Active Employees and Pre-65 Retirees (Non-Medicare Only)	Kaiser Permanente HMO - Northern & Southern California*	

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Plan Changes are in Orange	2026 In-Network	Comments
General Information		
Lifetime Maximum Benefit	None	
Annual Maximum Benefit	None	
Coinsurance Percentage	100% after applicable copay	
Precertification Requirements	None	
Precertification Penalty	None	
Health Savings Account (HSA)	N/A	
Health Reimbursement Account (HRA)	N/A	
R & C	N/A	
Deductibles		
Individual Annual Deductible	None	
Family Annual Deductible	None	
Applies to Out-of-Pocket Maximum	N/A	
Prescription benefits are covered under medical deductible	N/A	
Out-of-Pocket Mx per Plan Year		
Individual Out-of-Pocket Maximum Per Year	$3,000	
Family Out-of-Pocket Maximum Per Year	$6,000	
Outpatient Services		
Primary Care Physician Visits	$20 per visit	
Specialist Visit	$35 per visit	
Lab tests and X-ray	No charge. $20 office visit copay may apply.	
Specialized Imaging	$100 Copay	
Outpatient Surgery	Outpatient Surgery Center: $100 per procedure; PCP Office: $20 per procedure	
Allergy Testing	$35 per visit	
Allergy Injections	No charge; office visit copay may apply	
Preventive Care		
Well Child Care Office Visit	100% covered	
Well Child Age limit	23 months	
Adult Routine Physical Exams	100% covered	
Adult Immunizations	No charge; office visit copay may apply	
Routine Mammogram	No charge	
Pap Smear	100% covered	
Prostate Screening (PSA)	100% covered	
Colon Cancer Screenings	100% covered	
Cardiovascular screenings	100% covered	
Hearing Evaluations	Preventive: 100% covered; PCP Diagnostic: $20 copay; Specialist Diagnostic: $35 copay	
Inpatient Hospital		
Deductible per Confinement	None	
Deductible per Day	None	
Hospital Services	No charge	
Physicians and Surgeons' Services	No charge	
Emergency Services		
Emergency Room Treatment	$75 per visit; waived if admitted	
Non-emergency or non-urgent use of ER	Not covered	
Ambulance	No charge	
Urgent Care Facility Services	$20 per visit	
Physician Office Visit	Included in $75 ER copay	
After Hours	$20 per Urgent Care visit; $75 per ER visit	
Maternity Care		
Physician Office Visit	No charge	
Maternity Care - Inpatient Delivery	No charge	

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Midwife delivery services	No charge; at facilities where available	Effective 1/1/2025, coverage for doula services, including prenatal and postpartum visits and support during labor and delivery is available in response to AB 904. For pregnant members (or those pregnant in the past twelve months), we will cover the following doula services: 11 visit limit per pregnancy, an initial visit, up to 8 one-hour visits that may be provided in any combination of prenatal and postpartum visits. Up to two additional postpartum visits may be available after the end of a pregnancy. Support during labor and delivery is available. Visits are $0 cost sharing and is not subject to any deductible.
Mental Health		
Deductible per Confinement	None	
Deductible per Day	None	
Mental Health Inpatient	No charge	
Mental Health-Inpatient Plan Maximums	None	
Mental Health Outpatient	$20 per individual visit	
Mental Health - Group Therapy	$10 per group visit	
Mental Health-Outpatient Plan Maximums	None	
Severe Mental Illness	No charge for inpatient; $20 per individual outpatient visit; $10 per group outpatient visit; no day or visit limits	
Substance Abuse		
Deductible per Confinement	None	
Deductible per Day	None	
Detoxification	No charge	
Substance Abuse - Inpatient Treatment	No charge for Transitional Residential Recovery Services (TRRS) in a non-medical setting	
Substance Abuse-Inpatient Plan Maximums	Limited to detox only Transitional Residential Recovery Services provided at no charge and with no day limits, in compliance with MHPA, as long as medically necessary and prescribed by a Plan physician	
Substance Abuse-Outpatient	$20 per individual visit; $5 per group visit	
Substance Abuse-Outpatient Plan Maximums	Unlimited	
Rehabilitation Therapy		
Inpatient Rehabilitation	No charge	
Outpatient Physical, Occupational, and Speech Therapy	$20 copay per visit. Benefits limited to medically necessary therapy authorized by a Plan physician.	
Alternative Care		
Chiropractic Care	$15 per visit, up to 30 visits per calendar year with American Specialty Health Plans rider	
Acupuncture	$35 per visit when approved by a Plan physician, generally as a component of a multidisciplinary pain management program for the treatment of chronic pain	
Acupressure	Not covered	
Massage Therapy	Not covered	
Other Services		
Private-Duty Nursing Care	Not covered	
Durable Medical Equipment	No charge when prescribed by a Plan physician in accordance with Formulary guidelines	
Prosthetic and Orthotic Appliances	No charge when prescribed by a Plan physician in accordance with Formulary guidelines	
Smoking Cessation	Covered health education classes are at no charge. Smoking cessation drugs are covered the same as other drugs when members participate in a behavioral health class.	
Weight control program	Covered health education classes are at no charge	
Bariatric surgery	If determined medically necessary by a Plan physician, and program requirements are met, covered at $35 per visit, no charge for inpatient hospitalization	
TMJ	Inpatient: 100% covered; Outpatient: PCP $20 copay per encounter; Surgery Center or Specialist: $35 copay per encounter. Must be deemed medically necessary (i.e. etiology must be medical, not dental).	
Podiatry Services	$35 per visit when medically necessary	

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Home Health Care	No charge when prescribed by a Plan physician; limited to 2 hours/visit, 3 visits/day, 100 visits per year	
Skilled Nursing Facility Care	No charge, up to 100 days per benefit period	
Hospice Care	No charge when authorized by a Plan physician for a terminal diagnosis with life expectancy of less than one year	
Hearing Aids	Not covered	
Family Planning		
Tubal ligation	No charge; after appropriate counseling	
Vasectomy	No charge; after appropriate counseling	
Contraceptive Drugs	100% covered	
Contraceptive Devices	100% covered	
Infertility Testing	100% covered	In accordance with SB720. Members will have the same cost share for fertility services as they do when they receive those services for other conditions. Deductibles, copayments, and coinsurance for fertility services will be applied to any out-of-pocket maximums for their benefit plan.
Infertility Treatments - Office Visit	100% covered	In accordance with SB720. Members will have the same cost share for fertility services as they do when they receive those services for other conditions. Deductibles, copayments, and coinsurance for fertility services will be applied to any out-of-pocket maximums for their benefit plan.
Infertility Treatments - Surgery	100% covered	In accordance with SB720. Members will have the same cost share for fertility services as they do when they receive those services for other conditions. Deductibles, copayments, and coinsurance for fertility services will be applied to any out-of-pocket maximums for their benefit plan.
In Vitro Fertilization	100% covered	In accordance with SB720. Members will have the same cost share for fertility services as they do when they receive those services for other conditions. Deductibles, copayments, and coinsurance for fertility services will be applied to any out-of-pocket maximums for their benefit plan.
Infertility Treatments - Lifetime Maximum	Treatment for involuntary infertility is covered as authorized by a Plan physician	In accordance with SB720. Members will have the same cost share for fertility services as they do when they receive those services for other conditions. Deductibles, copayments, and coinsurance for fertility services will be applied to any out-of-pocket maximums for their benefit plan. Up to 3 completed oocyte retrievals with unlimited embryo transfers.
Vision Care		
Eye Examination	Preventive: 100% covered; PCP Diagnostic: $20 copay; Specialist Diagnostic: $35 copay	
Lenses	Not covered	
Frames	Not covered	
Contact lenses- necessary	When prescribed by a Plan physician, no charge for contact lenses to treat aniridia (missing iris), up to two lenses per eye every 12 months. When prescribed by a Plan physician for aphakia (absence of the crystalline lens of the eye), no charge for up to 6 lenses per eye every 12 months, through age 9	
Contact lenses-elective	Not covered	
Lasik Eye Surgery	Not covered	
Organ and Tissue Transplants		
Organ Transplant -Inpatient	No charge for inpatient	
Organs covered	Heart, lung, heart/lung, liver, kidney, small bowel, pancreas, simultaneous pancreas/kidney and liver/kidney, cornea, and bone marrow, when transplant is determined to be medically necessary	
Transplant Travel	Covered when pre-authorized by the Plan physician and related to the provision of covered services, in accordance with Plan policies	
Transplant donor expenses	Certain medical and hospital expenses are covered if approved by Health Plan and the expenses are directly related to the transplant	
Lifetime Maximum	None	
Prescription Drug Coverage		
Annual Prescription Deductible - Family	None	
Annual Prescription Deductible - Individual	None	
Out-of-Pocket Maximums - Individual	N/A	
Out-of-Pocket Maximums - Family	N/A	
Annual Maximum Benefit	Unlimited	
Lifetime Maximum Benefit	Unlimited	
Generic Substitution	Determined by patient's Plan physician	
Retail Refill Penalty	None	
Prescription Drug Retail		

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Retail - Generic	$10 per prescription, up to a 30-day supply All prescriptions must be medically necessary, prescribed by a Plan physician, and obtained from a Plan pharmacy of from Plan mail order to be covered	
Retail - Brand Formulary	$25 per prescription; up to 30-day supply; when medically necessary, prescribed by a Plan physician, and filled at Plan pharmacies	
Retail - Brand Non-Formulary	$25 per prescription; up to 30-day supply; when medically necessary, prescribed by a Plan physician, and filled at Plan pharmacies	
Single Source Brand	$25 per prescription; up to 30-day supply; when medically necessary, prescribed by a Plan physician, and filled at Plan pharmacies	
Multi Source Brand	$25 per prescription; up to 30-day supply; when medically necessary, prescribed by a Plan physician, and filled at Plan pharmacies	
Injectable Medications	$10 per generic/$25 per brand prescription, up to a 30-day supply	
Prescription Drug Mail Order		
Mail-Order - Generic	$10 for up to a 30-day supply, or $20 for a 31 to 100-day supply	
Mail-Order - Brand Formulary	$25 for up to 30-day supply; $50 for a 31- day up to a 100-day supply; when medically necessary, prescribed by a Plan physician and filled at Plan mail order	
Mail-Order - Brand Non-Formulary	$25 for up to 30-day supply; $50 for a 31 -day up to a 100-day supply; when medically necessary, prescribed by a Plan physician and filled at Plan mail order	
Single Source Brand	$25 for up to 30-day supply; $50 for a 31 -day up to a 100-day supply; when medically necessary, prescribed by a Plan physician and filled at Plan mail order	
Multi Source Brand	$25 for up to 30-day supply; $50 for a 31 -day up to a 100-day supply; when medically necessary, prescribed by a Plan physician and filled at Plan mail order	
Injectable Medications	$10 Generic/$25 brand for up to a 30-day supply, or $20 generic/$50 brand for a 31- to 100-day supply	
Day Supply	Up to 100	
Other Services - Prescription Drugs		
Over the Counter	FDA-approved over-the-counter contraceptive drugs and devices won't require a prescription to be covered at $0	
Prenatal Vitamins	Not covered	
Diabetic Supplies	Insulin: $10 copay for up to 100-day supply; Testing supplies: 100% covered up to 100-day supply in accordance with DME base formulary guidelines	
Lifestyle Drugs	Drugs for the treatment of sexual dysfunction are covered at 50% of charges with a maximum dosage limit of 8 doses for 30-day supply or 27 doses for 100-day supply	
Contraceptives - Injectable	Covered at no charge when dispensed in Plan Medical Offices	
Fertility Drugs	Covered at applicable prescription copay	
Smoking Cessation	Covered at applicable prescription copay if prescribed by a Plan physician and patient is concurrently participating in a Plan-approved behavioral modification program	
Cosmetic Medications	Not covered	
Nutritional Supplements	Not covered	