| Product | Plan | Plan Deductible (Individual/Family) | Out-of-Pocket Maximum (Individual/Family) | Primary Care Office Visit | Specialist Office Visit | Inpatient Hospital | Prescription Drugs (Generic/Brand/Specialty) | Available in Covered California and CaliforniaChoice® |
|---|---|---|---|---|---|---|---|---|
| **Copay HMO plans** | Platinum 90 HMO 0/10 + Child Dental Alt | $0/$0 | $3,000/$6,000 | $10 | $20 | $500 per admission | $5<br>$15<br>10% per prescription up to $250 maximum | Yes |
| | Platinum 90 HMO 0/20 + Child Dental | $0/$0 | $4,500/$9,000 | $20 | $30 | $250/day up to 5 days per admission | $5<br>$20<br>10% per prescription up to $250 maximum | Yes |
| | Gold 80 HMO 0/30 + Child Dental Alt | $0/$0 | $7,000/$14,000 | $30 | $35 | $600/day up to 5 days per admission | $15<br>$40<br>20% per prescription up to $250 maximum | Yes |
| **Deductible HMO plans** | Gold 80 HMO 250/3 + Child Dental | $250/$500 | $7,800/$15,600 | $35 | $55 | $600/day up to 5 days per admission (after plan deductible) | $15<br>$40<br>20% per prescription up to $250 maximum | Yes |
| | Gold 80 HMO 1000/40 + Child Dental Alt | $1,000/$2,000 | $7,800/$15,600 | $40 | $60 | $600/day up to 5 days per admission (after plan deductible) | $20<br>$50 (after $250 drug deductible)<br>20% per prescription up to $250 maximum (after $250 drug deductible) | Yes |
| | Silver 70 HMO 1650/55 + Child Dental Alt | $1,650/$3,300 | $8,200/$16,400 | $55 | $80 | 40% (after plan deductible) | $20<br>$75 (after $350 drug deductible)<br>20% per prescription up to $250 maximum (after $350 drug deductible) | Yes |
| | Silver 70 HMO 2100/55 + Child Dental Alt | $2,100/$4,200 | $8,200/$16,400 | $55 | $80 | 45% (after plan deductible) | $20<br>$75 (after $500 drug deductible)<br>20% per prescription up to $250 maximum (after $500 drug deductible) | Yes |
| | Silver 70 HMO 2250/55 + Child Dental | $2,250/$4,500 | $8,200/$16,400 | $55 | $90 | 30% (after plan deductible) | $17<br>$80 (after $300 drug deductible)<br>30% per prescription up to $250 maximum (after $300 drug deductible) | Yes |
| | Silver 70 HMO 2600/55 +Child Dental Alt | $2,600/$5,200 | $8,200/$16,400 | $55 | $80 | 45% (after plan deductible) | $20<br>$75 (after plan deductible)<br>45% per prescription up to $250 maximum (after plan deductible) | Yes |
| | Bronze 60 HMO 5400/60 + Child Dental Alt | $5,400/$10,800 | $8,200/$16,400 | $60 (after plan deductible) | $80 (after plan deductible) | 50% (after plan deductible) | $20<br>50% per prescription up to $500 maximum (after plan deductible)<br>50% per prescription up to $500 maximum (after plan deductible) | Yes |
| | Bronze 60 HMO 6300/65 + Child Dental | $6,300/$12,600 | $8,200/$16,400 | $65 (after plan deductible) | $95 (after plan deductible) | 40% (after plan deductible) | $18 (after $500 drug deductible)<br>40% per prescription up to $500 maximum (after $500 drug deductible)<br>40% per prescription up to $500 maximum (after $500 drug deductible) | Yes |

This is only a summary. It doesn't fully describe benefit coverage for every plan. For complete coverage details, including exclusions, limitations, and plan terms, contact a Kaiser Permanente representative or refer to your service agreement.

*(continues)*

| Product | Plan | Plan Deductible (Individual/Family) | Out-of-Pocket Maximum (Individual/Family) | Primary Care Office Visit | Specialist Office Visit | Inpatient Hospital | Prescription Drugs (Generic/Brand/Specialty) | Available in Covered California and CaliforniaChoice® |
|---|---|---|---|---|---|---|---|---|
| **HSA-qualified High Deductible Health Plans** | Silver 70 HDHP HMO 2500/20% + Child Dental | Self/Individual/Family $2,500/$2,800/$5,000 | $6,850/$13,700 | 20% (after plan deductible) | 20% (after plan deductible) | 20% (after plan deductible) | 20% per prescription up to $250 maximum (after plan deductible) | Yes |
| | Bronze 60 HDHP HMO 7000/0 + Child Dental | $7,000/$14,000 | $7,000/$14,000 | $0 (after plan deductible) | $0 (after plan deductible) | $0 (after plan deductible) | $0 (after plan deductible) | Yes |
| **Deductible HMO with Health Reimbursement Arrangement plan** | Gold 80 HRA HMO 2250/35 + Child Dental | $2,250/$4,500 | $7,800/$15,600 | $35 | $50 | 25% (after plan deductible) | $15<br>$30 (after $100 drug deductible)<br>20% per prescription up to $250 maximum (after $100 drug deductible) | No |
| **PPO plans** | Platinum 90 PPO 0/15 + Child Dental | **In-network:** $0/$0<br>**Out-of-network:** $500/$1,000 | **In-network:** $4,500/$9,000<br>**Out-of-network:** $9,000/$18,000 | **In-network:** $15<br>**Out-of-network:** 30% (after plan deductible) | **In-network:** $30<br>**Out-of-network:** 30% (after plan deductible) | **In-network:** 10%<br>**Out-of-network:** 30% (after plan deductible) | $10<br>$25<br>10% per prescription up to $250 maximum | No |
| | Gold 80 PPO 350/25 + Child Dental | **In-network:** $350/$700<br>**Out-of-network:** $1,000/$2,000 | **In-network:** $7,800/$15,600<br>**Out-of-network:** $15,600/$31,200 | **In-network:** $25<br>**Out-of-network:** 40% (after plan deductible) | **In-network:** $50<br>**Out-of-network:** 40% (after plan deductible) | **In-network:** 20% (after plan deductible)<br>**Out-of-network:** 40% (after plan deductible) | $15<br>$50<br>20% per prescription up to $250 maximum | No |
| | Silver 70 PPO 2250/55 + Child Dental | **In-network:** $2,250/$4,500<br>**Out-of-network:** $4,500/$9,000 | **In-network:** $8,200/$16,400<br>**Out-of-network:** $16,400/$32,800 | **In-network:** $55<br>**Out-of-network:** 40% (after plan deductible) | **In-network:** $90<br>**Out-of-network:** 40% (after plan deductible) | **In-network:** 30% (after plan deductible)<br>**Out-of-network:** 40% (after plan deductible) | $17<br>$80 (after $300 drug deductible)<br>30% per prescription up to $250 maximum (after $300 drug deductible) | No |
| | Bronze 60 PPO 6300/65 + Child Dental | **In-network:** $6,300/$12,600<br>**Out-of-network:** $12,600/$25,200 | **In-network:** $8,200/$16,400<br>**Out-of-network:** $16,400/$32,800 | **In-network:** $65 (after plan deductible)<br>**Out-of-network:** 100% up to out-of-pocket maximum* | **In-network:** $95 (after plan deductible)<br>**Out-of-network:** 100% up to out-of-pocket maximum* | **In-network:** 40% (after plan deductible)<br>**Out-of-network:** 100% up to out-of-pocket maximum* | $18 (after $500 drug deductible)<br>40% per prescription up to $500 maximum (after $500 drug deductible)<br>40% per prescription up to $500 maximum (after $500 drug deductible) | No |

*Even when the deductible is met, members will still pay 100% coinsurance for select benefits until the out-of-pocket maximum has been met. Once the out-of-pocket maximum is met, there is no charge for covered services.
Information may have changed since publication.