

**Kaiser Permanente Health Plans
October 1, 2025 - September 30 2026**

BENEFIT Member Responsibility	Kaiser Plan 1	Kaiser Plan 2	Kaiser HSA Plan
Pre-Loaded Benefit Card	Ind: \$3,300 Fam: \$6,200	Ind: \$2,300 Fam: \$4,200	Pre-Loaded Benefit Card Does Not Apply
Use Your Pre-Loaded Benefit Card To Pay For All Services Until The Card Is Exhausted. All Benefits Below Refelct The Member's Out-Of-Pocket Cost Once The Benefit Card Is Exhausted.			
Calendar Year Out-of-Pocket Maximum	Ind: \$0 Fam: \$0	Ind: \$1,200 Fam: \$2,000	Ind: \$3,300 Fam: \$6,200
Calendar Year Deductible	Ind: \$0 Fam: \$0	Ind: \$0 Fam: \$0	Ind: \$2,000 Fam: \$3,300/\$4,000
Coinsurance	No Charge	20%	20% After Deductible
Preventive Care/Immunizations	No Charge	No Charge	No Charge
Doctor Visits (Primary Care)	\$0	\$30 Copay Per Visit	\$30 Copay Per Visit After Deductible
Doctor Visits (Specialists)	\$0	\$30 Copay Per Visit	\$30 Copay Per Visit After Deductible
Urgent Care	\$0	\$30 Copay Per Visit	\$30 Copay Per Visit After Deductible
Teledoc-Medical Services	No Charge	No Charge	No Charge After Plan Deductible
Chiropractic	\$0 (20 vists per year)	\$15 Copay Per Visit (20 visits per year)	\$15 Copay Per Visit After Deductible (20 visits per year)
Physical Therapy	\$0	\$30 Copay Per Visit	\$30 Copay Per Visit After Deductible
Infertility	\$0	Covered	Covered
Prescription Drugs (Tier 1)	\$0	\$10 Copay (30 Day Supply)	\$10 Copay After Deductible (30 Day Supply)
Prescription Drugs (Tier 2)	\$0	\$30 Copay (30 Day Supply)	\$30 Copay After Deductible (30 Day Supply)
Prescription Drugs (Tier 4)	\$0	20% not to exceed \$150 (30 Day Supply)	20% not to exceed \$150 After Deductible (30 Day Supply)
Mail Order Tier 1	\$0	\$20 Copay (100 Day Supply)	\$20 Copay After Deductible (100 Day Supply)
Mail Order Tier 2	\$0	\$60 Copay (100 Day Supply)	\$60 Copay After Deductible (100 Day Supply)
Hospital Emergency Room	\$0	\$100 Copay Per Visit	\$100 Copay Per Visit After Deductible
Hospital Inpatient	\$0	\$250 Copay per admission	\$250 Copay per admission After Deductible
Outpatient Surgery	\$0	\$150 Copay Per Procedure	\$150 Copay Per Procedure After Deductible
Home Health Care	\$0	No Charge (Limited to 100 Days Per Calendar Year)	No Charge After Deductible (Limited to 100 Days Per Calendar Year)
Outpatient Diagnostic Tests/Imaging	\$0	\$50 Copay Per Procedure	\$50 Copay Per Procedure After Deductible
Radiation Therapy Chemotherapy	\$0	\$150 Copay	\$150 Copay After Deductible
Durable Medical Equipment	\$0	20%	20% After Deductible
Ambulance-Ground/Air	\$0	\$100 Copay Per Trip	\$100 Copay Per Trip After Deductible
Mental Health/Substance Abuse Outpatient	\$0	\$30	\$30 After Deductible
Mental Health/Substance Abuse Inpatient	\$0	\$250 Per Admission	\$250 Per Admission After Deductible
2025-2026 Rates	Kaiser Plan 1	Kaiser Plan 2	Kaiser HSA Plan
Composite	\$ 2,182.00	\$ 2,082.00	\$ 1,796.00