Understanding the plans: benefit highlights

The charts on the next few pages show you a sample of each plan's benefits. Review the diagram below to help you understand how to read those charts.

Here's a quick look at how to use the chart

Benefit highlights	KP Kaiser Permanente - Silver 70 HMO Off Exchange
Plan type	**Deductible**
Annual medical deductible (individual/family)	$5,400/$10,800
Annual out-of-pocket maximum (individual/family)	$9,100/$18,200
Benefits	
Virtual care	
Chat, Email, E-visit, Phone, and Video visit	No charge
Preventive care	
Routine physical exam, mammograms, etc.	No charge
Outpatient services (per visit or procedure)	
Primary care office visit	$50
Specialty care office visit	$90
Most X-rays	$95
Most lab tests	$50
MRI, CT, PET	$325
Outpatient surgery	30%
Mental health visit	$50
Inpatient hospital care	
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	30% after deductible
Maternity	
Routine prenatal care visit, first postpartum visit	No charge
Delivery and inpatient well-baby care	30% after deductible
Emergency and urgent care	
Emergency Department visit	$450
Urgent care visit	$50
Prescription drugs (up to a 30-day supply)	
Generic (Tier 1)	$19*
Preferred brand (Tier 2)	$60 after $150 pharmacy deductible*
Non-preferred brand (Tier 2)	$60 after $150 pharmacy deductible*
Specialty (Tier 4)	20% after $150 pharmacy deductible, up to $250 per prescription
Whole health	
Healthy services	Optical promotions† kp2020.org

*Mail order: Up to a 100-day supply of qualified prescriptions for the cost of a 60-day supply.

†Optical promotions and other services shown may be provided by groups other than Kaiser Permanente, and aren't offered or guaranteed under your coverage. Additional fees you pay won't count toward your deductible or out-of-pocket maximum.

KP Offered through Kaiser Permanente

E Offered through the health benefit exchange

Annual deductible

You need to pay this amount before your plan starts helping you pay for most covered services. Under this sample plan, you'd pay the full charges for covered services until you reach $5,400 for yourself or $10,800 for your family. Then you'd start paying copays or coinsurance.

Annual out-of-pocket maximum

This is the most you'll pay for care during the calendar year before your plan starts paying 100% for most covered services. In this example, you'd never pay more than $9,100 for yourself and no more than $18,200 for your family for your copays, coinsurance, and deductible in a calendar year.

Preventive care at no charge

Most preventive care services—including routine physical exams and mammograms—are covered at no charge. Plus, they're not subject to the deductible.

Covered before you reach the deductible

With some services, you'll only pay a copay or coinsurance, regardless of whether you've reached your deductible. Under this plan, primary care visits are covered at a $50 copay—even before you meet your deductible. With our Silver deductible plans, primary care, specialty care, and urgent care visits all are covered before you reach the deductible.

Coinsurance

After reaching your deductible, this is a percentage of the charges that you may pay for covered services. Here, you'd pay 30% of the cost per day for your inpatient hospital care after you reach your deductible. Your plan would pay the rest for the remainder of the calendar year.

Copay

This is the set amount you pay for covered services, usually after you reach your deductible. In this example, you'd start paying a $50 copay for urgent care visits, whether or not you have met your deductible.

KP Offered through Kaiser Permanente

E Offered through the health benefit exchange, Covered California

Financial assistance options with lower copays, coinsurance, and deductibles are available for certain plans, and for Native Alaskans and American Indians on CoveredCA.com.

Benefit highlights	KP Kaiser Permanente - Bronze 60 HMO 8200/0%	KP E Kaiser Permanente - Bronze 60 HDHP HMO	KP E Kaiser Permanente - Bronze 60 HMO
Plan type	**Deductible**	**HSA-qualified**	**Deductible**
Annual medical deductible (individual/family)	$8,200/$16,400	$7,050/$14,100	$6,300/$12,600
Annual out-of-pocket maximum (individual/family)	$8,200/$16,400	$7,050/$14,100	$9,100/$18,200
Benefits			
Virtual care			
Email, E-visit, Phone and Video visit	No charge	Email, E-visit: No charge. Phone and Video visit: No charge after deductible	No charge
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	No charge after deductible	No charge after deductible	First 3 visits $60; then $60 after deductible‡
Specialty care office visit	No charge after deductible	No charge after deductible	First 3 visits $95; then $95 after deductible‡
Most X-rays	No charge after deductible	No charge after deductible	40% after deductible
Most lab tests	No charge after deductible	No charge after deductible	$40
MRI, CT, PET	No charge after deductible	No charge after deductible	40% after deductible
Outpatient surgery	No charge after deductible	No charge after deductible	40% after deductible
Mental health visit	No charge after deductible	No charge after deductible	No charge
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	No charge after deductible	No charge after deductible	40% after deductible
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	No charge after deductible	No charge after deductible	40% after deductible
Emergency and urgent care			
Emergency Department visit	No charge after deductible	No charge after deductible	40% after deductible
Urgent care visit	No charge after deductible	No charge after deductible	First 3 visits $60; then $60 after deductible‡
Prescription drugs (up to a 30-day supply)			
Generic (Tier 1)	$20*	No charge after deductible	$17 after $500 pharmacy deductible*
Preferred brand (Tier 2)	No charge after deductible	No charge after deductible	40% after $500 pharmacy deductible up to $500 per prescription
Non-preferred brand (Tier 2)	No charge after deductible	No charge after deductible	40% after $500 pharmacy deductible up to $500 per prescription
Specialty (Tier 4)	No charge after deductible	No charge after deductible	40% after $500 pharmacy deductible up to $500 per prescription
Whole health			
Healthy services	Optical promotions† kp2020.org	Optical promotions† kp2020.org	Optical promotions† kp2020.org

‡ The Kaiser Permanente Bronze 60 HMO plan includes three office visits for the benefit copay before you reach your deductible. Office visits include primary, specialty, urgent, or outpatient mental health and substance use care.

* Mail order: Up to a 100-day supply of qualified prescriptions for the cost of a 60-day supply.

† Optical promotions and other services shown may be provided by groups other than Kaiser Permanente, and aren't offered or guaranteed under your coverage. Additional fees you pay won't count toward your deductible or out-of-pocket maximum.

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E Offered through the health benefit exchange, Covered California

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Benefit highlights	KP Kaiser Permanente - Silver 70 HDHP HMO 3600/25%	KP Kaiser Permanente - Silver 70 HMO Off Exchange	E Kaiser Permanente - Silver 70 HMO	KP Kaiser Permanente - Silver 70 HMO 2850/50
Plan type	**HSA-qualified**	**Deductible**	**Deductible**	**Deductible**
Annual medical deductible (individual/family)	$3,600/$7,200	$5,400/$10,800	$5,400/$10,800	$2,850/$5,700
Annual out-of-pocket maximum (individual/family)	$7,200/$14,400	$9,100/$18,200	$9,100/$18,200	$8,750/$17,500
Benefits				
Virtual care				
Email, E-visit, Phone and Video visit	Email, E-visit: No charge. Phone and Video visit: No charge after deductible	No charge	No charge	No charge
Preventive care				
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)				
Primary care office visit	25% after deductible	$50	$50	$50
Specialty care office visit	25% after deductible	$90	$90	$80
Most X-rays	25% after deductible	$95	$95	$70 after deductible
Most lab tests	25% after deductible	$50	$50	$30 after deductible
MRI, CT, PET	25% after deductible	$325	$325	$350 after deductible
Outpatient surgery	25% after deductible	30%	30%	35% after deductible
Mental health visit	25% after deductible	$50	$50	$50
Inpatient hospital care				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	25% after deductible	30% after deductible	30% after deductible	35% after deductible
Maternity				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	25% after deductible	30% after deductible	30% after deductible	35% after deductible
Emergency and urgent care				
Emergency Department visit	25% after deductible	$450	$450	$350 after deductible
Urgent care visit	25% after deductible	$50	$50	$50
Prescription drugs (up to a 30-day supply)				
Generic (Tier 1)	25% after deductible, up to $250 per prescription	$19*	$19*	$20*
Preferred brand (Tier 2)	25% after deductible, up to $250 per prescription	$60 after $150 pharmacy deductible*	$60 after $150 pharmacy deductible*	$75 after $450 pharmacy deductible*
Non-preferred brand (Tier 2)	25% after deductible, up to $250 per prescription	$60 after $150 pharmacy deductible*	$60 after $150 pharmacy deductible*	$75 after $450 pharmacy deductible*
Specialty (Tier 4)	25% after deductible, up to $250 per prescription	20% after $150 pharmacy deductible, up to $250 per prescription	20% after $150 pharmacy deductible, up to $250 per prescription	35% after $450 pharmacy deductible, up to $250 per prescription
Whole health				
Healthy services	Optical promotions† kp2020.org	Optical promotions† kp2020.org	Optical promotions† kp2020.org	Optical promotions† kp2020.org

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Benefit highlights	KP E Kaiser Permanente - Gold 80 HMO	KP E Kaiser Permanente - Gold 80 HMO Coinsurance	KP E Kaiser Permanente - Platinum 90 HMO	KP E Kaiser Permanente - Minimum Coverage HMO††
Plan type	**Copayment**	**Copayment**	**Copayment**	**Deductible**
Annual medical deductible (individual/family)	None/None	None/None	None/None	$9,450/$18,900
Annual out-of-pocket maximum (individual/family)	$8,700/$17,400	$8,700/$17,400	$4,500/$9,000	$9,450/$18,900
Benefits				
Virtual care				
Email, E-visit, Phone and Video visit	No charge	No charge	No charge	No charge
Preventive care				
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)				
Primary care office visit	$35	$35	$15	First 3 office visits no charge.*** Additional visits no charge after deductible
Specialty care office visit	$65	$65	$30	No charge after deductible
Most X-rays	$75	$75	$30	No charge after deductible
Most lab tests	$40	$40	$15	No charge after deductible
MRI, CT, PET	$75	25%	$75	No charge after deductible
Outpatient surgery	$170	30%	$95	No charge after deductible
Mental health visit	$35	$35	$15	No charge
Inpatient hospital care				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	$330 per day up to 5 days**	30%	$225 per day up to 5 days**	No charge after deductible
Maternity				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	$330 per day up to 5 days**	30%	$225 per day up to 5 days**	No charge after deductible
Emergency and urgent care				
Emergency Department visit	$350	$350	$150	No charge after deductible
Urgent care visit	$35	$35	$15	First 3 office visits no charge.*** Additional visits no charge after deductible
Prescription drugs (up to a 30-day supply)				
Generic (Tier 1)	$15*	$15*	$7*	No charge after deductible
Preferred brand (Tier 2)	$60*	$60*	$16*	No charge after deductible
Non-preferred brand (Tier 2)	$60*	$60*	$16*	No charge after deductible
Specialty (Tier 4)	20% up to $250 per prescription	20% up to $250 per prescription	10% up to $250 per prescription	No charge after deductible
Whole health				
Healthy services	Optical promotions† kp2020.org	Optical promotions† kp2020.org	Optical promotions† kp2020.org	Optical promotions† kp2020.org

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† Optical promotions and other services shown may be provided by groups other than Kaiser Permanente, and aren't offered or guaranteed under your coverage. Additional fees you pay won't count toward your deductible or out-of-pocket maximum.

** After 5 days, there is no charge for covered services related to the admission.

†† Only applicants younger than age 30, or applicants age 30 and older who provide a certificate from Covered California demonstrating hardship or lack of affordable coverage, may purchase a Minimum Coverage HMO plan.

*** The Kaiser Permanente Minimum Coverage HMO plan includes three office visits at no charge before you reach your deductible. Office visits include primary and urgent care.

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E Offered through the health benefit exchange, Covered California

Cost Share Reduction (CSR) Plans

You must qualify for and enroll in the CSR plans on this page through Covered California.

Benefit highlights	E Kaiser Permanente - Silver 73 HMO	E Kaiser Permanente - Silver 87 HMO	E Kaiser Permanente - Silver 94 HMO
Plan type	**Copayment**	**Copayment**	**Copayment**
Annual medical deductible (individual/family)	None/None	None/None	None/None
Annual out-of-pocket maximum (individual/family)	$6,100/$12,200	$3,000/$6,000	$1,150/$2,300
Benefits			
Virtual care			
Email, E-visit, Phone and Video visit	No charge	No charge	No charge
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	$35	$15	$5
Specialty care office visit	$85	$25	$8
Most X-rays	$95	$40	$8
Most lab tests	$50	$20	$8
MRI, CT, PET	$325	$100	$50
Outpatient surgery	30%	20%	10%
Mental health visit	$35	$15	$5
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	30%	20%	10%
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	30%	20%	10%
Emergency and urgent care			
Emergency Department visit	$350	$150	$50
Urgent care visit	$35	$15	$5
Prescription drugs (up to a 30-day supply)			
Generic (Tier 1)	$15*	$5*	$3*
Preferred brand (Tier 2)	$55*	$25*	$10*
Non-preferred brand (Tier 2)	$55*	$25*	$10*
Specialty (Tier 4)	20% up to $250 per prescription	15% up to $150 per prescription	10% up to $150 per prescription
Whole health			
Healthy services	Optical promotions† kp2020.org	Optical promotions† kp2020.org	Optical promotions† kp2020.org

* Mail order: Up to a 100-day supply of qualified prescriptions for the cost of a 60-day supply.

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