20% after deductible	30% after deductible	30% after deductible	30% after deductible
Outpatient surgery (per procedure)	20% after deductible	30% after deductible	30% after deductible	30% after deductible
Emergency care	20% after deductible	30% after deductible	30% after deductible	30% after deductible
Prescription drugs				
Generic	$15	30%, not to exceed $50	30%, not to exceed $50	30%, not to exceed $50
Brand	$30	30%, not to exceed $100	30%, not to exceed $100	30%, not to exceed $100
Specialty	20%, after deductible not to exceed $250	30%, after deductible not to exceed $250	30%, after deductible not to exceed $250	30%, after deductible not to exceed $250
Emergency ambulance services (per trip)	20% after deductible, not to exceed $150	30% after deductible	30% after deductible	30% after deductible
Urgent care	$20 after deductible	30% after deductible	30% after deductible	30% after deductible
CT/PET/MRI (per procedure)	20% after deductible, not to exceed $150	30% after deductible	30% after deductible	30% after deductible
Lab/X-ray (per encounter)	$15 after deductible	30% after deductible	30% after deductible	30% after deductible
Durable medical equipment	20%	30%	30%	30%
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Prosthetics and orthotics	No charge	No charge	No charge	No charge

1. Deductible HMO CDO—preventive care is covered at no cost. A deductible applies to most services, including pharmacy. **2.** Telehealth —telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans | Plans selected:

Complete Suite category	DHMO		
	Deductible HMO CDO[1]	Deductible HMO CDO[1]	Deductible HMO CDO[1]
NCAL/SCAL plan ID	13860/13861	13858/13859	21375/21376
Plan deductible (individual/family)	$5,000/$10,000	$5,500/$11,000	$6,500/$13,000
Out-of-pocket maximum (individual/family)	$7,000/$14,000	$7,500/$15,000	$8,500/$17,000
Telehealth[2]	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge
Primary/specialty care visit	$50 after deductible[3]	$50 after deductible[3]	$50 after deductible[3]
Hospital inpatient (per admission)	30% after deductible	40% after deductible	40% after deductible
Outpatient surgery (per procedure)	30% after deductible	40% after deductible	40% after deductible
Emergency care	30% after deductible	40% after deductible	40% after deductible
Prescription drugs			
Generic	$15 after deductible[4]	$15 after deductible[4]	$15 after deductible[4]
Brand	$50 after deductible	40% after deductible, not to exceed $100	40% after deductible, not to exceed $100
Specialty	30% after deductible, not to exceed $250	40% after deductible, not to exceed $250	$250 after deductible
Emergency ambulance services (per trip)	30% after deductible	40% after deductible	40% after deductible
Urgent care	$50 after deductible[3]	$50 after deductible[3]	$50 after deductible[3]
CT/PET/MRI (per procedure)	30% after deductible	40% after deductible	40% after deductible
Lab/X-ray (per encounter)	30% after deductible	40% after deductible	40% after deductible
Durable medical equipment	30%	40%	40%
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge
Prosthetics and orthotics	No charge	No charge	No charge

1. Deductible HMO CDO—preventive care is covered at no cost. A deductible applies to most services, including pharmacy. **2.** Telehealth—telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers. **3.** Plan deductible doesn't apply to the first 3 visits combined for primary care, urgent care, mental health, and substance use disorder treatment. **4.** Supplemental preventive drugs available at a lower cost share and before plan deductible. All other prescriptions are subject to plan deductible.

Compare plans Plans selected:

Complete Suite category	HDHP		
	HSA-qualified HDHP HMO[1]	HSA-qualified HDHP HMO[1]	HSA-qualified HDHP HMO[1]
NCAL/SCAL plan ID	TBD	TBD	TBD
Plan deductible[2]			
Self-only	$1,750	$1,750	$2,000
Family member/family	$3,500/$4,000	$3,500/$4,000	$3,500/$4,500
Out-of-pocket maximum[2]			
Self-only	$4,000	$4,000	$4,000
Family member/family	$4,000/$8,000	$4,000/$8,000	$4,000/$8,000
Telehealth[3]	$0 after deductible	$0 after deductible	$0 after deductible
Preventive care	No charge	No charge	No charge
Primary/specialty care visit	10% after deductible	$20 after deductible	$30/$50 after deductible
Hospital inpatient (per admission)	10% after deductible	$250 after deductible	$250 after deductible
Outpatient surgery (per procedure)	10% after deductible	$150 after deductible	$150 after deductible
Emergency care	10% after deductible	$200 after deductible	$200 after deductible
Prescription drugs			
Generic	$10 after deductible	$10 after deductible	$10 after deductible
Brand	$30 after deductible	$30 after deductible	$30 after deductible
Specialty	20% after deductible, not to exceed $250	20% after deductible, not to exceed $250	20% after deductible, not to exceed $250
Emergency ambulance services (per trip)	10% after deductible	$100 after deductible	30% after deductible, not to exceed $100
Urgent care	10% after deductible	$20 after deductible	$30 after deductible
CT/PET/MRI (per procedure)	10% after deductible	$150 after deductible	$150 after deductible
Lab/X-ray (per encounter)	10% after deductible	$10 after deductible	$10 after deductible
Durable medical equipment	10% after deductible	20% after deductible	20% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge
Prosthetics and orthotics	No charge after deductible	No charge after deductible	No charge after deductible

1. HSA-qualified HDHP HMO—all services, except preventive services, are subject to a deductible. **2.** Plan designs are subject to change. Once IRS rules for 2027 HDHPs are available, plan designs may need to change to align with HDHP requirements. **3.** Telehealth—telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans | Plans selected:

Complete Suite category	HDHP		
	HSA-qualified HDHP HMO[1]	HSA-qualified HDHP HMO[1]	HSA-qualified HDHP HMO[1]
NCAL/SCAL plan ID	TBD	TBD	TBD
Plan deductible[2]			
Self-only	$3,500	$2,500	$3,500
Family member/family	$3,500/$7,000	$3,500/$5,000	$3,500/$7,000
Out-of-pocket maximum[2]			
Self-only	$3,500	$4,600	$5,350
Family member/family	$3,500/$7,000	$4,600/$9,200	$5,350/$10,700
Telehealth[3]	$0 after deductible	$0 after deductible	$0 after deductible
Preventive care	No charge	No charge	No charge
Primary/specialty care visit	$0 after deductible	$30/$50 after deductible	$30/$50 after deductible
Hospital inpatient (per admission)	$0 after deductible	$250 after deductible	30% after deductible
Outpatient surgery (per procedure)	$0 after deductible	$150 after deductible	30% after deductible
Emergency care	$0 after deductible	$200 after deductible	30% after deductible
Prescription drugs			
Generic	$0 after deductible	$10 after deductible	$15 after deductible
Brand	$0 after deductible	$30 after deductible	$30 after deductible
Specialty	$0 after deductible	20% after deductible, not to exceed $250	20% after deductible, not to exceed $250
Emergency ambulance services (per trip)	$0 after deductible	$100 after deductible	30% after deductible, not to exceed $100
Urgent care	$0 after deductible	$30 after deductible	$30 after deductible
CT/PET/MRI (per procedure)	$0 after deductible	$150 after deductible	30% after deductible, not to exceed $150
Lab/X-ray (per encounter)	$0 after deductible	$10 after deductible	$10 after deductible
Durable medical equipment	$0 after deductible	20% after deductible	20% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge
Prosthetics and orthotics	No charge after deductible	No charge after deductible	No charge after deductible

1. HSA-qualified HDHP HMO—all services, except preventive services, are subject to a deductible. **2.** Plan designs are subject to change. Once IRS rules for 2027 HDHPs are available, plan designs may need to change to align with HDHP requirements. **3.** Telehealth—telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans | Plans selected:

Complete Suite category	HDHP		
	HSA-qualified HDHP HMO[1]	HSA-qualified HDHP HMO[1]	HSA-qualified HDHP HMO[1]
NCAL/SCAL plan ID	14670/14671	14674/14675	13854/13855
Plan deductible			
Self-only	$3,500	$4,500	$4,500
Family member/family	$3,500/$7,000	$4,500/$9,000	$4,500/$9,000
Out-of-pocket maximum			
Self-only	$6,000	$6,250	$6,500
Family member/family	$6,000/$12,000	$6,250/$12,500	$6,500/$13,000
Telehealth[2]	$0 after deductible	$0 after deductible	$0 after deductible
Preventive care	No charge	No charge	No charge
Primary/specialty care visit	$30/$50 after deductible	$40/$50 after deductible	40% after deductible
Hospital inpatient (per admission)	30% after deductible	40% after deductible	40% after deductible
Outpatient surgery (per procedure)	30% after deductible	40% after deductible	40% after deductible
Emergency care	30% after deductible	$250 after deductible	40% after deductible
Prescription drugs			
Generic	$15 after deductible	$15 after deductible	30% after deductible, not to exceed $50
Brand	$35 after deductible	$35 after deductible	40% after deductible, not to exceed $100
Specialty	30% after deductible, not to exceed $250	30% after deductible, not to exceed $250	40% after deductible, not to exceed $250
Emergency ambulance services (per trip)	30% after deductible	$250 after deductible	40% after deductible
Urgent care	$30 after deductible	$40 after deductible	40% after deductible
CT/PET/MRI (per procedure)	30% after deductible	40% after deductible, not to exceed $150	40% after deductible
Lab/X-ray (per encounter)	$10 after deductible	40% after deductible	40% after deductible
Durable medical equipment	30% after deductible	40% after deductible	40% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	No charge
Prosthetics and orthotics	No charge after deductible	No charge after deductible	No charge after deductible

1. HSA-qualified HDHP HMO—all services, except preventive services, are subject to a deductible. **2.** Telehealth—telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	HDHP	
	HSA-qualified HDHP HMO[1]	HSA-qualified HDHP HMO[1]
NCAL/SCAL plan ID	13850/13851	21380/21381
Plan deductible Self-only Family member/family	 $5,500 $5,500/$11,000	 $6,500 $6,500/$13,000
Out-of-pocket maximum Self-only Family member/family	 $7,000 $7,000/$14,000	 $8,500 $8,500/$17,000
Telehealth[2]	$0 after deductible	$0 after deductible
Preventive care	No charge	No charge
Primary/specialty care visit	$50 after deductible	$50 after deductible
Hospital inpatient (per admission)	40% after deductible	40% after deductible
Outpatient surgery (per procedure)	40% after deductible	40% after deductible
Emergency care	40% after deductible	40% after deductible
Prescription drugs Generic Brand Specialty	 $15 after deductible[3] 40% after deductible, not to exceed $100 40% after deductible, not to exceed $250	 $15 after deductible[3] 40% after deductible, not to exceed $100 $250 after deductible
Emergency ambulance services (per trip)	40% after deductible	40% after deductible
Urgent care	$50 after deductible	$50 after deductible
CT/PET/MRI (per procedure)	40% after deductible	40% after deductible
Lab/X-ray (per encounter)	40% after deductible	40% after deductible
Durable medical equipment	40% after deductible	40% after deductible
Fertility services	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge
Prosthetics and orthotics	No charge after deductible	No charge after deductible

1. HSA-qualified HDHP HMO—all services, except preventive services, are subject to a deductible. **2.** Telehealth—telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers. **3.** Supplemental preventive drugs available at a lower cost share and before plan deductible.

Compare plans   Plans selected: ☐

Complete Suite category	POS[1]		
NCAL/SCAL plan ID	☐ 17209/17210		
Tier	HMO tier	Participating provider tier	Nonparticipating provider tier
Plan deductible (individual/family)	$0/$0	$1,000/ $2,000	$2,000/ $4,000
Out-of-pocket maximum (individual/family)	$2,000/$4,000	$4,000/$8,000	$8,000/$16,000
Telehealth[2]	No charge	$50	50% after deductible
Preventive care	No charge	No charge	50%
Primary/specialty care visit	$30	$50	50% after deductible
Hospital inpatient (per admission)	$500	$500, then 30% after deductible	$1,000, then 50% after deductible
Outpatient surgery (per procedure)	$250	30% after deductible	50% after deductible
Emergency care	$250	Covered under the HMO tier	Covered under the HMO tier
Prescription drugs			
Generic	$15	$30 preferred, $55 nonpreferred	Not covered
Brand	$35	$45 preferred, $55 nonpreferred	Not covered
Specialty	30%, not to exceed $250	40%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	$150	Covered under the HMO tier	Covered under the HMO tier
Urgent care	$30	30% after deductible	50% after deductible
CT/PET/MRI (per procedure)	$30	$50	50% after deductible
Lab/X-ray (per encounter)	$10	$50	50% after deductible
Durable medical equipment	30%	30% after deductible	50% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	50%
Prosthetics and orthotics	No charge	30% after deductible	50% after deductible

1. The HMO tier of the point-of-service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP), while the participating provider and nonparticipating provider tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP.
2. Telehealth – telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans Plans selected:

Complete Suite category	POS[1]		
NCAL/SCAL plan ID	☐ 17213/17214		
Tier	HMO tier	Participating provider tier	Nonparticipating provider tier
Plan deductible (individual/family)	$0/$0	$2,000/$4,000	$4,000/$8,000
Out-of-pocket maximum (individual/family)	$3,000/$6,000	$6,000/$12,000	$9,000/$18,000
Telehealth[2]	No charge	30% after deductible	50% after deductible
Preventive care	No charge	No charge	50%
Primary/specialty care visit	$30	30% after deductible	50% after deductible
Hospital inpatient (per admission)	$500	$500, then 30% after deductible	$1,000, then 50% after deductible
Outpatient surgery (per procedure)	$250	30% after deductible	50% after deductible
Emergency care	$250	Covered under the HMO tier	Covered under the HMO tier
Prescription drugs			
Generic	$15	$30 preferred, $55 nonpreferred	Not covered
Brand	$35	$45 preferred, $55 nonpreferred	Not covered
Specialty	30%, not to exceed $250	40%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	$150	Covered under the HMO tier	Covered under the HMO tier
Urgent care	$30	30% after deductible	50% after deductible
CT/PET/MRI (per procedure)	$100	30% after deductible	50% after deductible
Lab/X-ray (per encounter)	$10	30% after deductible	50% after deductible
Durable medical equipment	30%	30% after deductible	50% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	50%
Prosthetics and orthotics	No charge	30% after deductible	50% after deductible

1. The HMO tier of the point-of-service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP), while the participating provider and nonparticipating provider tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP.
2. Telehealth – telehealth services include scheduled phone and video visits when appropriate and available.

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Compare plans Plans selected:

Complete Suite category	POS[1]		
NCAL/SCAL plan ID	☐ 19572/19573		
Tier	HMO tier	Participating provider tier	Nonparticipating provider tier
Plan deductible (individual/family)	$0/$0	$2,500/$5,000	$5,000/$10,000
Out-of-pocket maximum (individual/family)	$4,000/$8,000	$5,000/$10,000	$16,000/$32,000
Telehealth[2]	No charge	$60	50% after deductible
Preventive care	No charge	No charge	50%
Primary/specialty care visit	$40	$60	50% after deductible
Hospital inpatient (per admission)	30%	40% after deductible	50% after deductible
Outpatient surgery (per procedure)	30%	40% after deductible	50% after deductible
Emergency care	30%	Covered under the HMO tier	Covered under the HMO tier
Prescription drugs			
Generic	$15	$30 preferred, $60 nonpreferred	Not covered
Brand	$40	$50 preferred, $60 nonpreferred	Not covered
Specialty	30%, not to exceed $250	40%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	30%, not to exceed $150	Covered under the HMO tier	Covered under the HMO tier
Urgent care	$40	40% after deductible	50% after deductible
CT/PET/MRI (per procedure)	30%, not to exceed $150	40% after deductible	50% after deductible
Lab/X-ray (per encounter)	$15	$60	50% after deductible
Durable medical equipment	30%	40% after deductible	50% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	50%
Prosthetics and orthotics	No charge	40% after deductible	50% after deductible

1. The HMO tier of the point-of-service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP), while the participating provider and nonparticipating provider tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP.
2. Telehealth – telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans Plans selected: ☐

Complete Suite category	POS[1]		
NCAL/SCAL plan ID	☐ 17845/17846		
Tier	HMO tier	Participating provider tier	Nonparticipating provider tier
Plan deductible (individual/family)	$250/$500	$500/$1,000	$1,000/$2,000
Out-of-pocket maximum (individual/family)	$3,000/$6,000	$4,500/$9,000	$12,000/$24,000
Telehealth[2]	No charge	$40	40% after deductible
Preventive care	No charge	No charge	40%
Primary/specialty care visit	$20	$40	40% after deductible
Hospital inpatient (per admission)	10% after deductible	$250, then 20% after deductible	$500, then 40% after deductible
Outpatient surgery (per procedure)	10% after deductible	20% after deductible	40% after deductible
Emergency care	$250	Covered under the HMO tier	Covered under the HMO tier
Prescription drugs			
Generic	$10	$20 preferred, $50 nonpreferred	Not covered
Brand	$30	$40 preferred, $50 nonpreferred	Not covered
Specialty	20%, not to exceed $250	30%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	$150	Covered under the HMO tier	Covered under the HMO tier
Urgent care	$20	20% after deductible	40% after deductible
CT/PET/MRI (per procedure)	10% up to $20	$40	40% after deductible
Lab/X-ray (per encounter)	$10	$40	40% after deductible
Durable medical equipment	20%	30% after deductible	50% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	40%
Prosthetics and orthotics	No charge	20% after deductible	40% after deductible

1. The HMO tier of the point-of-service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP), while the participating provider and nonparticipating provider tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP.
2. Telehealth – telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans | Plans selected: ☐

Complete Suite category	POS[1]		
NCAL/SCAL plan ID	☐ 17847/17848		
Tier	HMO tier	Participating provider tier	Nonparticipating provider tier
Plan deductible (individual/family)	$500/$1,000	$1,000/$2,000	$2,000/$4,000
Out-of-pocket maximum (individual/family)	$3,000/$6,000	$4,500/$9,000	$12,000/$24,000
Telehealth[2]	No charge	$50	50% after deductible
Preventive care	No charge	No charge	50%
Primary/specialty care visit	$30	$50	50% after deductible
Hospital inpatient (per admission)	20% after deductible	$500, then 30% after deductible	$1,000, then 50% after deductible
Outpatient surgery (per procedure)	20% after deductible	30% after deductible	50% after deductible
Emergency care	$250	Covered under the HMO tier	Covered under the HMO tier
Prescription drugs			
Generic	$15	$30 preferred, $55 nonpreferred	Not covered
Brand	$35	$45 preferred, $55 nonpreferred	Not covered
Specialty	30%, not to exceed $250	40%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	$150	Covered under the HMO tier	Covered under the HMO tier
Urgent care	$30	30% after deductible	50% after deductible
CT/PET/MRI (per procedure)	20% up to $30	$50	50% after deductible
Lab/X-ray (per encounter)	$10	$50	50% after deductible
Durable medical equipment	20%	30% after deductible	50% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	50%
Prosthetics and orthotics	No charge	30% after deductible	50% after deductible

1. The HMO tier of the point-of-service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP), while the participating provider and nonparticipating provider tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP.
2. Telehealth – telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans   Plans selected: ☐

Complete Suite category	POS[1]		
NCAL/SCAL plan ID	☐ 17849/17850		
Tier	HMO tier	Participating provider tier	Nonparticipating provider tier
Plan deductible (individual/family)	$750/$1,500	$1,500/$3,000	$3,000/$6,000
Out-of-pocket maximum (individual/family)	$3,000/$6,000	$4,500/$9,000	$12,000/$24,000
Telehealth[2]	No charge	30% after deductible	50% after deductible
Preventive care	No charge	No charge	50%
Primary/specialty care visit	$30	30% after deductible	50% after deductible
Hospital inpatient (per admission)	20% after deductible	$500, then 30% after deductible	$1,000, then 50% after deductible
Outpatient surgery (per procedure)	20% after deductible	30% after deductible	50% after deductible
Emergency care	$250	Covered under the HMO tier	Covered under the HMO tier
Prescription drugs			
Generic	$15	$30 preferred, $55 nonpreferred	Not covered
Brand	$35	$45 preferred, $55 nonpreferred	Not covered
Specialty	30%, not to exceed $250	40%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	$150	Covered under the HMO tier	Covered under the HMO tier
Urgent care	$30	30% after deductible	50% after deductible
CT/PET/MRI (per procedure)	20% up to $100	30% after deductible	50% after deductible
Lab/X-ray (per encounter)	$10	30% after deductible	50% after deductible
Durable medical equipment	20%	30% after deductible	50% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	50%
Prosthetics and orthotics	No charge	30% after deductible	50% after deductible

1. The HMO tier of the point-of-service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP), while the participating provider and nonparticipating provider tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP.
2. Telehealth – telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans   Plans selected: ☐

Complete Suite category	POS[1]		
NCAL/SCAL plan ID	☐ 17851/17852		
Tier	HMO tier	Participating provider tier	Nonparticipating provider tier
Plan deductible (individual/family)	$1,000/$2,000	$2,000/$4,000	$4,000/$8,000
Out-of-pocket maximum (individual/family)	$3,000/$6,000	$6,000/$12,000	$12,000/$24,000
Telehealth[2]	No charge	30% after deductible	50% after deductible
Preventive care	No charge	No charge	50%
Primary/specialty care visit	$30	30% after deductible	50% after deductible
Hospital inpatient (per admission)	20% after deductible	$500, then 30% after deductible	$1,000, then 50% after deductible
Outpatient surgery (per procedure)	20% after deductible	30% after deductible	50% after deductible
Emergency care	$250	Covered under the HMO tier	Covered under the HMO tier
Prescription drugs			
Generic	$15	$30 preferred, $55 nonpreferred	Not covered
Brand	$35	$45 preferred, $55 nonpreferred	Not covered
Specialty	30%, not to exceed $250	40%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	$150	Covered under the HMO tier	Covered under the HMO tier
Urgent care	$30	30% after deductible	50% after deductible
CT/PET/MRI (per procedure)	20% up to $100	30% after deductible	50% after deductible
Lab/X-ray (per encounter)	$10	30% after deductible	50% after deductible
Durable medical equipment	30%	30% after deductible	50% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	50%
Prosthetics and orthotics	No charge	30% after deductible	50% after deductible

1. The HMO tier of the point-of-service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP), while the participating provider and nonparticipating provider tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP.
2. Telehealth – telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans Plans selected:

Complete Suite category	POS[1]		
NCAL/SCAL plan ID	☐ 19575/19576		
Tier	HMO tier	Participating provider tier	Nonparticipating provider tier
Plan deductible (individual/family)	$1,000/$2,000	$2,000/$4,000	$4,000/$8,000
Out-of-pocket maximum (individual/family)	$4,000/$8,000	$5,000/$10,000	$16,000/$32,000
Telehealth[2]	No charge	$50	50% after deductible
Preventive care	No charge	No charge	50%
Primary/specialty care visit	$30	$50	50% after deductible
Hospital inpatient (per admission)	30% after deductible	$500, then 40% after deductible	$1,000, then 50% after deductible
Outpatient surgery (per procedure)	30% after deductible	40% after deductible	50% after deductible
Emergency care	30% after deductible	Covered under the HMO tier	Covered under the HMO tier
Prescription drugs			
Generic	$15	$30 preferred, $55 nonpreferred	Not covered
Brand	$35	$45 preferred, $55 nonpreferred	Not covered
Specialty	30%, not to exceed $250	40%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	30% after deductible, not to exceed $150	Covered under the HMO tier	Covered under the HMO tier
Urgent care	$30	40% after deductible	50% after deductible
CT/PET/MRI (per procedure)	30% after deductible	40% after deductible	50% after deductible
Lab/X-ray (per encounter)	$15 after deductible	$50 after deductible	50% after deductible
Durable medical equipment	20%	30% after deductible	50% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	50%
Prosthetics and orthotics	No charge	40% after deductible	50% after deductible

1. The HMO tier of the point-of-service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP), while the participating provider and nonparticipating provider tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP.
2. Telehealth – telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans   Plans selected:

Complete Suite category	POS XA[1]		
NCAL/SCAL plan ID	☐ 19587/19588		
Tier	HMO tier	Participating provider tier	Nonparticipating provider tier
Plan deductible (individual/family)	$1,500/$3,000	$2,500/$5,000	$6,000/$12,000
Out-of-pocket maximum (individual/family)	$4,000/$8,000	$6,000/$12,000	$16,000/$32,000
Telehealth[2]	No charge	$60	50% after deductible
Preventive care	No charge	No charge	50%
Primary/specialty care visit	$40	$60	50% after deductible
Hospital inpatient (per admission)	30% after deductible	$500, then 40% after deductible	$1,000, then 50% after deductible
Outpatient surgery (per procedure)	30% after deductible	40% after deductible	50% after deductible
Emergency care	30% after deductible	Covered under the HMO tier	Covered under the HMO tier
Prescription drugs			
Generic	$15	$30 preferred, $55 nonpreferred	Not covered
Brand	$35	$45 preferred, $55 nonpreferred	Not covered
Specialty	30%, not to exceed $250	40%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	30%, not to exceed $150	Covered under the HMO tier	Covered under the HMO tier
Urgent care	$40	40% after deductible	50% after deductible
CT/PET/MRI (per procedure)	30% after deductible	40% after deductible	50% after deductible
Lab/X-ray (per encounter)	$15	40%	50% after deductible
Durable medical equipment	30% after deductible	40% after deductible	50% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	50%
Prosthetics and orthotics	No charge	40%	50% after deductible

1. The HMO tier of the point-of-service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP), while the participating provider and nonparticipating provider tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP. Payments made toward the satisfaction of the deductible or out-of-pocket maximum in the HMO tier or participating provider tier will cross accumulate and apply to the deductible or out-of-pocket maximum in both tiers. **2.** Telehealth—telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans   Plans selected: ☐

Complete Suite category	POS XA[1]		
NCAL/SCAL plan ID	☐ 19595/19596		
Tier	HMO tier	Participating provider tier	Nonparticipating provider tier
Plan deductible (individual/family)	$2,000/$4,000	$3,000/$6,000	$8,000/$16,000
Out-of-pocket maximum (individual/family)	$4,000/$8,000	$6,000/$12,000	$16,000/$32,000
Telehealth[2]	No charge	$60	50% after deductible
Preventive care	No charge	No charge	50%
Primary/specialty care visit	$40	$60	50% after deductible
Hospital inpatient (per admission)	30% after deductible	$500, then 40% after deductible	$1,000, then 50% after deductible
Outpatient surgery (per procedure)	30% after deductible	40% after deductible	50% after deductible
Emergency care	30% after deductible	Covered under the HMO tier	Covered under the HMO tier
Prescription drugs			
Generic	$15	$30 preferred, $55 nonpreferred	Not covered
Brand	$35	$45 preferred, $55 nonpreferred	Not covered
Specialty	30%, not to exceed $250	40%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	30% after deductible, not to exceed $150	Covered under the HMO tier	Covered under the HMO tier
Urgent care	$40	40% after deductible	50% after deductible
CT/PET/MRI (per procedure)	30% after deductible	40% after deductible	50% after deductible
Lab/X-ray (per encounter)	$15 after deductible	40% after deductible	50% after deductible
Durable medical equipment	30% after deductible	40% after deductible	50% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	50%
Prosthetics and orthotics	No charge	40%	50% after deductible

1. The HMO tier of the point-of-service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP), while the participating provider and nonparticipating provider tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP. Payments made toward the satisfaction of the deductible or out-of-pocket maximum in the HMO tier or participating provider tier will cross accumulate and apply to the deductible or out-of-pocket maximum in both tiers. **2.** Telehealth—telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans Plans selected:

Complete Suite category	POS XA[1]		
NCAL/SCAL plan ID	☐ 19591/19592		
Tier	HMO tier	Participating provider tier	Nonparticipating provider tier
Plan deductible (individual/family)	$2,500/$5,000	$4,000/$8,000	$10,000/$20,000
Out-of-pocket maximum (individual/family)	$6,000/$12,000	$8,000/$16,000	$20,000/$40,000
Telehealth[2]	No charge	$50	50% after deductible
Preventive care	No charge	No charge	50%
Primary/specialty care visit	$30	$50	50% after deductible
Hospital inpatient (per admission)	20% after deductible	$500, then 30% after deductible	$1,000, then 50% after deductible
Outpatient surgery (per procedure)	20% after deductible	30% after deductible	50% after deductible
Emergency care	20% after deductible	Covered under the HMO tier	Covered under the HMO tier
Prescription drugs			
Generic	$15	$30 preferred, $55 nonpreferred	Not covered
Brand	$35	$45 preferred, $55 nonpreferred	Not covered
Specialty	30%, not to exceed $250	40%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	20%, not to exceed $150	Covered under the HMO tier	Covered under the HMO tier
Urgent care	$30	30% after deductible	50% after deductible
CT/PET/MRI (per procedure)	20% after deductible	30% after deductible	50% after deductible
Lab/X-ray (per encounter)	$15	30%	50% after deductible
Durable medical equipment	20% after deductible	30% after deductible	50% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	50%
Prosthetics and orthotics	No charge	30%	50% after deductible

1. The HMO tier of the point-of-service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP), while the participating provider and nonparticipating provider tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP. Payments made toward the satisfaction of the deductible or out-of-pocket maximum in the HMO tier or participating provider tier will cross accumulate and apply to the deductible or out-of-pocket maximum in both tiers. **2.** Telehealth – telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans   Plans selected:

Complete Suite category	POS XA[1]		
NCAL/SCAL plan ID	☐ 19603/19604		
Tier	HMO tier	Participating provider tier	Nonparticipating provider tier
Plan deductible (individual/family)	$2,500/$5,000	$4,000/$8,000	$10,000/$20,000
Out-of-pocket maximum (individual/family)	$5,000/$10,000	$8,000/$16,000	$20,000/$40,000
Telehealth[2]	No charge	$40 after deductible	50% after deductible
Preventive care	No charge	No charge	50%
Primary/specialty care visit	$20 after deductible	$40 after deductible	50% after deductible
Hospital inpatient (per admission)	20% after deductible	$500, then 30% after deductible	$1,000, then 50% after deductible
Outpatient surgery (per procedure)	20% after deductible	30% after deductible	50% after deductible
Emergency care	20% after deductible	Covered under the HMO tier	Covered under the HMO tier
Prescription drugs			
Generic	$15	$30 preferred, $55 nonpreferred	Not covered
Brand	$35	$45 preferred, $55 nonpreferred	Not covered
Specialty	30%, not to exceed $250	40%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	20% after deductible, not to exceed $150	Covered under the HMO tier	Covered under the HMO tier
Urgent care	$20 after deductible	30% after deductible	50% after deductible
CT/PET/MRI (per procedure)	20% after deductible	30% after deductible	50% after deductible
Lab/X-ray (per encounter)	$15 after deductible	$40 after deductible	50% after deductible
Durable medical equipment	20% after deductible	30% after deductible	50% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	50%
Prosthetics and orthotics	No charge	30%	50% after deductible

1. The HMO tier of the point-of-service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP), while the participating provider and nonparticipating provider tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP. Payments made toward the satisfaction of the deductible or out-of-pocket maximum in the HMO tier or participating provider tier will cross accumulate and apply to the deductible or out-of-pocket maximum in both tiers. **2.** Telehealth—telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans   Plans selected: ☐

Complete Suite category	POS XA[1]		
NCAL/SCAL plan ID	☐ 19599/19600		
Tier	HMO tier	Participating provider tier	Nonparticipating provider tier
Plan deductible (individual/family)	$3,500/$7,000	$5,500/$11,000	$14,000/$28,000
Out-of-pocket maximum (individual/family)	$6,500/$13,000	$9,000/$18,000	$26,000/$52,000
Telehealth[2]	No charge	$60	50% after deductible
Preventive care	No charge	No charge	50%
Primary/specialty care visit	$40	$60	50% after deductible
Hospital inpatient (per admission)	30% after deductible	40% after deductible	50% after deductible
Outpatient surgery (per procedure)	30% after deductible	40% after deductible	50% after deductible
Emergency care	30% after deductible	Covered under the HMO tier	Covered under the HMO tier
Prescription drugs			
Generic	$15	$30 preferred, $55 nonpreferred	Not covered
Brand	$35	$45 preferred, $55 nonpreferred	Not covered
Specialty	30%, not to exceed $250	40%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	30% after deductible, not to exceed $150	Covered under the HMO tier	Covered under the HMO tier
Urgent care	$40	40% after deductible	50% after deductible
CT/PET/MRI (per procedure)	30% after deductible	40% after deductible	50% after deductible
Lab/X-ray (per encounter)	$15 after deductible	40% after deductible	50% after deductible
Durable medical equipment	30% after deductible	40% after deductible	50% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	50%
Prosthetics and orthotics	No charge	40%	50% after deductible

1. The HMO tier of the point-of-service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP), while the participating provider and nonparticipating provider tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP. Payments made toward the satisfaction of the deductible or out-of-pocket maximum in the HMO tier or participating provider tier will cross accumulate and apply to the deductible or out-of-pocket maximum in both tiers. **2.** Telehealth—telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans Plans selected:

Complete Suite category	POS XA[1]		
NCAL/SCAL plan ID	☐ 19607/19608		
Tier	HMO tier	Participating provider tier	Nonparticipating provider tier
Plan deductible (individual/family)	$4,000/$8,000	$6,000/$12,000	$16,000/$32,000
Out-of-pocket maximum (individual/family)	$7,000/$14,000	$9,000/$18,000	$28,000/$56,000
Telehealth[2]	No charge	40% after deductible	50% after deductible
Preventive care	No charge	No charge	50%
Primary/specialty care visit	30% after deductible	40% after deductible	50% after deductible
Hospital inpatient (per admission)	30% after deductible	40% after deductible	50% after deductible
Outpatient surgery (per procedure)	30% after deductible	40% after deductible	50% after deductible
Emergency care	30% after deductible	Covered under the HMO tier	Covered under the HMO tier
Prescription drugs			
Generic	30%, not to exceed $50	40% preferred, 40% nonpreferred	Not covered
Brand	30%, not to exceed $100	40% preferred, 40% nonpreferred	Not covered
Specialty	30% after deductible, not to exceed $250	40% after deductible, not to exceed $250	Not covered
Emergency ambulance services (per trip)	30% after deductible	Covered under the HMO tier	Covered under the HMO tier
Urgent care	30% after deductible	40% after deductible	50% after deductible
CT/PET/MRI (per procedure)	30% after deductible	40% after deductible	50% after deductible
Lab/X-ray (per encounter)	30% after deductible	40% after deductible	50% after deductible
Durable medical equipment	30% after deductible	40% after deductible	50% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	50%
Prosthetics and orthotics	No charge	40%	50% after deductible

1. The HMO tier of the point-of-service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP), while the participating provider and nonparticipating provider tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP. Payments made toward the satisfaction of the deductible or out-of-pocket maximum in the HMO tier or participating provider tier will cross accumulate and apply to the deductible or out-of-pocket maximum in both tiers. **2.** Telehealth—telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans   Plans selected: ☐

Complete Suite category	POS XA[1]		
NCAL/SCAL plan ID	☐ 19611/19612		
Tier	HMO tier	Participating provider tier	Nonparticipating provider tier
Plan deductible (individual/family)	$6,000/$12,000	$9,000/$18,000	$24,000/$48,000
Out-of-pocket maximum (individual/family)	$6,000/$12,000	$9,000/$18,000	$24,000/$48,000
Telehealth[2]	No charge	$50	No charge after deductible
Preventive care	No charge	No charge	50%
Primary/specialty care visit	$30	$50	No charge after deductible
Hospital inpatient (per admission)	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient surgery (per procedure)	No charge after deductible	No charge after deductible	No charge after deductible
Emergency care	No charge after deductible	Covered under the HMO tier	Covered under the HMO tier
Prescription drugs			
Generic	$15	$30 preferred, $75 nonpreferred	Not covered
Brand	$50	$65 preferred, $75 nonpreferred	Not covered
Specialty	30%, not to exceed $250	40%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	No charge	Covered under the HMO tier	Covered under the HMO tier
Urgent care	$30	No charge after deductible	No charge after deductible
CT/PET/MRI (per procedure)	No charge after deductible	No charge after deductible	No charge after deductible
Lab/X-ray (per encounter)	$15	$50	No charge after deductible
Durable medical equipment	No charge after deductible	No charge after deductible	No charge after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	50%
Prosthetics and orthotics	No charge	30%	No charge after deductible

1. The HMO tier of the point-of-service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP), while the participating provider and nonparticipating provider tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP. Payments made toward the satisfaction of the deductible or out-of-pocket maximum in the HMO tier or participating provider tier will cross accumulate and apply to the deductible or out-of-pocket maximum in both tiers. **2.** Telehealth—telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans Plans selected:

Complete Suite category	POS XA HDHP[1]		
NCAL/SCAL plan ID	19615/19616		
Tier	HMO tier	Participating provider tier	Nonparticipating provider tier
Plan deductible (individual/family)	$3,500/$7,000	$5,500/$11,000	$14,000/$28,000
Out-of-pocket maximum (individual/family)	$6,000/$12,000	$9,000/$18,000	$24,000/$48,000
Telehealth[2]	No charge after deductible	$50 after deductible	50% after deductible
Preventive care	No charge	No charge	50%
Primary/specialty care visit	$30 after deductible	$50 after deductible	50% after deductible
Hospital inpatient (per admission)	30% after deductible	40% after deductible	50% after deductible
Outpatient surgery (per procedure)	30% after deductible	40% after deductible	50% after deductible
Emergency care	30% after deductible	Covered under the HMO tier	Covered under the HMO tier
Prescription drugs			
Generic	$15 after deductible	$30 preferred after deductible, $55 non-preferred after deductible	Not covered
Brand	$35 after deductible	$45 preferred after deductible, $55 non-preferred after deductible	Not covered
Specialty	30%, not to exceed $250	40% after deductible, not to exceed $250	Not covered
Emergency ambulance services (per trip)	30% after deductible	Covered under the HMO tier	Covered under the HMO tier
Urgent care	$30 after deductible	40% after deductible	50% after deductible
CT/PET/MRI (per procedure)	30% after deductible	40% after deductible	50% after deductible
Lab/X-ray (per encounter)	$15 after deductible	$50 after deductible	50% after deductible
Durable medical equipment	30% after deductible	40% after deductible	50% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	No charge	No charge	50%
Prosthetics and orthotics	No charge after deductible	40% after deductible	50% after deductible

1. The HMO tier of the point-of-service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP), while the participating provider and nonparticipating provider tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP. Payments made toward the satisfaction of the deductible or out-of-pocket maximum in the HMO tier or participating provider tier will cross accumulate and apply to the deductible or out-of-pocket maximum in both tiers. All services, except preventive services, are subject to a deductible.
2. Telehealth – telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans Plans selected:

Complete Suite category	PPO[1]			
NCAL/SCAL plan ID	☐ 10229/10230		☐ 17611/17612	
Tier	Participating provider	Nonparticipating provider	Participating provider	Nonparticipating provider
Plan deductible (individual/family)	\$500/\$1,000	\$1,000/\$2,000	\$1,000/\$2,000	\$2,000/\$4,000
Out-of-pocket maximum (individual/family)	\$3,000/\$6,000	\$6,000/\$12,000	\$3,000/\$6,000	\$6,000/\$12,000
Telehealth[2]	\$20	40%	\$30	40% after deductible
Preventive care	\$0	40%	\$0	40%
Primary/specialty care visit	\$20	40%	\$30	40% after deductible
Hospital inpatient (per admission)	\$250, then 20% after deductible	\$500, then 40% after deductible	\$250, then 20% after deductible	\$500, then 40% after deductible
Outpatient surgery (per procedure)	\$100, then 20% after deductible	\$150, then 40% after deductible	\$100, then 20% after deductible	\$150, then 40% after deductible
Emergency care	\$100, then 20% after deductible	\$100, then 20% after deductible	\$150, then 20% after deductible	\$150, then 20% after deductible
Prescription drugs				
Generic	\$15	Not covered	\$15	Not covered
Brand	\$40	Not covered	\$40	Not covered
Specialty	30%, not to exceed \$250	Not covered	30%, not to exceed \$250	Not covered
Emergency ambulance services (per trip)	40% after deductible	40% after deductible	40% after deductible	40% after deductible
Urgent care	20% after deductible	40% after deductible	\$50	40% after deductible
CT/PET/MRI (per procedure)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Lab/X-ray (per encounter)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Durable medical equipment	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	\$0	40%	\$0	40%
Prosthetics and orthotics	20% after deductible	40% after deductible	20% after deductible	40% after deductible

1. The Kaiser Permanente PPO plan is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc.
2. Telehealth – telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans Plans selected:

Complete Suite category	PPO[1]			
NCAL/SCAL plan ID	☐ 17615/17616		☐ 17619/17620	
Tier	Participating provider	Nonparticipating provider	Participating provider	Nonparticipating provider
Plan deductible (individual/family)	$1,500/$3,000	$3,000/$6,000	$2,000/$4,000	$4,000/$8,000
Out-of-pocket maximum (individual/family)	$4,000/$8,000	$8,000/ $16,000	$4,500/$9,000	$9,000/$18,000
Telehealth[2]	$40	50% after deductible	$30	40% after deductible
Preventive care	$0	50%	$0	40%
Primary/specialty care visit	$40	50% after deductible	$30	40% after deductible
Hospital inpatient (per admission)	$250, then 30% after deductible	$500, then 50% after deductible	$500, then 20% after deductible	$1,000, then 40% after deductible
Outpatient surgery (per procedure)	$100, then 30% after deductible	$150, then 50% after deductible	$100, then 20% after deductible	$150, then 40% after deductible
Emergency care	$150, then 30% after deductible	$150, then 30% after deductible	$150, then 20% after deductible	$150, then 20% after deductible
Prescription drugs				
Generic	$15	Not covered	$15	Not covered
Brand	$40	Not covered	$40	Not covered
Specialty	30%, not to exceed $250	Not covered	30%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	50% after deductible	50% after deductible	40% after deductible	40% after deductible
Urgent care	$60	50% after deductible	$50	40% after deductible
CT/PET/MRI (per procedure)	30% after deductible	50% after deductible	20% after deductible	40% after deductible
Lab/X-ray (per encounter)	30% after deductible	50% after deductible	20% after deductible	40% after deductible
Durable medical equipment	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	$0	50%	$0	40%
Prosthetics and orthotics	30% after deductible	50% after deductible	20% after deductible	40% after deductible

1. The Kaiser Permanente PPO plan is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc.
2. Telehealth – telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans   Plans selected:

Complete Suite category	PPO[1]			
NCAL/SCAL plan ID	☐ 17623/17624		☐ 19581/19582	
Tier	Participating provider	Nonparticipating provider	Participating provider	Nonparticipating provider
Plan deductible (individual/family)	$3,000/$6,000	$6,000/$12,000	$3,500/$7,000	$7,000/$14,000
Out-of-pocket maximum (individual/family)	$6,000/$12,000	$12,000/$24,000	$6,500/$13,000	$13,000/$26,000
Telehealth[2]	$40	50% after deductible	$40	50% after deductible
Preventive care	$0	50%	$0	50%
Primary/specialty care visit	$40	50% after deductible	$40	50% after deductible
Hospital inpatient (per admission)	$500, then 30% after deductible	$1,000, then 50% after deductible	$500, then 30% after deductible	$1,000, then 50% after deductible
Outpatient surgery (per procedure)	$100, then 30% after deductible	$150, then 50% after deductible	$100, then 30% after deductible	$150, then 50% after deductible
Emergency care	$150, then 30% after deductible	$150, then 30% after deductible	$150 copay per visit, then 30% after deductible	$150 copay per visit, then 30% after deductible
Prescription drugs				
Generic	$15	Not covered	$15 for up to a 30-day supply	Not covered
Brand	$40	Not covered	$40 for up to a 30-day supply	Not covered
Specialty	30%, not to exceed $250	Not covered	30%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Urgent care	$60	50% after deductible	$60	50% after deductible
CT/PET/MRI (per procedure)	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Lab/X-ray (per encounter)	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Durable medical equipment	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit	Same as medical benefit
Prenatal care and well-baby visits	$0	50%	$0	50%
Prosthetics and orthotics	30% after deductible	50% after deductible	30% after deductible	50% after deductible

1. The Kaiser Permanente PPO plan is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc.
2. Telehealth – telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans

Plans selected:

Complete Suite category			
NCAL/SCAL plan ID			
Plan deductible Individual (Self-only)/ Family member/Family			
Out-of-pocket maximum Individual (Self-only)/ Family member/Family			
Telehealth			
Preventive care			
Primary/specialty care visit			
Hospital inpatient (per admission)			
Outpatient surgery (per procedure)			
Emergency care			
Prescription drugs Generic Brand Specialty			
Emergency ambulance services (per trip)			
Urgent care			
CT/PET/MRI (per procedure)			
Lab/X-ray (per encounter)			
Durable medical equipment			
Fertility services			
Prenatal care and well-baby visits			
Prosthetics and orthotics			

The plan summary highlights the most frequently asked-about benefits and is for illustration purposes only. For a complete description, please refer to the appropriate *Evidence of Coverage* or *Certificate of Insurance* booklet, or contact your broker or Kaiser Permanente account manager.

Information may have changed since publication.

Start over

Kaiser Permanente Plus™ plans

Offering more affordability than PPO plans, our new **KP Plus** product combines Kaiser Permanente's integrated care delivery system with access to any licensed provider nationwide, giving your employees the option to seek care outside Kaiser Permanente's network.*

In addition to the high-quality care provided within the Kaiser Permanente network, your employees may see out-of-network providers for up to 10 outpatient medical services and 5 prescription fills or refills per year.

KP Plus benefit design summary

Services	KP Plus benefit: Out-of-network coverage
Medical visits Telehealth visit Primary care physician office visit Specialty office visit Outpatient mental health and substance use disorder services Physical therapy, occupational therapy, speech therapy, and labs/X-rays	Generally $20 higher copay than in-network coverage. Includes 10 out-of-network services per member, per year, combined, including preventive care, outpatient medical services, lab, and radiology.
Pharmacy fills Generic Brand Specialty Kaiser Permanente mail-order pharmacy: 90-day supply for 2 copays	$5 to $20 higher copay than in-network coverage. Includes up to 5 out-of-network prescription fills or refills per year. Each prescription fill can be for up to a 30-day supply. You may be asked to pay the full cost for out-of-network prescriptions and submit a claim for reimbursement. Specialty drugs and mail-order pharmacy are not covered out of network.
Hospital inpatient Outpatient surgery Skilled nursing facilities	Not covered out of network

*KP Plus out-of-network coverage is subject to exclusions. For the full list of exclusions, see the *Evidence of Coverage*.

These are 2 sample KP Plus plans.

Complete Suite category	Sample KP Plus plans			
Plan	KP Plus HMO plan		KP Plus DHMO plan	
Network	In network	Out of network	In network	Out of network
Plus benefit		10 visits for medical services 5 pharmacy fills or refills		10 visits for medical services 5 pharmacy fills or refills
Plan deductible (individual/family)	None	None	$1,000/$2,000	None
Out-of-pocket maximum (individual/family)	$2,000/$4,000		$3,000/$6,000	
Telehealth	No charge	$20	No charge	$20
Preventive care	No charge	No charge	No charge	No charge
Primary care visit	$20	$40	$30	$50
Specialty care visit	$30	$50	$40	$60
Hospital inpatient (per admission)	$250 per admit	Not covered	20% after deductible	Not covered
Outpatient surgery (per procedure)	$100	Not covered	20% after deductible	Not covered
Emergency care	$200	Covered under the in-network tier	20% after deductible	Covered under the in-network tier
Prescription drugs				
Generic	$10	$20	$15	$20
Brand	$30	$50	$35	$55
Specialty	20%, not to exceed $250	Not covered	20%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	$50	Covered under the in-network tier	20%, not to exceed $150	Covered under the in-network tier
Urgent care	$20	Covered under the in-network tier*	$30	Covered under the in-network tier*
CT/PET/MRI (per procedure)	$100	Not covered	20% not to exceed $150	Not covered
Lab/X-ray	$10	$30	$15	$35
Durable medical equipment	20%	Not covered	20%	Not covered
Fertility services	Same as medical benefit	Not covered	Same as medical benefit	Not covered
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Prosthetic and orthotics	No charge	Not covered	No charge	Not covered

*Covered under the in-network tier when outside a Kaiser Permanente service area.

Start over

KAISER PERMANENTE®

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