

2027 Level Funded Product Portfolio

GEORGIA HEALTH PLANS

Level Funded plan comparison chart

Use this overview of our Level Funded 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.

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

Contents

Exclusive provider organization (EPO) plans 4

Deductible EPO (DEPO) plans 5

Kaiser Permanente Everyday Care (EC) plans 13

HSA-qualified high deductible health plans (HDHPs) 15

Dual Choice PPO (POS) plans 17

How to compare plans

With our Level Funded interactive plan comparison chart, you can choose up to 3 plans 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 top of the page.

You can also get more detailed information about each plan type by clicking the tabs at the top of the page. 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.

Ready to connect? Contact Kaiser Permanente at **levelfunded@kp.org** or 855-336-4995 or call your broker.

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.

EPO plans*

Plans selected ☐ Compare Plans Reset

	KPLF 0/10/1500	KPLF 0/20/1500	KPLF 0/15/3000	KPLF 0/20/3000	KPLF 0/30/4000	KPLF 0/40/8000
Product type	EPO	EPO	EPO	EPO	EPO	LFEPO
Deductible Individual/Family	$0	$0	$0	$0	$0	0/$0
Out-of-pocket maximum Individual/Family	$1,500/$3,000	$1,500/$3,000	$3,000/$6,000	$3,000/$6,000	$4,000/$8,000	$8,000/$16,000
Coinsurance (member's cost)	10%	10%	20%	20%	20%	30%
Emergency room	$250	$250	$250	$250	$300	$500
Urgent care	$50	$50	$50	$50	$75	$75
Inpatient hospital	$500 per day (3 days)	$500 per day (3 days)	$750 per day (3 days)	$750 per day (3 days)	$750 per day (3 days)	$750 per day (3 days)
Virtual care services (Chat, video visit, email, phone)[1]	$0	$0	$0	$0	$0	$0
PCP office visit	$10	$20	$15	$20	$30	$40
Specialist office visit	$30	$30	$25	$40	$50	$60
Mental health outpatient	$10	$20	$15	$20	$30	$40
MRI, CT, and PET	$100	$100	$150	$150	$200	$500
Lab & X-ray	$0	$0	$0	$0	$0	$0
Outpatient surgery	$500	$500	$500	$500	$500	$500
Prescription drugs[2]						
Generic	$5	$5	$5	$5	$5	$10
Brand	$30	$30	$30	$30	$30	$40
Brand non-preferred	$45	$45	$45	$45	$45	$75
Specialty	$500	$500	$500	$500	$500	$500
Pharmacy deductible	N/A	N/A	N/A	N/A	N/A	$0

Deductible EPO plans*

Plans selected [ ] Compare Plans Reset

	KPLF 250/10%/3000	KPLF 500/10%/3000	KPLF 500/20%/3000	KPLF 750/10%/3000	KPLF 750/20%/3000
Product type	DEPO	DEPO	DEPO	DEPO	DEPO
Deductible Individual/Family	$250/$500	$500/$1,000	$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	$3,000/$6,000
Coinsurance (member's cost)	10%	10%	20%	10%	20%
Emergency room	$300	$300	$300	$300	$300
Urgent care	$50	$50	$50	$50	$50
Inpatient hospital	10% after deductible	10% after deductible	20% after deductible	10% after deductible	20% after deductible
Virtual care services (Chat, video visit, email, phone)[1]	$0	$0	$0	$0	$0
PCP office visit	$20	$20	$30	$15	$20
Specialist office visit	$40	$40	$50	$25	$50
Outpatient mental health	$20	$20	$30	$15	$20
MRI, CT, and PET	$200	$200	$200	$200	$200
Lab & X-ray	$0	10% after deductible	$0	10% after deductible	20% after deductible
Outpatient surgery	10% after deductible	10% after deductible	20% after deductible	10% after deductible	20% after deductible
Prescription drugs[2]					
Generic	$5	$5	$5	$5	$10
Brand	$30	$30	$30	$30	$35
Brand non-preferred	$45	$45	$45	$45	$60
Specialty	$500	$500	$500	$500	$500
Pharmacy deductible	N/A	N/A	N/A	N/A	N/A

Deductible EPO plans* *(continued)*

Plans selected Compare Plans Reset

	KPLF 1000/10%/3000	KPLF 1000/20%/3500	KPLF 1000/20%/4000	KPLF 1500/10%/4000	KPLF 1500/20%/4000
Product type	DEPO	DEPO	DEPO	DEPO	DEPO
Deductible Individual/Family	$1,000/$2,000	$1,000/$2,000	$1,000/$2,000	$1,500/$3,000	$1,500/$3,000
Out-of-pocket maximum Individual/Family	$3,000/$6,000	$3,500/$7,000	$4,000/$8,000	$4,000/$8,000	$4,000/$8,000
Coinsurance (member's cost)	10%	20%	20%	10%	20%
Emergency room	$300	$300	$300	$300	$300
Urgent care	$50	$50	$50	$50	$50
Inpatient hospital	10% after deductible	20% after deductible	20% after deductible	10% after deductible	20% after deductible
Virtual care services (Chat, video visit, email, phone)[1]	$0	$0	$0	$0	$0
PCP office visit	$20	$25	$30	$20	$30
Specialist office visit	$50	$75	$50	$40	$50
Outpatient mental health	$20	$25	$30	$20	$30
MRI, CT, and PET	$200	$200	$200	$200	$200
Lab & X-ray	10% after deductible	20% after deductible	20% after deductible	10% after deductible	20% after deductible
Outpatient surgery	10% after deductible	20% after deductible	20% after deductible	10% after deductible	20% after deductible
Prescription drugs[2]					
Generic	$10	$10	$10	$10	$10
Brand	$35	$35	$35	$35	$35
Brand non-preferred	$60	$60	$60	$60	$60
Specialty	$500	$500	$500	$500	$500
Pharmacy deductible	N/A	N/A	N/A	N/A	N/A

Deductible EPO plans* *(continued)*

Plans selected Compare Plans Reset

	KPLF 2000/0%/4500	KPLF 2000/20%/4500	KPLF 2000/30%/4500	KPLF 2500/0%/4500	KPLF 2500/20%/4500
Product type	DEPO	DEPO	DEPO	DEPO	DEPO
Deductible Individual/Family	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000	$2,500/$5,000	$2,500/$5,000
Out-of-pocket maximum Individual/Family	$4,500/$9,000	$4,500/$9,000	$4,500/$9,000	$4,500/$9,000	$4,500/$9,000
Coinsurance (member's cost)	0%	20%	30%	0%	20%
Emergency room	$300	$300	$300	$300	$300
Urgent care	$50	$50	$50	$50	$50
Inpatient hospital	0% after deductible	20% after deductible	30% after deductible	0% after deductible	20% after deductible
Virtual care services (Chat, video visit, email, phone)[1]	$0	$0	$0	$0	$0
PCP office visit	$20	$30	$30	$20	$30
Specialist office visit	$40	$50	$50	$40	$50
Outpatient mental health	$20	$30	$30	$20	$30
MRI, CT, and PET	$200	$200	$200	$200	$200
Lab & X-ray	$0	20% after deductible	30% after deductible	$0	20% after deductible
Outpatient surgery	0% after deductible	20% after deductible	30% after deductible	0% after deductible	20% after deductible
Prescription drugs[2]					
Generic	$15	$15	$15	$15	$15
Brand	$50	$50	$50	$50	$50
Brand non-preferred	$75	$75	$75	$75	$75
Specialty	$500	$500	$500	$500	$500
Pharmacy deductible	N/A	N/A	N/A	N/A	N/A

Deductible EPO plans* *(continued)*

Plans selected Compare Plans Reset

	KPLF 2500/20%/10000	KPLF 2500/30%/6000	KPLF 3000/0%/6000	KPLF 3000/20%/6000	KPLF 3000/30%/6000	KPLF 3000/30%/6500
Product type	DEPO	DEPO	DEPO	DEPO	DEPO	DEPO
Deductible Individual/Family	$2,500/$5,000	$2,500/$5,000	$3,000/$6,000	$3,000/$6,000	$3,000/$6,000	$3,000/$6,000
Out-of-pocket maximum Individual/Family	$10,000/$20,000	$6,000/$12,000	$6,000/$12,000	$6,000/$12,000	$6,000/$12,000	$6,500/$13,000
Coinsurance (member's cost)	20%	30%	0%	20%	30%	30%
Emergency room	$300	$300	$400	$400	$400	$400
Urgent care	$75	$50	$75	$75	$75	$75
Inpatient hospital	20% after deductible	30% after deductible	0% after deductible	20% after deductible	30% after deductible	30% after deductible
Virtual care services (Chat, video visit, email, phone)[1]	$0	$0	$0	$0	$0	$0
PCP office visit	$30	$30	$30	$30	$40	$25
Specialist office visit	$60	$50	$50	$50	$60	$75
Outpatient mental health	$30	$30	$30	$30	$40	$25
MRI, CT, and PET	$200	$200	$300	$300	$300	$300
Lab & X-ray	20% after deductible	30% after deductible	$0	20% after deductible	30% after deductible	30% after deductible
Outpatient surgery	20% after deductible	30% after deductible	0% after deductible	20% after deductible	30% after deductible	30% after deductible
Prescription drugs[2]						
Generic	$15	$15	$15	$15	$15	$15
Brand	$50	$50	$50	$50	$50	$50
Brand non-preferred	$75	$75	$75	$75	$75	$75
Specialty	$500	$500	$500	$500	$500	$500
Pharmacy deductible	N/A	N/A	N/A	N/A	N/A	N/A

Deductible EPO plans* *(continued)*

Plans selected Compare Plans Reset

	KPLF 3500/0%/6500	KPLF 3500/20%/6500	KPLF 3500/30%/6000	KPLF 3500/30%/6500	KPLF 4000/0%/6500
Product type	DEPO	DEPO	DEPO	DEPO	DEPO
Deductible Individual/Family	$3,500/$7,000	$3,500/$7,000	$3,500/$7,000	$3,500/$7,000	$4,000/$8,000
Out-of-pocket maximum Individual/Family	$6,500/$13,000	$6,500/$13,000	$6,000/$12,000	$6,500/$13,000	$6,500/$13,000
Coinsurance (member's cost)	0%	20%	30%	30%	0%
Emergency room	$500	$500	$400	$500	$500
Urgent care	$100	$100	$75	$100	$100
Inpatient hospital	0% after deductible	20% after deductible	30% after deductible	30% after deductible	0% after deductible
Virtual care services (Chat, video visit, email, phone)[1]	$0	$0	$0	$0	$0
PCP office visit	$30	$30	$30	$40	$30
Specialist office visit	$50	$50	$60	$60	$50
Outpatient mental health	$30	$30	$30	$40	$30
MRI, CT, and PET	$300	$300	$300	$300	$300
Lab & X-ray	$0	20% after deductible	30% after deductible	30% after deductible	$0
Outpatient surgery	0% after deductible	20% after deductible	30% after deductible	30% after deductible	0% after deductible
Prescription drugs[2]					
Generic	$15	$15	$15	$15	$20
Brand	$50	$50	$50	$50	$65
Brand non-preferred	$75	$75	$75	$75	$90
Specialty	$500	$500	$500	$500	$500
Pharmacy deductible	N/A	N/A	N/A	N/A	N/A

Deductible EPO plans* *(continued)*

Plans selected Compare Plans Reset

	KPLF 4000/20%/8000	KPLF 4000/30%/8000	KPLF 4000/40%/8000	KPLF 4000/50%/8000	KPLF 5000/0%/8000
Product type	DEPO	DEPO	DEPO	DEPO	DEPO
Deductible Individual/Family	$4,000/$8,000	$4,000/$8,000	$4,000/$8,000	$4,000/$8,000	$5,000/$10,000
Out-of-pocket maximum Individual/Family	$8,000/$16,000	$8,000/$16,000	$8,000/$16,000	$8,000/$16,000	$8,000/$16,000
Coinsurance (member's cost)	20%	30%	40%	50%	0%
Emergency room	$500	$500	$500	$500	$500
Urgent care	$100	$100	$100	$100	$100
Inpatient hospital	20% after deductible	30% after deductible	40% after deductible	50% after deductible	0% after deductible
Virtual care services (Chat, video visit, email, phone)[1]	$0	$0	$0	$0	$0
PCP office visit	$30	$40	$50	$50	$40
Specialist office visit	$50	$60	$70	$70	$60
Outpatient mental health	$30	$40	$50	$50	$40
MRI, CT, and PET	$300	$300	$300	$300	$300
Lab & X-ray	20% after deductible	30% after deductible	40% after deductible	50% after deductible	$0
Outpatient surgery	20% after deductible	30% after deductible	40% after deductible	50% after deductible	0% after deductible
Prescription drugs[2]					
Generic	$20	$20	$20	$20	$20
Brand	$65	$65	$65	$65	$65
Brand non-preferred	$90	$90	$90	$90	$90
Specialty	$500	$500	$500	$500	$500
Pharmacy deductible	N/A	N/A	N/A	N/A	N/A

Deductible EPO plans* *(continued)*

Plans selected Compare Plans Reset

	KPLF 5000/20%/9000	KPLF 5000/30%/9000	KPLF 5000/40%/9000	KPLF 5000/50%/9000	KPLF 6000/40%/9000
Product type	DEPO	DEPO	DEPO	DEPO	DEPO
Deductible Individual/Family	$5,000/$10,000	$5,000/$10,000	$5,000/$10,000	$5,000/$10,000	$6,000/$12,000
Out-of-pocket maximum Individual/Family	$9,000/$18,000	$9,000/$18,000	$9,000/$18,000	$9,000/$18,000	$9,000/$18,000
Coinsurance (member's cost)	20%	30%	40%	50%	40%
Emergency room	20% after deductible	30% after deductible	40% after deductible	50% after deductible	40% after deductible
Urgent care	$100	$100	$100	$100	$100
Inpatient hospital	20% after deductible	30% after deductible	40% after deductible	50% after deductible	40% after deductible
Virtual care services (Chat, video visit, email, phone)[1]	$0	$0	$0	$0	$0
PCP office visit	$40	$50	$50	$50	$50
Specialist office visit	$60	$70	$70	$70	$70
Outpatient mental health	$40	$50	$50	$50	$50
MRI, CT, and PET	20% after deductible	30% after deductible	40% after deductible	50% after deductible	40% after deductible
Lab & X-ray	20% after deductible	30% after deductible	40% after deductible	50% after deductible	40% after deductible
Outpatient surgery	20% after deductible	30% after deductible	40% after deductible	50% after deductible	40% after deductible
Prescription drugs[2]					
Generic	$20	$20	$20	$20	$20
Brand	$65	$65	$65	$65	$65
Brand non-preferred	$90	$90	$90	$90	$90
Specialty	$500	$500	$500	$500	$500
Pharmacy deductible	N/A	N/A	N/A	N/A	N/A

Deductible EPO plans* *(continued)*

Plans selected Compare Plans Reset

	KPLF 6000/50%/9000	KPLF 6000/50%/9500
Product type	DEPO	DEPO
Deductible Individual/Family	$6,000/$12,000	$6,000/$12,000
Out-of-pocket maximum Individual/Family	$9,000/$18,000	$9,500/$19,000
Coinsurance (member's cost)	50%	50%
Emergency room	50% after deductible	50% after deductible
Urgent care	$100	$100
Inpatient hospital	50% after deductible	50% after deductible
Virtual care services (Chat, video visit, email, phone)[1]	$0	$0
PCP office visit	$50	$50
Specialist office visit	$70	$80
Outpatient mental health	$50	$50
MRI, CT, and PET	50% after deductible	50% after deductible
Lab & X-ray	50% after deductible	50% after deductible
Outpatient surgery	50% after deductible	50% after deductible
Prescription drugs[2]		
Generic	$20	$20
Brand	$65	$65
Brand non-preferred	$90	$90
Specialty	$500	$500
Pharmacy deductible	N/A	N/A

Kaiser Permanente Everyday Care plans

Plans selected ☐ Compare Plans Reset

	KPLF Everyday Care $0/$4000	KPLF Everyday Care $0/$5000	KPLF Everyday Care $0/$7000	KPLF Everyday Care $0/$9000
Product type	DEPO	DEPO	DEPO	DEPO
Deductible Individual/Family	$4,000/$8,000	$5,000/$10,000	$7,000/$14,000	$9,000/$18,000
Out-of-pocket maximum Individual/Family	$4,000/$8,000	$5,000/$10,000	$7,000/$14,000	$9,000/$18,000
Coinsurance (member's cost)	0%	0%	0%	0%
Emergency room	$500	$500	$500	$500
Urgent care	$0	$0	$0	$0
Inpatient hospital	No cost after deductible	No cost after deductible	No cost after deductible	No cost after deductible
Virtual care services (Chat, video visit, email, phone)[1]	$0	$0	$0	$0
PCP office visit	$0	$0	$0	$0
Specialist office visit	$0	$0	$0	$0
Outpatient mental health	$0	$0	$0	$0
MRI, CT, and PET	$500	$500	$500	$500
Lab/X-ray	$0/$50	$0/$50	$0/$50	$0/$50
Outpatient surgery	0% after deductible	0% after deductible	0% after deductible	0% after deductible
Prescription drugs[2]				
Generic	$0	$0	$0	$0
Brand	$50	$50	$50	$50
Brand non-preferred	$125	$125	$125	$125
Specialty	$300	$300	$300	$300
Pharmacy deductible	N/A	N/A	N/A	N/A

Kaiser Permanente Everyday Care plans *(continued)*

Plans selected ☐ Compare Plans Reset

	☐ **KPLF Everyday Care** $10/$4000	☐ **KPLF Everyday Care** $10/$5000	☐ **KPLF Everyday Care** $10/$6000	☐ **KPLF Everyday Care** $10/$7000
Product type	DEPO	DEPO	DEPO	DEPO
Deductible Individual/Family	$4,000/$8,000	$5,000/$10,000	$6,000/$12,000	$7,000/$14,000
Out-of-pocket maximum Individual/Family	$4,000/$8,000	$5,000/$10,000	$6,000/$12,000	$7,000/$14,000
Coinsurance (member's cost)	0%	0%	0%	0%
Emergency room	$500	$500	$500	$500
Urgent care	$10	$10	$10	$10
Inpatient hospital	No cost after deductible	No cost after deductible	No cost after deductible	No cost after deductible
Virtual care services (Chat, video visit, email, phone)[1]	$0	$0	$0	$0
PCP office visit	$10	$10	$10	$10
Specialist office visit	$10	$10	$10	$10
Outpatient mental health	$10	$10	$10	$10
MRI, CT, and PET	$500	$500	$500	$500
Lab/X-ray	$10/$50	$10/$50	$10/$50	$10/$50
Outpatient surgery	0% after deductible	0% after deductible	0% after deductible	0% after deductible
Prescription drugs[2]				
Generic	$10	$10	$10	$10
Brand	$50	$50	$50	$50
Brand non-preferred	$125	$125	$125	$125
Specialty	$300	$300	$300	$300
Pharmacy deductible	N/A	N/A	N/A	N/A

HDHP plans

Plans selected ☐ Compare Plans Reset

	KPLF HDHP 1800/20%/3500	KPLF HDHP 2500/20%/5000	KPLF HDHP 3000/0%/3000	KPLF HDHP 3500/20%/6000	KPLF HDHP 4000/0%/4000
Product type	HSA	HSA	HSA	HSA	HSA
Deductible Individual/Family	$1,800[3]/$3,600	$2,500[3]/$5,000	$3,000[3]/$6,000	$3,500/$7,000	$4,000/$8,000
Out-of-pocket maximum Individual/Family	$3,500[3]/$7,000	$5,000[3]/$10,000	$3,000[3]/$6,000	$6,000/$12,000	$4,000/$8,000
Coinsurance (member's cost)	20%	20%	0%	20%	0%
Emergency room	20% after deductible	20% after deductible	0% after deductible	20% after deductible	0% after deductible
Urgent care	20% after deductible	20% after deductible	0% after deductible	20% after deductible	0% after deductible
Inpatient hospital	20% after deductible	20% after deductible	0% after deductible	20% after deductible	0% after deductible
Virtual care services (Chat, video visit, email, phone)[1]	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
PCP office visit	20% after deductible	20% after deductible	0% after deductible	20% after deductible	0% after deductible
Specialist office visit	20% after deductible	20% after deductible	0% after deductible	20% after deductible	0% after deductible
Outpatient mental health	20% after deductible	20% after deductible	0% after deductible	20% after deductible	0% after deductible
MRI, CT, and PET	20% after deductible	20% after deductible	0% after deductible	20% after deductible	0% after deductible
Lab & X-ray	20% after deductible	20% after deductible	0% after deductible	20% after deductible	0% after deductible
Outpatient surgery	20% after deductible	20% after deductible	0% after deductible	20% after deductible	0% after deductible
Prescription drugs[2]					
Generic	20% after deductible	20% after deductible	0% after deductible	20% after deductible	0% after deductible
Brand	20% after deductible	20% after deductible	0% after deductible	20% after deductible	0% after deductible
Brand non-preferred	20% after deductible	20% after deductible	0% after deductible	20% after deductible	0% after deductible
Specialty	20% after deductible	20% after deductible	0% after deductible	20% after deductible	0% after deductible
Pharmacy deductible	Medical deductible	Medical deductible	Medical deductible	Medical deductible	Medical deductible

HDHP plans *(continued)*

Plans selected ☐ Compare Plans Reset

	☐ KPLF HDHP 5000/30%/7000	☐ KPLF HDHP 6000/50%/8000	☐ KPLF HDHP 6000/0%/6000
Product type	HSA	HSA	LFDPHSA
Deductible Individual/Family	$5,000/$10,000	$6,000/$12,000	$6,000/$12,000
Out-of-pocket maximum Individual/Family	$7,000/$14,000	$8,000/$16,000	$6,000/$12,000
Coinsurance (member's cost)	30%	50%	0%
Emergency room	30% after deductible	50% after deductible	0% after deductible
Urgent care	30% after deductible	50% after deductible	0% after deductible
Inpatient hospital	30% after deductible	50% after deductible	0% after deductible
Virtual care services (Chat, video visit, email, phone)[1]	No charge after deductible	No charge after deductible	No charge after deductible
PCP office visit	30% after deductible	50% after deductible	0% after deductible
Specialist office visit	30% after deductible	50% after deductible	0% after deductible
Outpatient mental health	30% after deductible	50% after deductible	0% after deductible
MRI, CT, and PET	30% after deductible	50% after deductible	0% after deductible
Lab & X-ray	30% after deductible	50% after deductible	0% after deductible
Outpatient surgery	30% after deductible	50% after deductible	0% after deductible
Prescription drugs[2]			
Generic	30% after deductible	50% after deductible	0% after deductible
Brand	30% after deductible	50% after deductible	0% after deductible
Brand non-preferred	30% after deductible	50% after deductible	0% after deductible
Specialty	30% after deductible	50% after deductible	0% after deductible
Pharmacy deductible	Medical deductible	Medical deductible	Medical deductible

Dual Choice PPO plans

Plans selected ☐ Compare Plans Reset

	KPLF DC PPO 0/40/6500		
Provider Network	**KP Providers**	**Network Providers**	**Out of Network**
Deductible (Individual)	$0		$2,000
Deductible (Family)	$0		$4,000
Out-of-Pocket Max (Individual)	$6,500		$19,500
Out-of-Pocket Max (Family)	$13,000		$39,000
Telehealth Visit	Primary: $0 KP/$60 Network Specialty: $0 KP/$120 Network		40% after deductible
Primary Care	$40	$60	40% after deductible
Specialty Care	$70	$90	40% after deductible
Hospital Inpatient	$950 per day for 1st 3 days		40% after deductible
Outpatient Surgery	$700		40% after deductible
Emergency Care	$500		$500
Ambulance	$500		$500
Urgent Care (per visit)	$80	$120	40% after deductible
Lab	$0		30% after deductible
X-Ray	$0		30% after deductible
CT/PET/MRI	$500		40% after deductible
MH/CD Outpatient	$40	$60	40% after deductible
MH/CD Inpatient	$950 per day for 1st 3 days		40% after deductible
PT/ST/OT	$70		40% after deductible
Drug Deductible (Individual)	$0		Medical deductible applies
Drug Deductible (Family)	$0		Medical deductible applies
Generic Drugs (Maintenance) (OptumRx Formulary Tier 1)	$10	$20	40% after deductible
Generic Drugs (Preferred) (OptumRx Formulary Tier 1)	$10	$20	40% after deductible
Preferred Brand Drugs (OptumRx Formulary Tier 2)	$40	$60	40% after deductible
Non-Preferred Drugs (OptumRx Formulary Tier 3)	$70	$100	40% after deductible
Specialty Drugs (OptumRx Formulary/SP noted)	20% to $300 max	30%	40% after deductible
Mail-Order[4]	$20/$20/$80/$140/20% KP $60/$60/$180/$300/30% *OptumRx Retail*		40% after deductible

Plans selected [ ] Compare Plans Reset

	KPLF DC PPO 500/20%/4500		
Provider Network	**KP Providers**	**Network Providers**	**Out of Network**
Deductible (Individual)	$500		$1,500
Deductible (Family)	$1,000		$3,000
Out-of-Pocket Max (Individual)	$4,500		$13,500
Out-of-Pocket Max (Family)	$9,000		$27,000
Telehealth Visit	Primary: $0 KP/$40 Network Specialty: $0 KP/$60 Network		40% after deductible
Primary Care	$20	$40	40% after deductible
Specialty Care	$40	$60	40% after deductible
Hospital Inpatient	20% after deductible		40% after deductible
Outpatient Surgery	20% after deductible		40% after deductible
Emergency Care	$500		$500
Ambulance	$500		$500
Urgent Care (per visit)	$40	$80	40% after deductible
Lab	$0		30% after deductible
X-Ray	$0		30% after deductible
CT/PET/MRI	20% after deductible		40% after deductible
MH/CD Outpatient	$20	$40	40% after deductible
MH/CD Inpatient	20% after deductible		40% after deductible
PT/ST/OT	$40		40% after deductible
Drug Deductible (Individual)	$0		Medical deductible applies
Drug Deductible (Family)	$0		Medical deductible applies
Generic Drugs (Maintenance) (OptumRx Formulary Tier 1)	$10	$20	40% after deductible
Generic Drugs (Preferred) (OptumRx Formulary Tier 1)	$10	$20	40% after deductible
Preferred Brand Drugs (OptumRx Formulary Tier 2)	$40	$60	40% after deductible
Non-Preferred Drugs (OptumRx Formulary Tier 3)	$70	$100	40% after deductible
Specialty Drugs (OptumRx Formulary/SP noted)	20% to $300 max	30%	40% after deductible
Mail-Order[4]	$20/$20/$80/$140/20% KP $60/$60/$180/$300/30% *OptumRx Retail*		40% after deductible

Plans selected [ ] Compare Plans Reset

	KPLF DC PPO 1000/20%/5000		
Provider Network	**KP Providers**	**Network Providers**	**Out of Network**
Deductible (Individual)	$1,000		$3,000
Deductible (Family)	$2,000		$6,000
Out-of-Pocket Max (Individual)	$5,000		$15,000
Out-of-Pocket Max (Family)	$10,000		$30,000
Telehealth Visit	Primary: $0 KP/$50 Network Specialty: $0 KP/$70 Network		40% after deductible
Primary Care	$30	$50	40% after deductible
Specialty Care	$50	$70	40% after deductible
Hospital Inpatient	20% after deductible		40% after deductible
Outpatient Surgery	20% after deductible		40% after deductible
Emergency Care	$500		$500
Ambulance	$500		$500
Urgent Care (per visit)	$60	$100	40% after deductible
Lab	$0		30% after deductible
X-Ray	$0		30% after deductible
CT/PET/MRI	20% after deductible		40% after deductible
MH/CD Outpatient	$30	$50	40% after deductible
MH/CD Inpatient	20% after deductible		40% after deductible
PT/ST/OT	$50		40% after deductible
Drug Deductible (Individual)	$0		Medical deductible applies
Drug Deductible (Family)	$0		Medical deductible applies
Generic Drugs (Maintenance) (OptumRx Formulary Tier 1)	$10	$20	40% after deductible
Generic Drugs (Preferred) (OptumRx Formulary Tier 1)	$10	$20	40% after deductible
Preferred Brand Drugs (OptumRx Formulary Tier 2)	$40	$60	40% after deductible
Non-Preferred Drugs (OptumRx Formulary Tier 3)	$70	$100	40% after deductible
Specialty Drugs (OptumRx Formulary/SP noted)	20% to $300 max	30%	40% after deductible
Mail-Order[4]	$20/$20/$80/$140/20% KP $60/$60/$180/$300/30% *OptumRx Retail*		40% after deductible

Plans selected [ ] Compare Plans Reset

	KPLF DC PPO 1500/20%/6000		
Provider Network	**KP Providers**	**Network Providers**	**Out of Network**
Deductible (Individual)	$1,500		$4,500
Deductible (Family)	$3,000		$9,000
Out-of-Pocket Max (Individual)	$6,000		$18,000
Out-of-Pocket Max (Family)	$12,000		$36,000
Telehealth Visit	Primary: $0 KP/$50 Network Specialty: $0 KP/$70 Network		40% after deductible
Primary Care	$30	$50	40% after deductible
Specialty Care	$50	$70	40% after deductible
Hospital Inpatient	20% after deductible		40% after deductible
Outpatient Surgery	20% after deductible		40% after deductible
Emergency Care	$500		$500
Ambulance	$500		$500
Urgent Care (per visit)	$60	$100	40% after deductible
Lab	$0		30% after deductible
X-Ray	$0		30% after deductible
CT/PET/MRI	20% after deductible		40% after deductible
MH/CD Outpatient	$30	$50	40% after deductible
MH/CD Inpatient	20% after deductible		40% after deductible
PT/ST/OT	$50		40% after deductible
Drug Deductible (Individual)	$0		Medical deductible applies
Drug Deductible (Family)	$0		Medical deductible applies
Generic Drugs (Maintenance) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Generic Drugs (Preferred) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Preferred Brand Drugs (OptumRx Formulary Tier 2)	$50	$70	40% after deductible
Non-Preferred Drugs (OptumRx Formulary Tier 3)	$80	$110	40% after deductible
Specialty Drugs (OptumRx Formulary/SP noted)	20% to $300 max	30%	40% after deductible
Mail-Order[4]	$30/$30/$100/$160/20% KP $75/$75/$210/$330/30% *OptumRx Retail*		40% after deductible

Plans selected [ ] Compare Plans Reset

	KPLF DC PPO 1500/30%/6000		
Provider Network	**KP Providers**	**Network Providers**	**Out of Network**
Deductible (Individual)	$1,500		$4,500
Deductible (Family)	$3,000		$9,000
Out-of-Pocket Max (Individual)	$6,000		$18,000
Out-of-Pocket Max (Family)	$12,000		$36,000
Telehealth Visit	Primary: $0 KP/$50 Network Specialty: $0 KP/$70 Network		40% after deductible
Primary Care	$30	$50	40% after deductible
Specialty Care	$50	$70	40% after deductible
Hospital Inpatient	30% after deductible		40% after deductible
Outpatient Surgery	30% after deductible		40% after deductible
Emergency Care	$500		$500
Ambulance	$500		$500
Urgent Care (per visit)	$60	$100	40% after deductible
Lab	$0		30% after deductible
X-Ray	$0		30% after deductible
CT/PET/MRI	30% after deductible		40% after deductible
MH/CD Outpatient	$30	$50	40% after deductible
MH/CD Inpatient	30% after deductible		40% after deductible
PT/ST/OT	$50		40% after deductible
Drug Deductible (Individual)	$0		Medical deductible applies
Drug Deductible (Family)	$0		Medical deductible applies
Generic Drugs (Maintenance) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Generic Drugs (Preferred) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Preferred Brand Drugs (OptumRx Formulary Tier 2)	$50	$70	40% after deductible
Non-Preferred Drugs (OptumRx Formulary Tier 3)	$80	$110	40% after deductible
Specialty Drugs (OptumRx Formulary/SP noted)	20% to $300 max	30%	40% after deductible
Mail-Order[4]	$30/$30/$100/$160/20% KP $75/$75/$210/$330/30% *OptumRx Retail*		40% after deductible

Plans selected [ ] Compare Plans Reset

	KPLF DC PPO 2000/10%/7000		
Provider Network	**KP Providers**	**Network Providers**	**Out of Network**
Deductible (Individual)	$2,000		$6,000
Deductible (Family)	$4,000		$12,000
Out-of-Pocket Max (Individual)	$7,000		$21,000
Out-of-Pocket Max (Family)	$14,000		$42,000
Telehealth Visit	Primary: $0 KP/$50 Network Specialty: $0 KP/$70 Network		40% after deductible
Primary Care	$30	$50	40% after deductible
Specialty Care	$50	$70	40% after deductible
Hospital Inpatient	10% after deductible		40% after deductible
Outpatient Surgery	10% after deductible		40% after deductible
Emergency Care	$500		$500
Ambulance	$500		$500
Urgent Care (per visit)	$60	$100	40% after deductible
Lab	$0		30% after deductible
X-Ray	$0		30% after deductible
CT/PET/MRI	$500		40% after deductible
MH/CD Outpatient	$30	$50	40% after deductible
MH/CD Inpatient	10% after deductible		40% after deductible
PT/ST/OT	$50		40% after deductible
Drug Deductible (Individual)	$0		Medical deductible applies
Drug Deductible (Family)	$0		Medical deductible applies
Generic Drugs (Maintenance) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Generic Drugs (Preferred) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Preferred Brand Drugs (OptumRx Formulary Tier 2)	$50	$70	40% after deductible
Non-Preferred Drugs (OptumRx Formulary Tier 3)	$80	$110	40% after deductible
Specialty Drugs (OptumRx Formulary/SP noted)	20% to $300 max	30%	40% after deductible
Mail-Order[4]	$30/$30/$100/$160/20% KP $75/$75/$210/$330/30% *OptumRx Retail*		40% after deductible

Plans selected [ ] Compare Plans Reset

	KPLF DC PPO 2500/30%/7000		
Provider Network	**KP Providers**	**Network Providers**	**Out of Network**
Deductible (Individual)	$2,500		$4,500
Deductible (Family)	$5,000		$9,000
Out-of-Pocket Max (Individual)	$7,000		$18,000
Out-of-Pocket Max (Family)	$14,000		$36,000
Telehealth Visit	Primary: $0 KP/$60 Network Specialty: $0 KP/$80 Network		40% after deductible
Primary Care	$40	$60	40% after deductible
Specialty Care	$60	$80	40% after deductible
Hospital Inpatient	30% after deductible		40% after deductible
Outpatient Surgery	30% after deductible		40% after deductible
Emergency Care	$500		$500
Ambulance	$500		$500
Urgent Care (per visit)	$80	$120	40% after deductible
Lab	$0		30% after deductible
X-Ray	$0		30% after deductible
CT/PET/MRI	30% after deductible		40% after deductible
MH/CD Outpatient	$40	$60	40% after deductible
MH/CD Inpatient	30% after deductible		40% after deductible
PT/ST/OT	$60		40% after deductible
Drug Deductible (Individual)	$0		Medical deductible applies
Drug Deductible (Family)	$0		Medical deductible applies
Generic Drugs (Maintenance) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Generic Drugs (Preferred) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Preferred Brand Drugs (OptumRx Formulary Tier 2)	$50	$70	40% after deductible
Non-Preferred Drugs (OptumRx Formulary Tier 3)	$80	$110	40% after deductible
Specialty Drugs (OptumRx Formulary/SP noted)	20% to $300 max	30%	40% after deductible
Mail-Order[4]	$30/$30/$100/$160/20% KP $75/$75/$210/$330/30% *OptumRx Retail*		40% after deductible

Plans selected [ ] Compare Plans Reset

	KPLF DC PPO 3000/20%/7000		
Provider Network	**KP Providers**	**Network Providers**	**Out of Network**
Deductible (Individual)	$3,000		$9,000
Deductible (Family)	$6,000		$18,000
Out-of-Pocket Max (Individual)	$7,000		$21,000
Out-of-Pocket Max (Family)	$14,000		$42,000
Telehealth Visit	Primary: $0 KP/$60 Network Specialty: $0 KP/$80 Network		40% after deductible
Primary Care	$40	$60	40% after deductible
Specialty Care	$60	$80	40% after deductible
Hospital Inpatient	20% after deductible		40% after deductible
Outpatient Surgery	20% after deductible		40% after deductible
Emergency Care	$500		$500
Ambulance	$500		$500
Urgent Care (per visit)	$80	$120	40% after deductible
Lab	$0		30% after deductible
X-Ray	$0		30% after deductible
CT/PET/MRI	20% after deductible		40% after deductible
MH/CD Outpatient	$40	$60	40% after deductible
MH/CD Inpatient	20% after deductible		40% after deductible
PT/ST/OT	$60		40% after deductible
Drug Deductible (Individual)	$0		Medical deductible applies
Drug Deductible (Family)	$0		Medical deductible applies
Generic Drugs (Maintenance) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Generic Drugs (Preferred) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Preferred Brand Drugs (OptumRx Formulary Tier 2)	$50	$70	40% after deductible
Non-Preferred Drugs (OptumRx Formulary Tier 3)	$80	$110	40% after deductible
Specialty Drugs (OptumRx Formulary/SP noted)	20% to $300 max	30%	40% after deductible
Mail-Order[4]	$30/$30/$100/$160/20% KP $75/$75/$210/$330/30% *OptumRx Retail*		40% after deductible

Plans selected [ ] Compare Plans Reset

	KPLF DC PPO 3500/30%/7500		
Provider Network	**KP Providers**	**Network Providers**	**Out of Network**
Deductible (Individual)	$3,500		$10,500
Deductible (Family)	$7,000		$21,000
Out-of-Pocket Max (Individual)	$7,500		$22,500
Out-of-Pocket Max (Family)	$15,000		$45,000
Telehealth Visit	Primary: $0 KP/$60 Network Specialty: $0 KP/$80 Network		40% after deductible
Primary Care	$40	$60	40% after deductible
Specialty Care	$60	$80	40% after deductible
Hospital Inpatient	30% after deductible		40% after deductible
Outpatient Surgery	30% after deductible		40% after deductible
Emergency Care	30% after deductible		30% after deductible
Ambulance	30% after deductible		30% after deductible
Urgent Care (per visit)	$80	$120	40% after deductible
Lab	$0		30% after deductible
X-Ray	$0		30% after deductible
CT/PET/MRI	30% after deductible		40% after deductible
MH/CD Outpatient	$40	$60	40% after deductible
MH/CD Inpatient	30% after deductible		40% after deductible
PT/ST/OT	$60		40% after deductible
Drug Deductible (Individual)	$0		Medical deductible applies
Drug Deductible (Family)	$0		Medical deductible applies
Generic Drugs (Maintenance) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Generic Drugs (Preferred) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Preferred Brand Drugs (OptumRx Formulary Tier 2)	$50	$70	40% after deductible
Non-Preferred Drugs (OptumRx Formulary Tier 3)	$80	$110	40% after deductible
Specialty Drugs (OptumRx Formulary/SP noted)	20% to $300 max	30%	40% after deductible
Mail-Order[4]	$30/$30/$100/$160/20% KP $75/$75/$210/$330/30% *OptumRx Retail*		40% after deductible

Plans selected [ ] Compare Plans Reset

	KPLF DC PPO 4000/20%/8000		
Provider Network	**KP Providers**	**Network Providers**	**Out of Network**
Deductible (Individual)	$4,000		$12,000
Deductible (Family)	$8,000		$24,000
Out-of-Pocket Max (Individual)	$8,000		$24,000
Out-of-Pocket Max (Family)	$16,000		$48,000
Telehealth Visit	Primary: $0 KP/$60 Network Specialty: $0 KP/$80 Network		40% after deductible
Primary Care	$40	$60	40% after deductible
Specialty Care	$60	$80	40% after deductible
Hospital Inpatient	20% after deductible		40% after deductible
Outpatient Surgery	20% after deductible		40% after deductible
Emergency Care	20% after deductible		20% after deductible
Ambulance	20% after deductible		20% after deductible
Urgent Care (per visit)	$80	$120	40% after deductible
Lab	$0		30% after deductible
X-Ray	$0		30% after deductible
CT/PET/MRI	20% after deductible		40% after deductible
MH/CD Outpatient	$40	$60	40% after deductible
MH/CD Inpatient	20% after deductible		40% after deductible
PT/ST/OT	$60		40% after deductible
Drug Deductible (Individual)	$0		Medical deductible applies
Drug Deductible (Family)	$0		Medical deductible applies
Generic Drugs (Maintenance) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Generic Drugs (Preferred) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Preferred Brand Drugs (OptumRx Formulary Tier 2)	$50	$70	40% after deductible
Non-Preferred Drugs (OptumRx Formulary Tier 3)	$80	$110	40% after deductible
Specialty Drugs (OptumRx Formulary/SP noted)	20% to $300 max	30%	40% after deductible
Mail-Order[4]	$30/$30/$100/$160/20% KP $75/$75/$210/$330/30% *OptumRx Retail*		40% after deductible

Plans selected [ ] Compare Plans Reset

	KPLF DC PPO 4000/30%/8000		
Provider Network	**KP Providers**	**Network Providers**	**Out of Network**
Deductible (Individual)	$4,000		$12,000
Deductible (Family)	$8,000		$24,000
Out-of-Pocket Max (Individual)	$8,000		$24,000
Out-of-Pocket Max (Family)	$16,000		$48,000
Telehealth Visit	Primary: $0 KP/$60 Network Specialty: $0 KP/$80 Network		40% after deductible
Primary Care	$40	$60	40% after deductible
Specialty Care	$60	$80	40% after deductible
Hospital Inpatient	30% after deductible		40% after deductible
Outpatient Surgery	30% after deductible		40% after deductible
Emergency Care	30% after deductible		30% after deductible
Ambulance	30% after deductible		30% after deductible
Urgent Care (per visit)	$80	$120	40% after deductible
Lab	$0		30% after deductible
X-Ray	$0		30% after deductible
CT/PET/MRI	30% after deductible		40% after deductible
MH/CD Outpatient	$40	$60	40% after deductible
MH/CD Inpatient	30% after deductible		40% after deductible
PT/ST/OT	$60		40% after deductible
Drug Deductible (Individual)	$0		Medical deductible applies
Drug Deductible (Family)	$0		Medical deductible applies
Generic Drugs (Maintenance) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Generic Drugs (Preferred) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Preferred Brand Drugs (OptumRx Formulary Tier 2)	$50	$70	40% after deductible
Non-Preferred Drugs (OptumRx Formulary Tier 3)	$80	$110	40% after deductible
Specialty Drugs (OptumRx Formulary/SP noted)	20% to $300 max	30%	40% after deductible
Mail-Order[4]	$30/$30/$100/$160/20% KP $75/$75/$210/$330/30% *OptumRx Retail*		40% after deductible

Plans selected [ ] Compare Plans Reset

	KPLF DC PPO 4500/10%/8000		
Provider Network	**KP Providers**	**Network Providers**	**Out of Network**
Deductible (Individual)	$4,500		$13,500
Deductible (Family)	$9,000		$27,000
Out-of-Pocket Max (Individual)	$8,000		$24,000
Out-of-Pocket Max (Family)	$16,000		$48,000
Telehealth Visit	Primary: $0 KP/$50 Network Specialty: $0 KP/$70 Network		40% after deductible
Primary Care	$30	$50	40% after deductible
Specialty Care	$50	$70	40% after deductible
Hospital Inpatient	10% after deductible		40% after deductible
Outpatient Surgery	10% after deductible		40% after deductible
Emergency Care	$600		$600
Ambulance	$600		$600
Urgent Care (per visit)	$60	$100	40% after deductible
Lab	$0		30% after deductible
X-Ray	$0		30% after deductible
CT/PET/MRI	$500		40% after deductible
MH/CD Outpatient	$30	$50	40% after deductible
MH/CD Inpatient	10% after deductible		40% after deductible
PT/ST/OT	$50		40% after deductible
Drug Deductible (Individual)	$0		Medical deductible applies
Drug Deductible (Family)	$0		Medical deductible applies
Generic Drugs (Maintenance) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Generic Drugs (Preferred) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Preferred Brand Drugs (OptumRx Formulary Tier 2)	$50	$70	40% after deductible
Non-Preferred Drugs (OptumRx Formulary Tier 3)	$80	$110	40% after deductible
Specialty Drugs (OptumRx Formulary/SP noted)	20% to $300 max	30%	40% after deductible
Mail-Order[4]	$30/$30/$100/$160/20% KP $75/$75/$210/$330/30% OptumRx Retail		40% after deductible

Plans selected [ ] Compare Plans Reset

	KPLF DC PPO 5000/30%/8500		
Provider Network	**KP Providers**	**Network Providers**	**Out of Network**
Deductible (Individual)	$5,000		$15,000
Deductible (Family)	$10,000		$30,000
Out-of-Pocket Max (Individual)	$8,500		$25,500
Out-of-Pocket Max (Family)	$17,000		$51,000
Telehealth Visit	Primary: $0 KP/$70 Network Specialty: $0 KP/$90 Network		40% after deductible
Primary Care	$50	$70	40% after deductible
Specialty Care	$70	$90	40% after deductible
Hospital Inpatient	30% after deductible		40% after deductible
Outpatient Surgery	30% after deductible		40% after deductible
Emergency Care	30% after deductible		30% after deductible
Ambulance	30% after deductible		30% after deductible
Urgent Care (per visit)	$100	$140	40% after deductible
Lab	$0		30% after deductible
X-Ray	$0		30% after deductible
CT/PET/MRI	30% after deductible		40% after deductible
MH/CD Outpatient	$50	$70	40% after deductible
MH/CD Inpatient	30% after deductible		40% after deductible
PT/ST/OT	$70		40% after deductible
Drug Deductible (Individual)	$250 (except Tier 1 & 2 Generics)		Medical deductible applies
Drug Deductible (Family)	$500 (except Tier 1 & 2 Generics)		Medical deductible applies
Generic Drugs (Maintenance) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Generic Drugs (Preferred) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Preferred Brand Drugs (OptumRx Formulary Tier 2)	$50 after Rx Ded	$70 after Rx Ded	40% after deductible
Non-Preferred Drugs (OptumRx Formulary Tier 3)	$80 after Rx Ded	$110 after Rx Ded	40% after deductible
Specialty Drugs (OptumRx Formulary/SP noted)	20% to $300 max after Rx Ded	30% after Rx Ded	40% after deductible
Mail-Order[4]	$30/$30/$100/$160/20% KP $75/$75/$210/$330/30% *OptumRx Retail*		40% after deductible

Plans selected [ ] Compare Plans Reset

	KPLF DC PPO 5500/10%/8500		
Provider Network	**KP Providers**	**Network Providers**	**Out of Network**
Deductible (Individual)	$5,500		$16,500
Deductible (Family)	$11,000		$33,000
Out-of-Pocket Max (Individual)	$8,500		$25,500
Out-of-Pocket Max (Family)	$17,000		$51,000
Telehealth Visit	Primary: $0 KP/$50 Network Specialty: $0 KP/$70 Network		40% after deductible
Primary Care	$30	$50	40% after deductible
Specialty Care	$50	$70	40% after deductible
Hospital Inpatient	10% after deductible		40% after deductible
Outpatient Surgery	10% after deductible		40% after deductible
Emergency Care	$600		$600
Ambulance	$600		$600
Urgent Care (per visit)	$60	$100	40% after deductible
Lab	$0		30% after deductible
X-Ray	$0		30% after deductible
CT/PET/MRI	$500		40% after deductible
MH/CD Outpatient	$30	$50	40% after deductible
MH/CD Inpatient	10% after deductible		40% after deductible
PT/ST/OT	$50		40% after deductible
Drug Deductible (Individual)	$0		Medical deductible applies
Drug Deductible (Family)	$0		Medical deductible applies
Generic Drugs (Maintenance) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Generic Drugs (Preferred) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Preferred Brand Drugs (OptumRx Formulary Tier 2)	$50	$70	40% after deductible
Non-Preferred Drugs (OptumRx Formulary Tier 3)	$80	$110	40% after deductible
Specialty Drugs (OptumRx Formulary/SP noted)	20% to $300 max	30%	40% after deductible
Mail-Order[4]	$30/$30/$100/$160/20% KP $75/$75/$210/$330/30% *OptumRx Retail*		40% after deductible

Plans selected [ ] Compare Plans Reset

	KPLF DC PPO 5500/30%/8500		
Provider Network	**KP Providers**	**Network Providers**	**Out of Network**
Deductible (Individual)	$5,500		$16,500
Deductible (Family)	$11,000		$33,000
Out-of-Pocket Max (Individual)	$8,500		$25,500
Out-of-Pocket Max (Family)	$17,000		$51,000
Telehealth Visit	Primary: $0 KP/$70 Network Specialty: $0 KP/$90 Network		40% after deductible
Primary Care	$50	$70	40% after deductible
Specialty Care	$70	$90	40% after deductible
Hospital Inpatient	30% after deductible		40% after deductible
Outpatient Surgery	30% after deductible		40% after deductible
Emergency Care	30% after deductible		30% after deductible
Ambulance	30% after deductible		30% after deductible
Urgent Care (per visit)	$100	$140	40% after deductible
Lab	$0		30% after deductible
X-Ray	$0		30% after deductible
CT/PET/MRI	30% after deductible		40% after deductible
MH/CD Outpatient	$50	$70	40% after deductible
MH/CD Inpatient	30% after deductible		40% after deductible
PT/ST/OT	$70		40% after deductible
Drug Deductible (Individual)	$250 (except Tier 1 & 2 Generics)		Medical deductible applies
Drug Deductible (Family)	$500 (except Tier 1 & 2 Generics)		Medical deductible applies
Generic Drugs (Maintenance) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Generic Drugs (Preferred) (OptumRx Formulary Tier 1)	$15	$25	40% after deductible
Preferred Brand Drugs (OptumRx Formulary Tier 2)	$50 after Rx Ded	$70 after Rx Ded	40% after deductible
Non-Preferred Drugs (OptumRx Formulary Tier 3)	$80 after Rx Ded	$110 after Rx Ded	40% after deductible
Specialty Drugs (OptumRx Formulary/SP noted)	20% to $300 max after Rx Ded	30% after Rx Ded	40% after deductible
Mail-Order[4]	$30/$30/$100/$160/20% KP $75/$75/$210/$330/30% *OptumRx Retail*		40% after deductible

Plans selected ☐ Compare Plans Reset

	KPLF DC PPO HDHP 3500/20%/5500		
Provider Network	**KP Providers**	**Network Providers**	**Out of Network**
Deductible (Individual)	$3,500		$10,500
Deductible (Family)	$7,000		$21,000
Out-of-Pocket Max (Individual)	$5,500		$16,500
Out-of-Pocket Max (Family)	$11,000		$33,000
Telehealth Visit	Primary: 20% KP/30% Network Specialty: 20% KP/30% Network		40% after deductible
Primary Care	20% after deductible	30% after deductible	40% after deductible
Specialty Care	20% after deductible	30% after deductible	40% after deductible
Hospital Inpatient	20% after deductible		40% after deductible
Outpatient Surgery	20% after deductible		40% after deductible
Emergency Care	20% after deductible		20% after deductible
Ambulance	20% after deductible		20% after deductible
Urgent Care (per visit)	20% after deductible	30% after deductible	40% after deductible
Lab	20% after deductible		40% after deductible
X-Ray	20% after deductible		40% after deductible
CT/PET/MRI	20% after deductible		40% after deductible
MH/CD Outpatient	20% after deductible	30% after deductible	40% after deductible
MH/CD Inpatient	20% after deductible		40% after deductible
PT/ST/OT	20% after deductible		40% after deductible
Drug Deductible (Individual)	Medical deductible applies		Medical deductible applies
Drug Deductible (Family)	Medical deductible applies		Medical deductible applies
Generic Drugs (Maintenance) (OptumRx Formulary Tier 1)	20% after deductible	30% after deductible	40% after deductible
Generic Drugs (Preferred) (OptumRx Formulary Tier 1)	20% after deductible	30% after deductible	40% after deductible
Preferred Brand Drugs (OptumRx Formulary Tier 2)	20% after deductible	30% after deductible	40% after deductible
Non-Preferred Drugs (OptumRx Formulary Tier 3)	20% after deductible	30% after deductible	40% after deductible
Specialty Drugs (OptumRx Formulary/SP noted)	20% after deductible	30% after deductible	40% after deductible
Mail-Order[4]	20% after deductible	30% after deductible	40% after deductible

Plans selected [ ] Compare Plans Reset

	KPLF DC PPO HDHP 5000/30%/7000		
Provider Network	**KP Providers**	**Network Providers**	**Out of Network**
Deductible (Individual)	$5,000		$15,000
Deductible (Family)	$10,000		$30,000
Out-of-Pocket Max (Individual)	$7,000		$21,000
Out-of-Pocket Max (Family)	$14,000		$42,000
Telehealth Visit	Primary: 30% KP/35% Network Specialty: 30% KP/35% Network		40% after deductible
Primary Care	30% after deductible	35% after deductible	40% after deductible
Specialty Care	30% after deductible	35% after deductible	40% after deductible
Hospital Inpatient	30% after deductible		40% after deductible
Outpatient Surgery	30% after deductible		40% after deductible
Emergency Care	30% after deductible		30% after deductible
Ambulance	30% after deductible		30% after deductible
Urgent Care (per visit)	30% after deductible	35% after deductible	40% after deductible
Lab	30% after deductible		40% after deductible
X-Ray	30% after deductible		40% after deductible
CT/PET/MRI	30% after deductible		40% after deductible
MH/CD Outpatient	30% after deductible	35% after deductible	40% after deductible
MH/CD Inpatient	30% after deductible		40% after deductible
PT/ST/OT	30% after deductible		40% after deductible
Drug Deductible (Individual)	Medical deductible applies		Medical deductible applies
Drug Deductible (Family)	Medical deductible applies		Medical deductible applies
Generic Drugs (Maintenance) (OptumRx Formulary Tier 1)	30% after deductible	35% after deductible	40% after deductible
Generic Drugs (Preferred) (OptumRx Formulary Tier 1)	30% after deductible	35% after deductible	40% after deductible
Preferred Brand Drugs (OptumRx Formulary Tier 2)	30% after deductible	35% after deductible	40% after deductible
Non-Preferred Drugs (OptumRx Formulary Tier 3)	30% after deductible	35% after deductible	40% after deductible
Specialty Drugs (OptumRx Formulary/SP noted)	30% after deductible	35% after deductible	40% after deductible
Mail-Order[4]	30% after deductible	35% after deductible	40% after deductible

Plans selected [ ] Compare Plans Reset

	KPLF DC PPO HDHP 6000/10%/7000		
Provider Network	**KP Providers**	**Network Providers**	**Out of Network**
Deductible (Individual)	$6,000		$18,000
Deductible (Family)	$12,000		$36,000
Out-of-Pocket Max (Individual)	$7,000		$21,000
Out-of-Pocket Max (Family)	$14,000		$42,000
Telehealth Visit	Primary: 10% KP/20% Network Specialty: 10% KP/20% Network		40% after deductible
Primary Care	10% after deductible	20% after deductible	40% after deductible
Specialty Care	10% after deductible	20% after deductible	40% after deductible
Hospital Inpatient	10% after deductible		40% after deductible
Outpatient Surgery	10% after deductible		40% after deductible
Emergency Care	10% after deductible		10% after deductible
Ambulance	10% after deductible		10% after deductible
Urgent Care (per visit)	10% after deductible	20% after deductible	40% after deductible
Lab	10% after deductible		40% after deductible
X-Ray	10% after deductible		40% after deductible
CT/PET/MRI	10% after deductible		40% after deductible
MH/CD Outpatient	10% after deductible	20% after deductible	40% after deductible
MH/CD Inpatient	10% after deductible		40% after deductible
PT/ST/OT	10% after deductible		40% after deductible
Drug Deductible (Individual)	Medical deductible applies		Medical deductible applies
Drug Deductible (Family)	Medical deductible applies		Medical deductible applies
Generic Drugs (Maintenance) (OptumRx Formulary Tier 1)	10% after deductible	20% after deductible	40% after deductible
Generic Drugs (Preferred) (OptumRx Formulary Tier 1)	10% after deductible	20% after deductible	40% after deductible
Preferred Brand Drugs (OptumRx Formulary Tier 2)	10% after deductible	20% after deductible	40% after deductible
Non-Preferred Drugs (OptumRx Formulary Tier 3)	10% after deductible	20% after deductible	40% after deductible
Specialty Drugs (OptumRx Formulary/SP noted)	10% after deductible	20% after deductible	40% after deductible
Mail-Order[4]	10% after deductible	20% after deductible	40% after deductible

Compare plans – EPO, DEPO, EC, and HDHP

Plan options			
Product type			
Deductible Individual/Family			
Out-of-pocket maximum Individual/Family			
Coinsurance (member's cost)			
Emergency room			
Urgent care			
Inpatient hospital			
Virtual care services (Chat, video visit, email, phone)[1]			
PCP office visit			
Specialist office visit			
Outpatient mental health			
MRI, CT, and PET			
Lab & X-ray			
Outpatient surgery			
Prescription drugs[2]			
Generic			
Brand			
Brand non-preferred			
Specialty			
Pharmacy deductible			

Information may have changed since publication.

Start over

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

Compare plans – Dual Choice PPO

Provider Network	KP Providers	Network Providers	Out of Network	KP Providers	Network Providers	Out of Network	KP Providers	Network Providers	Out of Network
Deductible (Individual)									
Deductible (Family)									
Out-of-Pocket Max (Individual)									
Out-of-Pocket Max (Family)									
Telehealth Visit									
Primary Care									
Specialty Care									
Hospital Inpatient									
Outpatient Surgery									
Emergency Care									
Ambulance									
Urgent Care (per visit)									
Lab									
X-Ray									
CT/PET/MRI									
MH/CD Outpatient									
MH/CD Inpatient									
PT/ST/OT									
Drug Deductible (Individual)									
Drug Deductible (Family)									
Generic Drugs (Maintenance) (OptumRx Formulary Tier 1)									
Generic Drugs (Preferred) (OptumRx Formulary Tier 1)									
Preferred Brand Drugs (OptumRx Formulary Tier 2)									
Non-Preferred Drugs (OptumRx Formulary Tier 3)									
Specialty Drugs (OptumRx Formulary/SP noted)									
Mail-Order[4]									

Footnotes

*Plus is available on EPO/DEPO, except where coinsurance is 50%; Plus is not available on HDHP, Everyday Care (EDC), POS, or PPO.

This plan 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. Standard plans shown here. Plan documents will reflect final benefits resulting from any customization. Kaiser Permanente Insurance Company (KPIC) provides administrative services and underwrites stop loss insurance for the Kaiser Permanente Level Funded program. Plan availability is subject to change and is controlled via the quoting process.

1. Chat, video, and phone services are offered at no additional cost for most plans. For these services, some POS, PPO, or high-deductible health plans are subject to a copayment, coinsurance, or deductible first before being provided at no additional cost.
2. Depending on your specific plan provisions, maintenance medication refills must be filled at one of our Kaiser Permanente Plan Medical Office pharmacies or through the Kaiser Permanente mail-order program or the maintenance medication will not be covered. Some prescriptions are not eligible to be mailed or delivered.
3. Aggregate accumulation applies. All other plans utilize Embedded accumulation.
4. Available 90-day supply through Kaiser Permanente Pharmacy and OptumRx Retail Pharmacies. 30-day supply available for out-of-network.