

## 2025/2026 Plan Comparisons

Print Comparison

Features	2025 Gold 80 HDHP HMO 1750/15% PCP + Child Dental Alt		2026 Gold 80 HDHP HMO 1900/15% PCP + Child Dental Alt	
	HSA-qualified High Deductible Health Plan (HSA can be administered through Kaiser Permanente)		HSA-qualified High Deductible Health Plan (HSA can be administered through Kaiser Permanente) Member pays	
<b>PLAN DEDUCTIBLE</b> (embedded)	Self-only — \$1,750 (notes 2, 15) / Individual — \$3,300 (notes 2, 15) / Family — \$3,500 (notes 2, 15)		Self-only — \$1,900 (notes 2, 14) / Individual — \$3,300 (notes 2, 14) / Family — \$3,800 (notes 2, 14)	
<b>OUT-OF-POCKET MAXIMUM</b> (embedded)	Individual — \$4,000 (notes 2, 3) / Family — \$8,000 (notes 2, 3)		Individual — \$4,500 (notes 2, 3) / Family — \$9,000 (notes 2, 3)	
<b>IN THE MEDICAL OFFICE</b> Primary care visits	15% (after plan deductible)		15% (after plan deductible)	
Urgent care visits	15% (after plan deductible)		15% (after plan deductible)	
Specialty office visits	15% (after plan deductible)		15% (after plan deductible)	
Preventive services (for example: screening exams, prenatal and postpartum visits, and immunizations)	\$0 (notes 4, 5)		\$0 (notes 4, 5)	
Well-child preventive care visits	\$0 through age 23 months		\$0 through age 23 months	
Fertility services	Not covered (note 6)		Not covered (note 26)	
Physical, occupational, and speech therapy	15% (after plan deductible)		15% (after plan deductible)	
Most laboratory tests	15% (after plan deductible) (note 7)		15% (after plan deductible) (note 6)	
Most X-rays and diagnostic testing	15% (after plan deductible) (note 7)		15% (after plan deductible) (note 6)	
Most MRI/CT/PET scans	15% (after plan deductible) (note 7)		15% (after plan deductible) (note 6)	
Outpatient surgery (per procedure)	15% (after plan deductible)		15% (after plan deductible)	
<b>EMERGENCY SERVICES</b> Emergency department visits (waived if admitted directly to hospital)	15% (after plan deductible)		15% (after plan deductible)	
Ambulance	15% (after plan deductible)		15% (after plan deductible)	
<b>PRESCRIPTIONS</b> (up to 30-day supply)				
Generic (Tier 1)	\$15 (after plan deductible) (notes 8, 9)		\$15 (after plan deductible) (notes 7, 8, 9)	
Brand-name (Tier 2)	\$45 (after plan deductible) (notes 8, 9)		\$45 (after plan deductible) (notes 8, 9)	
Specialty drugs (Tier 4)	15% up to \$250 maximum (after plan deductible) (notes 8, 9)		15% up to \$250 maximum (after plan deductible) (notes 7, 8)	
<b>HOSPITAL INPATIENT CARE</b> Physicians' services, room and board, tests, medications, supplies, therapies, birth services	15% (after plan deductible)		15% (after plan deductible)	
<b>MENTAL HEALTH SERVICES</b> Outpatient (in the medical office)	15% (after plan deductible)		15% (after plan deductible)	
Inpatient (in the hospital)	15% (after plan deductible)		15% (after plan deductible)	
<b>SUBSTANCE USE DISORDER SERVICES</b> Outpatient (in the medical office)	15% (after plan deductible)		15% (after plan deductible)	
Inpatient (in the hospital) detoxification only	15% (after plan deductible)		15% (after plan deductible)	
<b>OTHER</b> Virtual care	\$0 (after plan deductible) (note 17)		\$0 (after plan deductible) (note 16)	
Chiropractic and acupuncture	15% per visit after deductible for physician-referred acupuncture only		15% per visit after deductible for physician-referred acupuncture only	
Certain durable medical equipment (DME) (supplemental and base)	15% (note 11)		15% (note 11)	
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year (note 12)		1 pair of eyeglasses or contact lenses per year (note 12)	
Pediatric vision exam	\$0		\$0	
Adult optical (eyewear)	Not covered (note 14)		Not covered (note 13)	
Adult vision exam (for eye refraction)	\$0		\$0	

For a complete description of benefits, please refer to the Evidence of Coverage or Certificate of Insurance, or [business.kp.org](https://business.kp.org).

Start over

## Footnotes for HMO plans

Cost-share amounts for all in-network services accumulate toward the out-of-pocket maximum.

Preventive services are available at no cost share except for services from the nonparticipating providers. For a complete list of preventive services, please refer to the *Evidence of Coverage, Certificate of Insurance*, or [business.kp.org](https://www.kp.org/business.kp.org).

Kaiser Permanente plans don't include a preexisting condition clause.

\* This plan is also offered at Covered California for Small Business and CaliforniaChoice®.

† The abbreviation "ALT," in certain plan names, indicates Kaiser Permanente developed plans.

1. This plan has an embedded out-of-pocket maximum. Individual family members aren't subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of-pocket maximum is met.
2. This plan has an embedded deductible and out-of-pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual deductible or out-of-pocket maximum (depending on the benefit), or when the family deductible or out-of-pocket maximum is satisfied. Individual family members aren't subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of-pocket maximum is met.
3. Out-of-pocket maximum is the maximum amount an individual or family will pay for certain services in a year.
4. Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam.
5. Scheduled prenatal visits and postpartum visits.
6. Laboratory and diagnostic test, X-rays, and MRI/CT/PET scans related to preventive services are no charge.
7. Prescription drugs are covered in accordance with our formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copays. For information on our formulary, including the drugs on the specialty tier, go to [kp.org/formulary](https://www.kp.org/formulary) or call our Member Services.
8. Mail order: Up to a 100-day supply of qualified prescriptions for the cost of a 60-day supply.
9. Insured is responsible for paying the brand-name copay plus the difference in cost between the generic drug and the brand-name drug when the insured requests a brand-name drug and a generic version is available.
10. After the 5 days, additional days for the same admission are covered at no charge.
11. Both base and supplemental DME are covered. Supplemental DME is limited to a combined maximum benefit of \$2,000 per year for services. Refer to the *Evidence of Coverage* for information on what's included in your DME benefit.
12. Under age 19. One pair of eyeglasses from a limited selection.
13. Kaiser Permanente members are entitled to a discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts can't be combined with any other Health Plan vision benefit. The discounts won't apply to any sale, promotion, or packaged eyewear program; for any contact lens extended purchase agreement; or to low-vision aids or devices. Visit [kp2020.org](https://www.kp2020.org) for Kaiser Permanente optical locations.
14. Self-only: a family of 1 member. Individual: each member in a family of 2 or more members. Family: entire family of 2 or more members.
15. Groups selecting the Gold 80 HRA HMO 2250/35 + Child Dental plan must establish and fund an HRA for each enrolled employee. The allowable funding options are \$200 or \$400 per employee and \$400 or \$800 respectively per family, if the group covers dependents.
16. For HSA-qualified HDHP HMO members, all scheduled, nonpreventive telehealth visits (phone and video).
17. This plan has a drug deductible of \$100 per individual and \$200 per family for prescription costs and out-of-pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual drug deductible or out-of-pocket maximum (depending on the benefit), or when the family deductible is satisfied. Individual family members aren't subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of-pocket maximum is met.
18. This plan has a drug deductible of \$250 per individual and \$500 for family for prescription costs and out-of-pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual drug deductible or out-of-pocket maximum (depending on the benefit), or when the family deductible is satisfied. Individual family members aren't subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of-pocket maximum is met.
19. This plan has a drug deductible of \$300 per individual and \$600 for family for prescription costs and out-of-pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual drug deductible or out-of-pocket maximum (depending on the benefit), or when the family deductible is satisfied. Individual family members aren't subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of-pocket maximum is met.
20. This plan has a drug deductible of \$500 per individual and \$1,000 for family for prescription costs and out-of-pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual drug deductible or out-of-pocket maximum (depending on the benefit), or when the family deductible is satisfied. Individual family members aren't subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of-pocket maximum is met.
21. This plan has a drug deductible of \$450 per individual and \$900 for family for prescription costs and out-of-pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual drug deductible or out-of-pocket maximum (depending on the benefit), or when the family deductible is satisfied. Individual family members aren't subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of-pocket maximum is met.
22. The plan deductible doesn't apply to your first 3 visits for specialty care as described in the EOC.
23. Payments are based upon the maximum allowable charge for covered services. Maximum allowable charge means the lesser of: the usual, customary, and reasonable charges; the negotiated rate; or the actual billed charges. The maximum allowable charge may be less than the amount actually billed by the provider. Covered persons may be responsible for payment of any amounts in excess of the maximum allowable charge for a covered service.
24. Covered charges incurred toward satisfaction of the out-of-pocket maximum at the nonparticipating provider tier won't accumulate toward satisfaction of the out-of-pocket maximum on the participating provider tier. Likewise, covered charges incurred toward satisfaction of the out-of-pocket maximum on the participating provider tier won't accumulate toward satisfaction of the out-of-pocket maximum on the nonparticipating provider tier. For a complete understanding of the out-of-pocket maximum, please refer to your *Certificate of Insurance*.
25. Routine prenatal care office visits are covered as required under the Affordable Care Act (ACA). This includes the initial and subsequent histories, physical examinations, recording of weight, blood pressures, fetal heart tones, and routine chemical urinalysis.
26. Fertility benefits may be added to this plan for an additional cost. For more information, contact your broker or Kaiser Permanente representative.