2023 PLANS AND PRODUCTS | CALIFORNIA

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 midmarket plans in this interactive plan comparison chart, which allows you to easily compare core and value-added supplemental plan benefits. And with a single request, you can get binding quotes in a matter of minutes for up to 1,000 members.

Virtual Complete Plans

With a Kaiser Permanente Virtual Complete™ plan, your employees can get affordable, high-quality, personalized care in a variety of ways. They have flexibility in how they choose to get care – taking full advantage of our many no-cost virtual care options while still having access to in-person care whenever they need it.

Other Changes for 2023

- A new Virtual Complete plan was added to the portfolio. Plan ID 14682/14683 has a $6,000 deductible, a $50 copay for primary care (first 3 visits not subject to deductible), and a $15 copay for generic drugs.
- A new DHMO XD plan was added to the portfolio. Plan ID 14678/14679 has a $5,000 deductible, a $40 copay for primary care, a $50 copay for specialty care, and a $15 copay for generic drugs.
- Selected plans in our portfolio have a higher copay for a specialist visit. This was done to maintain affordability and to align with the market.*
- HMO Mid plans 10682/10683 and 10684/10685 have been removed from the Complete Suite portfolio, but are still available for groups to renew on.
- Kaiser Permanente will increase deductibles on six Complete Suite HSA-qualified plans to ensure compliance with the 2023 IRS minimum deductible requirements for HSA-Qualified plans. Some deductibles and out-of-pocket maximums also may increase beyond the new IRS requirements to maintain current proportionality in plan design.

*Impacted groups will be auto-renewed onto plans with the higher specialty visit copay. Groups wishing to remain on their current plan may do so by notifying their KP Account Representative.

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), **CDHC** (consumer-directed health care), or **PPO, Point-of-Service**. To go back to the plan comparison page at any time, simply click the **Overview** tab at the top-left corner of the page.

Are you viewing this on a mobile device?
The interactive features work best when you download to a desktop or use an application such as 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 2023 plans and request a quote from your Kaiser Permanente representative today.

2023 Complete Suite plans

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

Plans selected: ☐

Compare plans

HMO | DHMO | CDHC | POS/PPO

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]
☐ **9961/9962** – $10/$0/$1,500	☐ **9983/9984** – $20/$250/$2,000	☐ **14602/14603** – $20/$250/$3,000 (formerly 9955/9956)
☐ **9965/9966** – $15/$0/$1,500	☐ **9989/9990** – $20/$500/$2,500	☐ **14606/14607** – $30/$250/$3,000 (formerly 9957/9958)
☐ **10003/10004** – $20/$0/$1,500	☐ **9930/9931** – $25/$500/$2,500	☐ **14610/14611** – $20/$500/$3,000 (formerly 9959/9960)
☐ **10650/10652**[3] – $20/$0/$1,500	☐ **9987/9988** – $30/$250/$2,000	☐ **14614/14615** – $30/$500/$3,000 (formerly 9967/9969)
☐ **10011/10012** – $15/$250/$1,500	☐ **9991/9992** – $30/$500/$2,500	☐ **14618/14619** – $30/$500/$3,000 (formerly 9973/9974)
☐ **10015/10016** – $20/$250/$1,500		☐ **9979/9980** – $30/$500/$3,500
☐ **10678/10679**[3] – $20/$250/$1,500		☐ **14622/14623** – $40/$500/$3,000 (formerly 9977/9978)
☐ **10048/10049** – $25/$250/$1,500		☐ **9942/9943** – $40/$500/$3,500
☐ **10052/10053** – $20/$500/$1,500		☐ **13058/13059**[4] – $40/30%/$4,000
☐ **9970/9972** – $25/$500/$1,500		
☐ **10680/10681**[3] – $25/$500/$1,500		
☐ **9981/9982** – $30/$500/$1,500		

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.** Available with optical hardware allowance. **4.** Coinsurance HMO—Pay office visit copays; coinsurance for most other services.

2023 Complete Suite plans

Click on the specific plan name to see your options for that plan.

Plans selected:

HMO | **DHMO** | CDHC | 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]	**Virtual Complete**
8776/8777 – $250/$10/10%	**8796/8797** – $250/$10/10%	**13770/13771** – $2,000/$30/20%
8780/8781 – $500/$20/10%	**8800/8801** – $500/$20/20%	**13774/13775** – $2,500/$40/20%
8782/8783 – $750/$25/20%	**8808/8809** – $750/$25/20%	**13778/13779** – $3,000/$40/30%
13872/13873[4] – $750/$25/20%	**8804/8805** – $1,000/$20/20%	**13782/13783** – $4,000/$50/30%
8784/8785 – $1,000/$20/20%	**8810/8811** – $1,000/$30/30%	**13786/13787** – $5,000/$50/40%
10690/10691[4] – $1,000/$20/20%	**8814/8815** – $1,500/$20/20%	**14682/14683** – $6,000/$50/40%
8790/8791 – $1,500/$20/20%	**8818/8819** – $2,000/$20/20%	**Deductible HMO CDO**[3]
10692/10693[4] – $1,500/$20/20%	**14642/14643** – $1,500/$40/30% (formerly 8816/8817)	**13860/13861** – $5,000/$50/30%
14626/14627 – $2,000/$20/20% (formerly 13046/13047)	**14646/14647** – $2,500/$40/30% (formerly 8820/8821)	**13858/13859** – $5,500/$50/40%
14630/14631 – $2,500/$20/20% (formerly 8794/8795)	**14650/14651** – $3,000/$40/30% (formerly 8822/8823)	
14634/14635 – $1,500/$40/30% (formerly 8792/8793)	**14654/14655** – $3,500/$40/30% (formerly 13864/13865)	
14638/14639 – $3,000/$40/30% (formerly 10208/10209)	**13868/13869** – $4,000/$40/30%	
	14678/14679 – $5,000/$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. **3.** Deductible HMO CDO – Preventive care is covered at no cost. A deductible applies to most services, including pharmacy. **4.** Available with optical hardware allowance.

2023 Complete Suite plans

Click on the specific plan name to see your options for that plan.

Plans selected:

Compare plans

Consumer-directed health care (CDHC) plans NCAL/SCAL plan ID – deductible/primary care office visit/hospital inpatient	
HSA-qualified HDHP HMO[1]	**Deductible HMO plans with HRA**[2]
☐ **14831/14832** – $1,500/$20/$250 (formerly 12189/12191)	☐ **8759/8760** – $1,000/$20/20%
☐ **14833/14834** – $1,500/10%/10% (formerly 12195/12196)	☐ **8761/8762** – $1,500/$20/20%
☐ **14830/14829** – $3,000/$0/$0 (formerly 12168/12167)	☐ **8763/8764** – $2,000/$20/20%
☐ **14658/14659** – $2,000/$30/$250 (formerly 12190/12193)	☐ **8765/8766** – $2,500/$20/20%
☐ **14662/14663** – $2,500/$30/$250 (formerly 11908/11909)	☐ **7823/7824** – $3,000/30%/30%
☐ **14666/14667** – $3,000/$30/30% (formerly 12187/12188)	☐ **13050/13051** – $3,500/30%/30%
☐ **14670/14671** – $3,500/$30/30% (formerly 10426/10427)	☐ **13822/13823** – $4,000/30%/30%
☐ **14674/14675** – $4,500/$40/40% (formerly 13877/13878)	
☐ **13854/13855** – $4,500/40%/40%	
☐ **13850/13851** – $5,500/$50/40%	

Reset

Clear all plans selected

1. HSA-qualified HDHP HMO – All services, except preventive services, are subject to a deductible. **2.** Deductible HMO – Plans with HRA have XP accumulation, meaning pharmacy is covered at a copay or coinsurance. A deductible applies to most other services.

2023 Complete Suite plans

Click on the specific plan name to see your options for that plan.

Plans selected:

Compare plans

HMO | DHMO | CDHC | **POS/PPO**

POS/PPO plans NCAL/SCAL plan ID – deductible by tier/office visit by tier	
POS plans	**PPO plans**
☐ **13886/13887** – $0/$500/$1,000; $20/$35/40%	☐ **13898/13899** – $500/$1,500; $20/40%
☐ **13890/13891** – $0/$1,000/$2,000; $25/$50/40%	☐ **13902/13903** – $750/$1,750; $30/40%
☐ **13894/13895** – $0/$1,500/$3,000; $30/20%/50%	☐ **13906/13907** – $1,000/$2,000; $35/40%
	☐ **13910/13911** – $1,500/$3,000; $35/40%
	☐ **13914/13915** – $2,000/$4,000; $40/50%
	☐ **HSA Qualified 13918/13919** – $3,000/$5,000; $40/40%

Reset

Clear all plans selected

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 Kaiser Foundation Health Plan, Inc.

Compare plans Plans selected:

Complete Suite category	HMO				
	HMO High[1]	HMO High[1]	HMO High[1]	HMO High[1]	HMO High[1]
NCAL/SCAL plan ID	9961/9962	9965/9966	10003/10004	10650/10652	10011/10012
Plan deductible (individual/family)	None	None	None	None	None
Out-of-pocket maximum (individual/family)	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000
Telehealth[2]	No charge	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge	No charge
Primary and specialty care visit	$10	$15	$20	$20	$15
Hospital inpatient (per admission)	No charge	No charge	No charge	No charge	$250 per admit
Outpatient surgery (per procedure)	$10	$15	$20	$20	$15
Emergency care	$100	$100	$100	$100	$100
Prescription drugs					
Generic	$10	$10	$10	$10	$10
Brand	$20	$20	$20	$20	$30
Specialty	20%, not to exceed $250	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	$50
CT/PET/MRI (per procedure)	No charge	No charge	No charge	No charge	No charge
Lab/X-ray (per encounter)	No charge	No charge	No charge	No charge	No charge
Durable medical equipment	20%	20%	20%	20%	20%
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit	Same as medical benefit	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	$150 hardware allowance/12 months	Not covered
Prosthetics and orthotics	No charge	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]	☐ HMO High[1]	☐ HMO High[1]
NCAL/SCAL plan ID	10015/10016	10678/10679	10048/10049	10052/10053	9970/9972
Plan deductible (individual/family)	None	None	None	None	None
Out-of-pocket maximum (individual/family)	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000
Telehealth[2]	No charge	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge	No charge
Primary and specialty care visit	$20	$20	$25	$20	$25
Hospital inpatient (per admission)	$250 per admit	$250 per admit	$250 per admit	$500 per admit	$500 per admit
Outpatient surgery (per procedure)	$20	$20	$25	$100	$100
Emergency care	$100	$100	$100	$100	$100
Prescription drugs					
Generic	$10	$10	$10	$15	$15
Brand	$30	$30	$30	$35	$35
Specialty	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250	30%, not to exceed $250	30%, not to exceed $250
Emergency ambulance services (per trip)	$50	$50	$50	$100	$100
CT/PET/MRI (per procedure)	No charge	No charge	No charge	$50	$50
Lab/X-ray (per encounter)	No charge	No charge	No charge	$10	$10
Durable medical equipment	20%	20%	20%	20%	20%
Fertility services	50%	50%	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge	No charge
Optical hardware	Not covered	$150 hardware allowance/12 months	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	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 Mid[1]	☐ HMO Mid[1]
NCAL/SCAL plan ID	10680/10681	9981/9982	9983/9984	9989/9990
Plan deductible (individual/family)	None	None	None	None
Out-of-pocket maximum (individual/family)	$1,500/$3,000	$1,500/$3,000	$2,000/$4,000	$2,500/$5,000
Telehealth[2]	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary and specialty care visit	$25	$30	$20	$20
Hospital inpatient (per admission)	$500 per admit	$500 per admit	$250 per admit	$500 per admit
Outpatient surgery (per procedure)	$100	$100	$100	$250
Emergency care	$100	$100	$100	$100
Prescription drugs				
Generic	$15	$15	$15	$15
Brand	$35	$35	$30	$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)	$100	$100	$100	$100
CT/PET/MRI (per procedure)	$50	$50	$50	$50
Lab/X-ray (per encounter)	$10	$10	$10	$10
Durable medical equipment	20%	20%	20%	20%
Fertility services	50%	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Optical hardware	$150 hardware allowance/24 months	Not covered	Not covered	Not covered
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 Mid[1]	☐ HMO Mid[1]	☐ HMO Mid[1]	☐ HMO Low[1]
NCAL/SCAL plan ID	9930/9931	9987/9988	9991/9992	14602/14603
Plan deductible (individual/family)	None	None	None	None
Out-of-pocket maximum (individual/family)	$2,500/$5,000	$2,000/$4,000	$2,500/$5,000	$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 and specialty care visit	$25	$30	$30	$20/$40
Hospital inpatient (per admission)	$500 per admit	$250 per admit	$500 per admit	$250 per day up to 3 days
Outpatient surgery (per procedure)	$250	$100	$250	$125
Emergency care	$100	$100	$100	$100
Prescription drugs				
Generic	$15	$15	$15	$10
Brand	$35	$30	$35	$30
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
CT/PET/MRI (per procedure)	$50	$50	$50	$100
Lab/X-ray (per encounter)	$10	$10	$10	$10
Durable medical equipment	20%	20%	20%	50%
Fertility services	50%	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered
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]	☐ HMO Low[1]
NCAL/SCAL plan ID	14606/14607	14610/14611	14614/14615	14618/14619	9979/9980
Plan deductible (individual/family)	None	None	None	None	None
Out-of-pocket maximum (individual/family)	$3,000/$6,000	$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	No charge
Preventive care	No charge	No charge	No charge	No charge	No charge
Primary and specialty care visit	$30/$40	$20/$40	$30/$40	$30/$40	$30/$50
Hospital inpatient (per admission)	$250 per day up to 3 days	$500 per day up to 3 days	$500 per day up to 3 days	$500 per day	$500 per day
Outpatient surgery (per procedure)	$125	$250	$250	$250	$250
Emergency care	$100	$150	$150	$150	$150
Prescription drugs					
Generic	$10	$15	$15	$15	$15
Brand	$30	$35	$35	$35	$35
Specialty	20%, not to exceed $250	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)	$100	$150	$150	$150	$150
CT/PET/MRI (per procedure)	$100	$100	$100	$100	$100
Lab/X-ray (per encounter)	$10	$10	$10	$10	$10
Durable medical equipment	50%	50%	50%	50%	50%
Fertility services	50%	50%	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	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 (Coinsurance)[2]
NCAL/SCAL plan ID	14622/14623	9942/9943	13058/13059
Plan deductible (individual/family)	None	None	None
Out-of-pocket maximum (individual/family)	$3,000/$6,000	$3,500/$7,000	$4,000/$8,000
Telehealth[3]	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge
Primary and specialty care visit	$40/$50	$40/$50	$40/$50
Hospital inpatient (per admission)	$500 per day	$500 per day	30%
Outpatient surgery (per procedure)	$250	$250	30%
Emergency care	$150	$150	30%
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)	$150	$150	$150
CT/PET/MRI (per procedure)	$100	$100	30%, not to exceed $150
Lab/X-ray (per encounter)	$10	$10	$15
Durable medical equipment	50%	50%	50%
Fertility services	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	No charge	No charge

1. Traditional HMO—Pay a simple copay for most covered services. **2.** Coinsurance HMO—Pay office visit copays; coinsurance for most other services. **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	DHMO			
	☐ Deductible HMO HO[1]	☐ Deductible HMO HO[1]	☐ Deductible HMO HO[1]	☐ Deductible HMO HO[1]
NCAL/SCAL plan ID	8776/8777	8780/8781	8782/8783	13872/13873
Plan deductible (individual/family)	$250/$500	$500/$1,000	$750/$1,500	$750/$1,500
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 and specialty care visit	$10	$20	$25	$25
Hospital inpatient (per admission)	10% after deductible	10% after deductible	20% after deductible	20% after deductible
Outpatient surgery (per procedure)	10% after deductible	10% after deductible	20% after deductible	20% after deductible
Emergency care	10% after deductible	10% after deductible	20% after deductible	20% after deductible
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)	$150	$150	$150	$150
CT/PET/MRI (per procedure)	10%, not to exceed $150	10%, not to exceed $150	20%, not to exceed $150	20%, not to exceed $150
Lab/X-ray (per encounter)	$10	$10	$10	$10
Durable medical equipment	20%	20%	20%	20%
Fertility services	50%	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	$150 hardware allowance/24 months
Prosthetics and orthotics	No charge	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]	☐ Deductible HMO HO[1]	☐ Deductible HMO HO[1]
NCAL/SCAL plan ID	8784/8785	10690/10691	8790/8791	10692/10693	14626/14627
Plan deductible (individual/family)	$1,000/$2,000	$1,000/$2,000	$1,500/$3,000	$1,500/$3,000	$2,000/$4,000
Out-of-pocket maximum (individual/family)	$3,000/$6,000	$3,000/$6,000	$4,000/$8,000	$4,000/$8,000	$4,500/$9,000
Telehealth[2]	No charge	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge	No charge
Primary and specialty care visit	$20	$20	$20	$20	$20/$40
Hospital inpatient (per admission)	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Outpatient surgery (per procedure)	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Emergency care	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Prescription drugs					
Generic	$10	$10	$10	$10	$10
Brand	$30	$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	20%, not to exceed $250
Emergency ambulance services (per trip)	$150	$150	$150	$150	$150
CT/PET/MRI (per procedure)	20%, not to exceed $150	20%, not to exceed $150	20%, not to exceed $150	20%, not to exceed $150	20%, not to exceed $150
Lab/X-ray (per encounter)	$10	$10	$10	$10	$10
Durable medical equipment	20%	20%	20%	20%	20%
Fertility services	50%	50%	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge	No charge
Optical hardware	Not covered	$150 hardware allowance/24 months	Not covered	$130 hardware allowance/24 months	Not covered
Prosthetics and orthotics	No charge	No charge	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	14630/14631	14634/14635	14638/14639
Plan deductible (individual/family)	$2,500/$5,000	$1,500/$3,000	$3,000/$6,000
Out-of-pocket maximum (individual/family)	$5,000/$10,000	$4,000/$8,000	$6,000/$12,000
Telehealth[2]	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge
Primary and specialty care visit	$20/$40	$40/$50	$40/$50
Hospital inpatient (per admission)	20% after deductible	30% after deductible	30% after deductible
Outpatient surgery (per procedure)	20% after deductible	30% after deductible	30% after deductible
Emergency care	20% after deductible	30% after deductible	30% after deductible
Prescription drugs			
Generic	$10	$10	$10
Brand	$30	$30	$30
Specialty	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250
Emergency ambulance services (per trip)	$150	$150	$150
CT/PET/MRI (per procedure)	20%, not to exceed $150	30%, not to exceed $150	30%, not to exceed $150
Lab/X-ray (per encounter)	$10	$15	$15
Durable medical equipment	20%	20%	20%
Fertility services	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered
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	8796/8797	8800/8801	8808/8809	8804/8805
Plan deductible (individual/family)	$250/$500	$500/$1,000	$750/$1,500	$1,000/$2,000
Out-of-pocket maximum (individual/family)	$2,500/$5,000	$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 and specialty care visit	$10	$20	$25	$20
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	$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)	$150 after deductible	$150 after deductible	$150 after deductible	$150 after deductible
CT/PET/MRI (per procedure)	10% not to exceed $150, after deductible	20% not to exceed $150, after deductible	20% not to exceed $150, after deductible	20% not to exceed $150, after deductible
Lab/X-ray (per encounter)	$10 after deductible	$10 after deductible	$10 after deductible	$10 after deductible
Durable medical equipment	20%	20%	20%	20%
Fertility services	50%	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered
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	8810/8811	8814/8815	8818/8819	14642/14643
Plan deductible (individual/family)	$1,000/$2,000	$1,500/$3,000	$2,000/$4,000	$1,500/$3,000
Out-of-pocket maximum (individual/family)	$3,000/$6,000	$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 and specialty care visit	$30	$20	$20	$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	$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)	$150 after deductible	$150 after deductible	$150 after deductible	$150 after deductible
CT/PET/MRI (per procedure)	30% not to exceed $150, after deductible	20% not to exceed $150, after deductible	20% not to exceed $150, after deductible	30% not to exceed $150, after deductible
Lab/X-ray (per encounter)	$10 after deductible	$10 after deductible	$10 after deductible	$15 after deductible
Durable medical equipment	20%	20%	20%	20%
Fertility services	50%	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered
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	14646/14647	14650/14651	14654/14655	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)	$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 and 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	$10	$10	$10	$15
Brand	$30	$30	$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)	$150 after deductible	$150 after deductible	$150 after deductible	$150 after deductible
CT/PET/MRI (per procedure)	30% not to exceed $150, after deductible	30% not to exceed $150, after deductible	30% not to exceed $150, after deductible	30% not to exceed $150, after deductible
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	50%	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered
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]	☐ Virtual Complete	☐ Virtual Complete	☐ Virtual Complete	☐ Virtual Complete
NCAL/SCAL plan ID	14678/14679	13770/13771	13774/13775	13778/13779	13782/13783
Plan deductible (individual/family)	$5,000/$10,000	$2,000/$4,000	$2,500/$5,000	$3,000/$6,000	$4,000/$8,000
Out-of-pocket maximum (individual/family)	$8,000/$16,000	$5,000/$10,000	$5,500/$11,000	$6,000/$12,000	$7,000/$14,000
Telehealth[2]	No charge	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge	No charge
Primary and specialty care visit	$40/$50	$30 after deductible[3]	$40 after deductible[3]	$40 after deductible[3]	$50 after deductible[3]
Hospital inpatient (per admission)	30% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Outpatient surgery (per procedure)	30% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Emergency care	30% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Prescription drugs					
Generic	$15	$15	$15	$15	$15
Brand	$40	$30 after deductible	$40 after deductible	$40 after deductible	$50 after deductible
Specialty	30%, not to exceed $250	20% not to exceed $250, after deductible	20% not to exceed $250, after deductible	30% not to exceed $250, after deductible	30% not to exceed $250, after deductible
Emergency ambulance services (per trip)	$150 after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
CT/PET/MRI (per procedure)	30% not to exceed $150, after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Lab/X-ray (per encounter)	$15 after deductible	Lab: $15 no ded X-ray: 20% after deductible	Lab: $15 no ded X-Ray: 20% after deductible	Lab: $15 no ded X-Ray: 30% after deductible	Lab: $15 no ded X-Ray: 30% after deductible
Durable medical equipment	30%	20%	20%	30%	30%
Fertility services	50%	50%	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	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. **3.** 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			
	☐ Virtual Complete	☐ Virtual Complete	☐ Deductible HMO CDO[1]	☐ Deductible HMO CDO[1]
NCAL/SCAL plan ID	13786/13787	14682/14683	13860/13861	13858/13859
Plan deductible (individual/family)	$5,000/$10,000	$6,000/$12,000	$5,000/$10,000	$5,500/$11,000
Out-of-pocket maximum (individual/family)	$8,000/$16,000	$8,000/$16,000	$7,000/$14,000	$7,500/$15,000
Telehealth[2]	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary and specialty care visit	$50 after deductible[3]	$50 after deductible[3]	$50 after deductible[3]	$50 after deductible[3]
Hospital inpatient (per admission)	40% after deductible	40% after deductible	30% after deductible	40% after deductible
Outpatient surgery (per procedure)	40% after deductible	40% after deductible	30% after deductible	40% after deductible
Emergency care	40% after deductible	40% after deductible	30% after deductible	40% after deductible
Prescription drugs				
Generic	$15	$15	$15 after deductible[4]	$15 after deductible[4]
Brand	$50 after deductible	$50 after deductible	$50 after deductible	40% not to exceed $100, after deductible
Specialty	40% not to exceed $250, after deductible	40% not to exceed $250, after deductible	30% not to exceed $250, after deductible	40% not to exceed $250, after deductible
Emergency ambulance services (per trip)	40% after deductible	40% after deductible	30% after deductible	40% after deductible
CT/PET/MRI (per procedure)	40% after deductible	40% after deductible	30% after deductible	40% after deductible
Lab/X-ray (per encounter)	Lab: $15 no ded X-Ray: 40% after deductible	Lab: $15 no ded X-Ray: 40% after deductible	30% after deductible	40% after deductible
Durable medical equipment	40%	40%	30%	40%
Fertility services	50%	50%	Not covered	Not covered
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered
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. **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	CDHC		
	☐ HSA-qualified HDHP HMO[1]	☐ HSA-qualified HDHP HMO[1]	☐ HSA-qualified HDHP HMO[1]
NCAL/SCAL plan ID	14831/14832	14833/14834	14830/14829
Plan deductible			
Self-only	$1,500	$1,500	$3,000
Family member/family	$3,000/$3,000	$3,000/$3,000	$3,000/$6,000
Out-of-pocket maximum			
Self-only	$3,000	$3,000	$3,000
Family member/family	$3,000/$6,000	$3,000/$6,000	$3,000/$6,000
Telehealth[2]	$0 after deductible	$0 after deductible	$0 after deductible
Preventive care	No charge	No charge	No charge
Primary and specialty care visit	$20 after deductible	10% after deductible	$0 after deductible
Hospital inpatient (per admission)	$250 after deductible	10% after deductible	$0 after deductible
Outpatient surgery (per procedure)	$150 after deductible	10% after deductible	$0 after deductible
Emergency care	$100 after deductible	10% after deductible	$0 after deductible
Prescription drugs			
Generic	$10 after deductible	$10 after deductible	$0 after deductible
Brand	$30 after deductible	$30 after deductible	$0 after deductible
Specialty	20% not to exceed $250, after deductible	20% not to exceed $250, after deductible	$0 after deductible
Emergency ambulance services (per trip)	$100 after deductible	10% after deductible	$0 after deductible
CT/PET/MRI (per procedure)	$150 after deductible	10% after deductible	$0 after deductible
Lab/X-ray (per encounter)	$10 after deductible	10% after deductible	$0 after deductible
Durable medical equipment	20% after deductible	10% after deductible	$0 after deductible
Fertility services	Not covered	Not covered	Not covered
Prenatal care and well-baby visits	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered
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	CDHC		
	☐ HSA-qualified HDHP HMO[1]	☐ HSA-qualified HDHP HMO[1]	☐ HSA-qualified HDHP HMO[1]
NCAL/SCAL plan ID	14658/14659	14662/14663	14666/14667
Plan deductible			
Self-only	$2,000	$2,500	$3,000
Family member/family	$3,000/$4,000	$3,000/$5,000	$3,000/$6,000
Out-of-pocket maximum			
Self-only	$3,500	$4,500	$5,250
Family member/family	$3,500/$7,000	$4,500/$9,000	$5,250/$10,500
Telehealth[2]	$0 after deductible	$0 after deductible	$0 after deductible
Preventive care	No charge	No charge	No charge
Primary and specialty care visit	$30/$50 after deductible	$30/$50 after deductible	$30/$50 after deductible
Hospital inpatient (per admission)	$250 after deductible	$250 after deductible	30% after deductible
Outpatient surgery (per procedure)	$150 after deductible	$150 after deductible	30% after deductible
Emergency care	$100 after deductible	$100 after deductible	30% after deductible
Prescription drugs			
Generic	$10 after deductible	$10 after deductible	$15 after deductible
Brand	$30 after deductible	$30 after deductible	$30 after deductible
Specialty	20% not to exceed $250, after deductible	20% not to exceed $250, after deductible	20% not to exceed $250, after deductible
Emergency ambulance services (per trip)	$100 after deductible	$100 after deductible	$100 after deductible
CT/PET/MRI (per procedure)	$150 after deductible	$150 after deductible	30% not to exceed $150, after deductible
Lab/X-ray (per encounter)	$10 after deductible	$10 after deductible	$10 after deductible
Durable medical equipment	20% after deductible	20% after deductible	20% after deductible
Fertility services	Not covered	Not covered	Not covered
Prenatal care and well-baby visits	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered
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	CDHC			
	☐ HSA-qualified HDHP HMO[1]	☐ 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	13850/13851
Plan deductible				
Self-only	$3,500	$4,500	$4,500	$5,500
Family member/family	$3,500/$7,000	$4,500/$9,000	$4,500/$9,000	$5,500/$11,000
Out-of-pocket maximum				
Self-only	$6,000	$6,250	$6,500	$7,000
Family member/family	$6,000/$12,000	$6,250/$12,500	$6,500/$13,000	$7,000/$14,000
Telehealth[2]	$0 after deductible	$0 after deductible	$0 after deductible	$0 after deductible
Preventive care	No charge	No charge	No charge	No charge
Primary and specialty care visit	$30/$50 after deductible	$40/$50 after deductible	40% after deductible	$50 after deductible
Hospital inpatient (per admission)	30% after deductible	40% after deductible	40% after deductible	40% after deductible
Outpatient surgery (per procedure)	30% after deductible	40% after deductible	40% after deductible	40% after deductible
Emergency care	30% after deductible	$250 after deductible	40% after deductible	40% after deductible
Prescription drugs				
Generic	$15 after deductible	$15 after deductible	30% not to exceed $50, after deductible	$15 after deductible[3]
Brand	$35 after deductible	$35 after deductible	40% not to exceed $100, after deductible	40% not to exceed $100, after deductible
Specialty	30% not to exceed $250, after deductible	30% not to exceed $250, after deductible	40% not to exceed $250, after deductible	40% not to exceed $250, after deductible
Emergency ambulance services (per trip)	30% after deductible	40% after deductible	40% after deductible	40% after deductible
CT/PET/MRI (per procedure)	30% after deductible	40% not to exceed $150, after deductible	40% after deductible	40% after deductible
Lab/X-ray (per encounter)	$10 after deductible	40% after deductible	40% after deductible	40% after deductible
Durable medical equipment	30% after deductible	40% after deductible	40% after deductible	40% after deductible
Fertility services	Not covered	Not covered	Not covered	Not covered
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge after deductible	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. **3.** Supplemental preventive drugs available at a lower cost share and before plan deductible.

Compare plans Plans selected:

Complete Suite category	CDHC			
	☐ DHMO with HRA[1]	☐ DHMO with HRA[1]	☐ DHMO with HRA[1]	☐ DHMO with HRA[1]
NCAL/SCAL plan ID	8759/8760	8761/8762	8763/8764	8765/8766
Plan deductible (individual/family)	$1,000/$2,000	$1,500/$3,000	$2,000/$4,000	$2,500/$5,000
Out-of-pocket maximum (individual/family)	$2,000/$4,000	$3,000/$6,000	$4,000/$8,000	$5,000/$10,000
Telehealth[2]	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary and specialty care visit	$20 after deductible	$20 after deductible	$20 after deductible	$20 after deductible
Hospital inpatient (per admission)	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Outpatient surgery (per procedure)	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Emergency care	20% after deductible	20% after deductible	20% after deductible	20% after deductible
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)	$150 after deductible	$150 after deductible	$150 after deductible	$150 after deductible
CT/PET/MRI (per procedure)	20% not to exceed $150, after deductible	20% not to exceed $150, after deductible	20% not to exceed $150, after deductible	20% not to exceed $150, after deductible
Lab/X-ray (per encounter)	$10 after deductible	$10 after deductible	$10 after deductible	$10 after deductible
Durable medical equipment	20%	20%	20%	20%
Fertility services	50%	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	No charge	No charge	No charge

1. Deductible HMO – Plans with HRA have XP accumulation, meaning pharmacy is 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	CDHC		
	☐ DHMO with HRA[1]	☐ DHMO with HRA[1]	☐ DHMO with HRA[1]
NCAL/SCAL plan ID	7823/7824	13050/13051	13822/13823
Plan deductible (individual/family)	$3,000/$6,000	$3,500/$7,000	$4,000/$8,000
Out-of-pocket maximum (individual/family)	$6,000/$12,000	$6,500/$13,000	$7,000/$14,000
Telehealth[2]	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge
Primary and specialty care visit	30% after deductible	30% after deductible	30% after deductible
Hospital inpatient (per admission)	30% after deductible	30% after deductible	30% after deductible
Outpatient surgery (per procedure)	30% after deductible	30% after deductible	30% after deductible
Emergency care	30% after deductible	30% after deductible	30% after deductible
Prescription drugs			
Generic	30%, not to exceed $50	30%, not to exceed $50	30%, not to exceed $50
Brand	30%, not to exceed $100	30%, not to exceed $100	30%, not to exceed $100
Specialty	30%, not to exceed $250	30%, not to exceed $250	30%, not to exceed $250
Emergency ambulance services (per trip)	30% after deductible	30% after deductible	30% after deductible
CT/PET/MRI (per procedure)	30% after deductible	30% after deductible	30% after deductible
Lab/X-ray (per encounter)	30% after deductible	30% after deductible	30% after deductible
Durable medical equipment	30%	30%	30%
Fertility services	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	No charge	No charge

1. Deductible HMO – Plans with HRA have XP accumulation, meaning pharmacy is 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	POS[1]		
NCAL/SCAL plan ID	☐ 13886/13887		
Tier	HMO Tier	Participating Provider Tier	Nonparticipating Provider Tier
Plan deductible (individual/family)	$0/$0	$500/$1,000	$1,000/$2,000
Out-of-pocket maximum (individual/family)	$1,500/$3,000	$3,000/$6,000	$6,000/$12,000
Telehealth[2]	No charge	$35	40% after deductible
Preventive care	No charge	No charge	40%
Primary and specialty care visit	$20	$35	40% after deductible
Hospital inpatient (per admission)	$250	$250 + 20% after deductible	$500 + 40% after deductible
Outpatient surgery (per procedure)	$100	20% after deductible	40% after deductible
Emergency care	$150	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
CT/PET/MRI (per procedure)	No charge	$35	40% after deductible
Lab/X-ray (per encounter)	No charge	$35	40% after deductible
Durable medical equipment	30%	30% after deductible	50% after deductible
Fertility services	$20	20%	40%
Prenatal care and well-baby visits	No charge	No charge	40%
Optical hardware	Not covered	Not covered	Not covered
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	☐ 13890/13891		
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	$3,500/$7,000	$7,000/$14,000
Telehealth[2]	No charge	$50	40% after deductible
Preventive care	No charge	No charge	40%
Primary and specialty care visit	$25	$50	40% after deductible
Hospital inpatient (per admission)	$250	$250 + 20% after deductible	$500 + 40% after deductible
Outpatient surgery (per procedure)	$100	20% after deductible	40% after deductible
Emergency care	$150	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
CT/PET/MRI (per procedure)	$10	$50	40% after deductible
Lab/X-ray (per encounter)	$10	$50	40% after deductible
Durable medical equipment	30%	30% after deductible	50% after deductible
Fertility services	$25	20%	40%
Prenatal care and well-baby visits	No charge	No charge	40%
Optical hardware	Not covered	Not covered	Not covered
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	☐ 13894/13895		
Tier	HMO Tier	Participating Provider Tier	Nonparticipating Provider Tier
Plan deductible (individual/family)	$0/$0	$1,500/$3,000	$3,000/$6,000
Out-of-pocket maximum (individual/family)	$2,500/$5,000	$4,500/$9,000	$9,000/$18,000
Telehealth[2]	No charge	20% after deductible	50% after deductible
Preventive care	No charge	No charge	50%
Primary and specialty care visit	$30	20% after deductible	50% after deductible
Hospital inpatient (per admission)	$500	$500 + 20% after deductible	$1,000 + 50% after deductible
Outpatient surgery (per procedure)	$250	20% after deductible	50% after deductible
Emergency care	$150	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
CT/PET/MRI (per procedure)	$100	20% after deductible	50% after deductible
Lab/X-ray (per encounter)	$10	20% after deductible	50% after deductible
Durable medical equipment	30%	30% after deductible	50% after deductible
Fertility services	$30	20%	50%
Prenatal care and well-baby visits	No charge	No charge	50%
Optical hardware	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	20% 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	PPO[1]			
NCAL/SCAL plan ID	☐ 13898/13899		☐ 13902/13903	
Tier	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider
Plan deductible (individual/family)	$500/$1,000	$1,500/$3,000	$750/$1,500	$1,750/$3,500
Out-of-pocket maximum (individual/family)	$3,500/$7,000	$7,000/$14,000	$5,000/$10,000	$10,000/$20,000
Telehealth[2]	$20	40% after deductible	$30	40% after deductible
Preventive care	$0	40%	$0	40%
Primary and specialty care visit	$20	40% after deductible	$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	$150 copay per visit, then 20% after deductible	Covered under the participating provider tier	$150 copay per visit, then 20% after deductible	Covered under the participating provider tier
Prescription drugs				
Generic	$15 for up to a 30-day supply	Not covered	$15 for up to a 30-day supply	Not covered
Brand	$40 for up to a 30-day supply	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)	40% after deductible	Covered as preferred provider	40% after deductible	Covered as preferred provider
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	20%	40%	20%	40%
Prenatal care and well-baby visits	$0	40%	$0	40%
Optical hardware	Not covered	Not covered	Not covered	Not covered
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	☐ 13906/13907		☐ 13910/13911	
Tier	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider
Plan deductible (individual/family)	$1,000/$2,000	$2,000/$4,000	$1,500/$3,000	$3,000/$6,000
Out-of-pocket maximum (individual/family)	$5,000/$10,000	$10,000/$20,000	$5,000/$10,000	$10,000/$20,000
Telehealth[2]	$35	40% after deductible	$35	40% after deductible
Preventive care	$0	40%	$0	40%
Primary and specialty care visit	$35	40% after deductible	$35	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	$150 copay per visit, then 20% after deductible	Covered under the participating provider tier	$150 copay per visit, then 20% after deductible	Covered under the participating provider tier
Prescription drugs				
Generic	$15 for up to a 30-day supply	Not covered	$15 for up to a 30-day supply	Not covered
Brand	$40 for up to a 30-day supply	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)	40% after deductible	Covered as preferred provider	40% after deductible	Covered as preferred provider
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	20%	40%	20%	40%
Prenatal care and well-baby visits	$0	40%	$0	40%
Optical hardware	Not covered	Not covered	Not covered	Not covered
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	☐ 13914/13915		☐ HSA Qualified 13918/13919	
Tier	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider
Plan deductible (individual/family)	$2,000/$4,000	$4,000/$8,000	$3,000/$6,000	$5,000/$10,000
Out-of-pocket maximum (individual/family)	$5,000/$10,000	$10,000/$20,000	$6,000/$12,000	$12,000/$24,000
Telehealth[2]	$40	50% after deductible	$40 after deductible	40% after deductible
Preventive care	$0	50%	$0	40%
Primary and specialty care visit	$40	50% after deductible	$40 after deductible	40% after deductible
Hospital inpatient (per admission)	$500, then 30% after deductible	$1,000, then 50% after deductible	20% after deductible	40% after deductible
Outpatient surgery (per procedure)	$100, then 30% after deductible	$150, then 50% after deductible	20% after deductible	40% after deductible
Emergency care	$150 copay per visit, then 30% after deductible	Covered under the participating provider tier	$150 copay per visit, then 20% after deductible	Covered under the participating provider tier
Prescription drugs				
Generic	$15 for up to a 30-day supply	Not covered	$15 after ded for up to a 30-day supply	Not covered
Brand	$40 for up to a 30-day supply	Not covered	$40 after ded for up to a 30-day supply	Not covered
Specialty	30%, not to exceed $250	Not covered	30%, not to exceed $250, after deductible	Not covered
Emergency ambulance services (per trip)	50% after deductible	Covered as preferred provider	40% after deductible	Covered as preferred provider
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	20% after deductible	40% after deductible
Fertility services	30%	50%	20% after deductible	40% after deductible
Prenatal care and well-baby visits	$0	50%	$0	40%
Optical hardware	Not covered	Not covered	Not covered	Not covered
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			
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 and specialty care visit			
Hospital inpatient (per admission)			
Outpatient surgery (per procedure)			
Emergency care			
Prescription drugs Generic Brand Specialty			
Emergency ambulance services (per trip)			
CT/PET/MRI (per procedure)			
Lab/X-ray (per encounter)			
Durable medical equipment			
Fertility services			
Prenatal care and well-baby visits			
Optical hardware			
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.

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