

Kaiser Permanente 2025 sample fee list¹

What's a sample fee list?

A sample fee list can help you understand your health care costs by showing the estimated amount you may pay for certain services.² Keep in mind that this list doesn't include costs for hospital services, and the amount you're ultimately charged may vary based on the care you receive, the type of facility you visit, your plan details, and whether you've reached your deductible.

Get a cost estimate

If you're a member, it's easy to get a sense of costs before you get care. Visit kp.org/costestimates to get a personalized estimate based on your plan benefits.

How can I use the list?

The sample fee list can help you:

- Choose the right Kaiser Permanente deductible HMO plan during open enrollment
- Estimate what you'll pay for services before you reach your deductible
- Identify preventive care services, most of which are covered at no cost (visit kp.org/prevention for a full list)
- Estimate how much to contribute to a flexible spending account (FSA) or health savings account (HSA) connected to your plan, based on the care you expect to receive

What happens after I reach my deductible?

You typically pay the full charge for covered services until you reach a set amount known as a deductible. Then you'll start paying less – a copay or a percentage of the charges (called a coinsurance) for the rest of the year. (Depending on your plan, you may pay copays or coinsurance for some services without having to reach your deductible.)

This means that for some services, you may pay less than the estimated fees shown on the sample fee list after you reach your deductible. Here are some examples:

Service	Estimated fees	What you pay before reaching deductible	What you pay after reaching deductible
X-ray of both knees	\$165	Full charges: \$165	Copay or coinsurance (e.g., \$10 or 20% of estimated fee)
Ultrasound of pelvis	\$435	Full charges: \$435	Copay or coinsurance (e.g., \$20 or 30% of estimated fee)
Stress test	\$268	Full charges: \$268	Copay or coinsurance (e.g., \$25 or 40% of estimated fee)

Have questions?

If you want more information or have questions about a service that's not listed, please call the number on your Kaiser Permanente ID card.

1. The estimated fees in this sample fee list are valid as of January 1, 2025, and may change without notice. This sample fee list only applies to members who get medical services from Kaiser Permanente facilities. **2.** Professional services are usually received at a medical office, including doctor's office visits, lab tests, and X-rays. They may also include physician-related services provided in a hospital.

The amount you're actually charged may be different depending on the care you get, the type of facility you visit, your plan details, and whether you've reached your deductible.

If your health benefits are self-insured by your employer, union, or Plan sponsor, Kaiser Permanente Insurance Company provides certain administrative services for the Plan and is not an insurer of the Plan or financially liable for health care benefits under the Plan.

SERVICE	ESTIMATED FEES
Office visits	
New patient visit, level 2*	\$150
New patient visit, level 3*	\$230
New patient visit, level 4*	\$340
New patient visit, level 5 (high severity)*	\$450
Established patient visit, level 1 (low severity)*	\$50
Established patient visit, level 2*	\$120
Established patient visit, level 3*	\$190
Established patient visit, level 4*	\$265
Established patient visit, level 5 (high severity)*	\$370
Office visits (preventive)	
Well-baby office visit, new patient (under 1 year)*	\$275
Well-child office visit, new patient (1 to 4 years)*	\$285
Well-child office visit, new patient (5 to 11 years)*	\$295
Well-child office visit, new patient (12 to 17 years)*	\$330
Well-adult office visit, new patient (18 to 39 years)*	\$320
Well-adult office visit, new patient (40 to 64 years)*	\$370
Well-adult office visit, new patient (65 and older)*	\$400
Well-baby office visit, established patient (under 1 year)*	\$245
Well-child office visit, established patient (1 to 4 years)*	\$260
Well-child office visit, established patient (5 to 11 years)*	\$260
Well-child office visit, established patient (12 to 17 years)*	\$285
Well-adult office visit, established patient (18 to 39 years)*	\$290
Well-adult office visit, established patient (40 to 64 years)*	\$305
Well-adult office visit, established patient (65 and older)*	\$330
Psychotherapy visits	
Group psychological therapy	\$38
Therapy	\$144

Your actual costs may vary

These are just sample fees. Members can get an estimate based on their plan details at kp.org/costestimates.

*Depending on your plan, these services may be preventive and covered at no cost or at a copay. For more information, see your *Evidence of Coverage* or *Summary Plan Description*.

These estimated fees are valid starting January 1, 2025, and may change without notice.

The fees shown are for professional services only and do not include fees for facility or other services. The amount you're actually charged may be different depending on the care you get, the type of facility you visit, your plan details, and whether you've reached your deductible.

SERVICE	ESTIMATED FEES
Eye examinations	
Eye exam, routine visit, new patient*	\$156
Eye exam and treatment, new patient	\$269
Eye exam, routine visit, established patient*	\$163
Eye exam and treatment, established patient	\$229
Vision screening test*	\$13
Hearing services	
Comprehensive audiometry evaluation	\$130
Ear cleaning	\$167
Eardrum test	\$60
Hearing screening test (pure tone, air only)*	\$50
Physical therapy services	
Electric stimulation therapy, treatment only	\$19
Physical therapy evaluation*	\$155
Physical therapy, hot and cold application, treatment only	\$10
Physical therapy, ultrasound, treatment only	\$22
Physical therapy exercises, treatment only	\$45
Vaccines and other injections	
Allergy shot	\$41
Chicken pox vaccine*	\$137
Diphtheria, tetanus booster vaccine*	\$38
Diphtheria, tetanus, pertussis vaccine*	\$47
Flu shot, (6 months and older)	\$38
Hepatitis B vaccine*	\$118
Measles, mumps, and rubella vaccine*	\$93
Polio vaccine*	\$53
Therapeutic, prophylactic, or diagnostic injection (administration only, does not include medication)*	\$53
Therapeutic, prophylactic, or diagnostic intra-arterial injection (administration only, does not include medication)*	\$70

Your actual costs may vary

These are just sample fees. Members can get an estimate based on their plan details at kp.org/costestimates.

*Depending on your plan, these services may be preventive and covered at no cost or at a copay. For more information, see your *Evidence of Coverage* or *Summary Plan Description*.

These estimated fees are valid starting January 1, 2025, and may change without notice.

The fees shown are for professional services only and do not include fees for facility or other services. The amount you're actually charged may be different depending on the care you get, the type of facility you visit, your plan details, and whether you've reached your deductible.

SERVICE	ESTIMATED FEES
Tests and procedures	
Breathing capacity test	\$104
Breathing treatment	\$31
Colonoscopy and removal of abnormal tissue using cautery*	\$1,762
Colonoscopy and removal of abnormal tissue using snare technique*	\$1,622
Colonoscopy and removal of colon tissue for examination*	\$1,576
Diagnostic colonoscopy	\$1,219
Diagnostic proctosigmoidoscopy	\$473
Diagnostic sigmoidoscopy	\$701
Draining fluid from around swollen joint	\$226
Electrocardiogram (EKG)	\$52
Fetal monitoring*	\$164
Incisional biopsy of skin (e.g., wedge), single lesion	\$575
Punch biopsy of skin, single lesion	\$463
Removal of abnormal areas of skin	\$25
Sigmoidoscopy and removal of tissue for examination*	\$1,082
Stress test	\$268
Surgically destroying an abnormal area of skin	\$247
Tangential biopsy of skin (e.g., shave, scoop, saucerize, curette), single lesion	\$373
Ultrasound test of heart	\$522
X-rays, CT scans, and other imaging studies	
CT scan of chest, including dye	\$1,055
CT scan of pelvis, including dye	\$1,455
CT scan of pelvis, without dye	\$835
CT scan of sinus and nasal passages	\$1,095
CT scan of stomach area, with dye	\$1,485
CT scan of stomach area, without dye	\$855
Mammogram, diagnostic (one view)	\$515
Mammogram, diagnostic (two views)	\$650

(continues)

Your actual costs may vary

These are just sample fees. Members can get an estimate based on their plan details at kp.org/costestimates.

*Depending on your plan, these services may be preventive and covered at no cost or at a copay. For more information, see your *Evidence of Coverage* or *Summary Plan Description*.

These estimated fees are valid starting January 1, 2025, and may change without notice.

The fees shown are for professional services only and do not include fees for facility or other services. The amount you're actually charged may be different depending on the care you get, the type of facility you visit, your plan details, and whether you've reached your deductible.

SERVICE	ESTIMATED FEES
X-rays, CT scans, and other imaging studies <i>(continued)</i>	
Mammogram (screening)*	\$530
MRI Brain stem with contrast	\$1,720
MRI Cardiac with, without contrast with stress	\$2,695
MRI neck with contrast	\$1,570
Pregnancy ultrasound	\$625
Review of CT scan of the head or brain	\$665
Ultrasound of pelvis	\$435
Ultrasound of stomach area	\$475
Vaginal ultrasound	\$490
X-ray for osteoporosis	\$160
X-ray of ankle	\$135
X-ray of ankle (complete)	\$150
X-ray of knee (complete)	\$195
X-ray of both knees	\$165
X-ray exam chest (one view)	\$105
X-ray exam chest (two views)	\$140
X-ray of finger	\$160
X-ray of foot (complete)	\$140
X-ray of hand (complete)	\$155
X-ray of stomach area (complete)	\$205
X-ray of wrist (complete)	\$170
Laboratory tests	
Albumin test	\$15
Alkaline phosphatase test	\$15
Allergy test	\$15
ALT test	\$15
Amylase test	\$20
AST test	\$15
<i>(continues)</i>	

Your actual costs may vary

These are just sample fees. Members can get an estimate based on their plan details at kp.org/costestimates.

*Depending on your plan, these services may be preventive and covered at no cost or at a copay. For more information, see your *Evidence of Coverage* or *Summary Plan Description*.

These estimated fees are valid starting January 1, 2025, and may change without notice.

The fees shown are for professional services only and do not include fees for facility or other services. The amount you're actually charged may be different depending on the care you get, the type of facility you visit, your plan details, and whether you've reached your deductible.

SERVICE	ESTIMATED FEES
Laboratory tests <i>(continued)</i>	
Bilirubin test (total)	\$15
Blood antibody test	\$10
Blood clotting test	\$10
Blood sugar test, diagnostic	\$10
Blood sugar test, monitoring*	\$30
Calcium test (total)	\$15
Cholesterol level test	\$10
Complete blood count	\$20
Creatinine test	\$15
Hepatitis B surface antigen test*	\$30
Hepatitis C test*	\$40
Kidney function test	\$10
Laboratory chemistry test for creatine kinase	\$20
Lipid panel test*	\$40
Magnesium test	\$20
Pap test, cervical cancer screening*	\$60

Your actual costs may vary

These are just sample fees. Members can get an estimate based on their plan details at kp.org/costestimates.

*Depending on your plan, these services may be preventive and covered at no cost or at a copay. For more information, see your *Evidence of Coverage* or *Summary Plan Description*.

These estimated fees are valid starting January 1, 2025, and may change without notice.

The fees shown are for professional services only and do not include fees for facility or other services. The amount you're actually charged may be different depending on the care you get, the type of facility you visit, your plan details, and whether you've reached your deductible.