Medical Plan Offerings– Kaiser Permanente 2025*

*Carrier availability is based on client headquartered location, as well as client selection.

Information shown in this document does not include all plan details or changes. Refer to the Carrier Certificate on TriNet (login.TriNet.com).

PY25 TN III-Q2

trinet

Plan Offerings

Plan Highlights	Kaiser (HMO 20 WA)	Kaiser (HMO 30 WA)	Kaiser HDHP 6650 CO	Kaiser HDHP 6650 GA	Kaiser HMO 20 CA	Kaiser HMO 20 CO
Network Name	Kaiser HMO	Kaiser HMO	Kaiser Permanente	Kaiser Permanente	Kaiser HMO	Kaiser HMO
Deductible						
Single (In-Network/OON)	$0 / Not Covered	$1,000 / Not Covered	$6,650 / Not Covered	$6,650 / Not Covered	$0 / Not Covered	$0 / Not Covered
Family (In-Network/OON)	$0 / Not Covered	$2,000 / Not Covered	$13,300 / Not Covered	$13,300 / Not Covered	$0 / Not Covered	$0 / Not Covered
Out-of-Pocket Max						
Single (In-Network/OON)	$2,000 / Not Covered	$2,000 / Not Covered	$6,650 / Not Covered	$6,650 / Not Covered	$1,500 / Not Covered	$2,000 / Not Covered
Family (In-Network/OON)	$4,000 / Not Covered	$4,000 / Not Covered	$13,300 / Not Covered	$13,300 / Not Covered	$3,000 / Not Covered	$4,000 / Not Covered
Coinsurance (In-Network /OON)	0% / Not Covered	20% / Not Covered	0% / Not Covered	0% / Not Covered	0% / Not Covered	0% / Not Covered
Primary / Specialist	$20 / $40	20% after ded + $30 / 20% after ded + $30	0% after ded / 0% after ded	0% after ded / 0% after ded	$20 / $35	$20 / $35
Lab & X-Ray	0%	20% after ded	0% after ded	0% after ded	0%	0%
Urgent Care Visit	$20	20% after ded + $30	0% after ded	0% after ded	$20	$50
Emergency Room Visit	$100	20% after ded + $150	0% after ded	0% after ded	$100	$100
Hospital Outpatient (Facility / Surgery)	$0 / $40	20% after ded / 20% after ded + $50	0% after ded / 0% after ded	0% after ded / 0% after ded	$0 / $35	$0 / $100
Hospital Inpatient	$250	20% after ded	0% after ded	0% after ded	$250	$250
Rx Deductible (Non-Generic)	N/A	N/A	Integrated w/Med	Integrated w/med	N/A	N/A
Prescriptions (Tier 1 / 2 / 3)	$10 / $35 / $70	$10 / $35 / $70	0% after ded / 0% after ded / 0% after ded	0% after ded / 0% after ded / 0% after ded	$10 / $35 / $35	$10 / $30 / $50

Plan Offerings

Plan Highlights	Kaiser HMO 20 DC /MD/VA	Kaiser HMO 20 GA	Kaiser HMO 20 Northwest	Kaiser HMO 25 DC /MD/VA	Kaiser HMO 30 CO	Kaiser HMO 30 Ded CA
Network Name	Kaiser HMO	Kaiser HMO	Kaiser HMO	Kaiser HMO	Kaiser HMO	Kaiser HMO
Deductible						
Single (In-Network/OON)	$0 / Not Covered	$0 / Not Covered	$0 / Not Covered	$1,000 / Not Covered	$1,000 / Not Covered	$1,000 / Not Covered
Family (In-Network/OON)	$0 / Not Covered	$0 / Not Covered	$0 / Not Covered	$2,000 / Not Covered	$2,000 / Not Covered	$2,000 / Not Covered
Out-of-Pocket Max						
Single (In-Network/OON)	$2,000 / Not Covered	$6,350 / Not Covered	$2,000 / Not Covered	$3,000 / Not Covered	$2,000 / Not Covered	$2,000 / Not Covered
Family (In-Network/OON)	$4,000 / Not Covered	$12,700 / Not Covered	$4,000 / Not Covered	$6,000 / Not Covered	$4,000 / Not Covered	$4,000 / Not Covered
Coinsurance (In-Network /OON)	0% / Not Covered	0% / Not Covered	0% / Not Covered	20% / Not Covered	20% / Not Covered	20% / Not Covered
Primary / Specialist	$20 / $35	$20 / $35	$20 / $35	$25 / $35	$30+20% / $45+20%	$30 / $45
Lab & X-Ray	0%	0%	0%	20% after ded	20%	$10 after ded
Urgent Care Visit	$35	$50	$50	$35	$75+20%	$30
Emergency Room Visit	$50	$100	$100	$75	$150+20%	20% after ded
Hospital Outpatient (Facility / Surgery)	$0 / $35	$0 / $100	$0 / $100	20% after ded / 20% after ded	20% after ded / 20% after ded	20% after ded / 20% after ded
Hospital Inpatient	$250	$250	$250	20% after ded	20% after ded	20% after ded
Rx Deductible (Non-Generic)	N/A	N/A	N/A	N/A	N/A	N/A
Prescriptions (Tier 1 / 2 / 3)	$10 (Kaiser Pharmacy) / $30 (Kaiser Pharmacy) / $50 (Kaiser Pharmacy)	$10 (Kaiser Pharmacy) / $30 (Kaiser Pharmacy) / $50 (Kaiser Pharmacy)	$10 / $30 / $50	$20 (Kaiser Pharmacy) / $30 (Kaiser Pharmacy) / $45 (Kaiser Pharmacy)	$10 / $30 / $50	$10 / $35 / $35

Plan Offerings

Plan Highlights	Kaiser HMO 30 GA	Kaiser HMO 30 Northwest	Kaiser HMO 30/co-pay CA	Kaiser HMO 3000 CO	Kaiser HMO 3000 GA	Kaiser HMO 4500 CA
Network Name	Kaiser HMO	Kaiser HMO	Kaiser HMO	Kaiser Permanente	Kaiser Permanente	Kaiser HMO
Deductible						
Single (In-Network/OON)	$1,000 / Not Covered	$1,000 / Not Covered	$0 / Not Covered	$3,000 / Not Covered	$3,000 / Not Covered	$4,500 / Not Covered
Family (In-Network/OON)	$2,000 / Not Covered	$2,000 / Not Covered	$0 / Not Covered	$6,000 / Not Covered	$6,000 / Not Covered	$9,000 / Not Covered
Out-of-Pocket Max						
Single (In-Network/OON)	$2,000 / Not Covered	$2,000 / Not Covered	$1,500 / Not Covered	$5,000 / Not Covered	$5,000 / Not Covered	$6,000 / Not Covered
Family (In-Network/OON)	$4,000 / Not Covered	$4,000 / Not Covered	$3,000 / Not Covered	$10,000 / Not Covered	$10,000 / Not Covered	$12,000 / Not Covered
Coinsurance (In-Network /OON)	20% / Not Covered	20% / Not Covered	0% / Not Covered	30% / Not Covered	30% / Not Covered	40% / Not Covered
Primary / Specialist	$30 / $45	$30 / $45	$30 / $30	$35+30% / $60+30%	$35 / $60	$50 after ded / $50 after ded
Lab & X-Ray	0%	20%	0%	30% after ded	30% after ded	40% after ded
Urgent Care Visit	$75	$50	$30	$75+30%	$75	$50 after ded
Emergency Room Visit	$150	$100 after ded	$100	30% after ded	30% after ded	$250 after ded
Hospital Outpatient (Facility / Surgery)	20% after ded / 20% after ded	20% after ded / 20% after ded	$0 / $200	30% after ded / 30% after ded	30% after ded / 30% after ded	40% after ded / 40% after ded
Hospital Inpatient	20% after ded	20% after ded	$500	30% after ded	30% after ded	40% after ded
Rx Deductible (Non-Generic)	N/A	N/A	N/A	N/A	N/A	$250
Prescriptions (Tier 1 / 2 / 3)	$10 (Kaiser Pharmacy) / $30 (Kaiser Pharmacy) / $50 (Kaiser Pharmacy)	$10 / $30 / $50	$15 / $35 / $35	$20 / $50 / 50%	$20 (Kaiser Pharmacy) / $50 (Kaiser Pharmacy) / 50% (Kaiser Pharmacy)	$15 / $35 after Rx ded / $35 after Rx ded

Plan Offerings

Plan Highlights	Kaiser HMO HI	Kaiser HMO/HDHP 3500 CA	Kaiser POS HI
Network Name	Kaiser HMO	Kaiser HMO	Kaiser Permanente Added Choice POS
Deductible			
Single (In-Network/OON)	$0 / Not Covered	$3,500 / Not Covered	$0 / $100
Family (In-Network/OON)	$0 / Not Covered	$7,000 / Not Covered	$0 / $300
Out-of-Pocket Max			
Single (In-Network/OON)	$2,000 / Not Covered	$7,000 / Not Covered	$2,000 / $2,000
Family (In-Network/OON)	$6,000 / Not Covered	$14,000 / Not Covered	$6,000 / $6,000
Coinsurance (In-Network /OON)	0% / Not Covered	10% / Not Covered	10% / 20%
Primary / Specialist	$14 / $14	10% after ded / 10% after ded	$15 / $15
Lab & X-Ray	10%	10% after ded	10%
Urgent Care Visit	$14	10% after ded	$15
Emergency Room Visit	$50	10% after ded	$75
Hospital Outpatient (Facility / Surgery)	$0 / $14	10% after ded / 10% after ded	$0 / $15
Hospital Inpatient	0%	10% after ded	$75/day
Rx Deductible (Non-Generic)	N/A	Integrated w/Med	N/A
Prescriptions (Tier 1 / 2 / 3)	$10 / $35 / $35	$10 after ded / $30 after ded / $30 after ded	$10 / $35 / $35