



**good health is no secret**

**WELCOME TO KAISER PERMANENTE**

# Benefit highlights

	COPAYMENT 25	COPAYMENT 40	COPAYMENT 50
<b>FEATURES</b>			
Individual plan annual deductible (subscriber only)	None		
Family plan annual deductible (individual/family)	None		
Individual plan annual out-of-pocket maximum (subscriber only)	\$2,500	\$3,000	\$3,500
Family plan annual out-of-pocket maximum (individual/family)	\$2,500/\$5,000	\$3,000/\$6,000	\$3,500/\$7,000
Lifetime benefit maximum	None		
<b>BENEFITS</b>			
<b>Preventive care</b>			
Immunizations	No charge		
Routine physical exam	\$25 copay	\$40 copay	\$50 copay
Well-child visit (0–23 months)	No charge	\$10 copay	\$15 copay
Well-woman visit	\$25 copay	\$40 copay	\$50 copay
Mammogram	\$10 copay		
<b>Outpatient services (per visit or procedure)</b>			
Primary care/Specialty office visit	\$25 copay	\$40 copay	\$50 copay
Most X-rays and lab tests	\$10 copay		
MRI, CT, and PET	\$50 copay		
Outpatient surgery	\$100 copay	\$200 copay	\$250 copay
<b>Inpatient hospital care</b>			
Room and board, surgery, anesthesia, X-rays, lab tests, and medication	\$200 copay per day	\$350 copay per day	\$500 copay per day
<b>Maternity</b> Coverage varies. Please consult the plan's <i>Membership Agreement</i> .			
Maternity care	Covered		
<b>Emergency and urgent care</b>			
Emergency Department visit (waived if admitted)	\$100 copay		\$150 copay
Urgent care visit	\$25 copay	\$40 copay	\$50 copay
Ambulance service	\$100 copay	\$200 copay	\$300 copay
<b>Prescription drugs</b>			
Plan pharmacy (up to a 30-day supply)	Generic: \$10 copay/Brand: \$35 copay		Not covered
Mail-order (up to a 100-day supply)	Generic: \$20 copay/Brand: \$70 copay		Not covered

This is a summary of the most frequently asked-about benefits and their copayments and coinsurance. For more information on benefits, copayments, and coinsurance, please refer to the *Disclosure Form* enclosed in this kit. Detailed information about your plan is included in the *Membership Agreement*, which will be mailed to you upon acceptance or upon request.

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# Benefit highlights

	20/500	25/1000	30/1500
<b>FEATURES</b>			
Individual plan annual deductible (subscriber only)	\$500	\$1,000	\$1,500
Family plan annual deductible (individual/family)	\$500/\$1,000	\$1,000/\$2,000	\$1,500/\$3,000
Individual plan annual out-of-pocket maximum (subscriber only)	\$2,500	\$3,000	\$3,500
Family plan annual out-of-pocket maximum (individual/family)	\$2,500/\$5,000	\$3,000/\$6,000	\$3,500/\$7,000
Lifetime benefit maximum	None		
<b>BENEFITS SERVICES NOT SUBJECT TO DEDUCTIBLE UNLESS OTHERWISE INDICATED</b>			
<b>Preventive care</b>			
Immunizations	No charge		
Routine physical exam	\$20 copay	\$25 copay	\$30 copay
Well-child visit (0–23 months)	No charge	\$10 copay	\$30 copay
Well-woman visit	\$20 copay	\$25 copay	\$30 copay
Mammogram	\$10 copay		
<b>Outpatient services (per visit or procedure)</b>			
Primary care/Specialty office visit	\$20 copay	\$25 copay	\$30 copay
Most X-rays and lab tests	\$10 copay (after deductible)		
MRI, CT, and PET	\$10 copay (after deductible)	\$50 copay (after deductible)	
Outpatient surgery	\$50 copay (after deductible)	\$150 copay (after deductible)	\$250 copay (after deductible)
<b>Inpatient hospital care</b>			
Room and board, surgery, anesthesia, X-rays, lab tests, and medications	\$100 copay per day (after deductible)	\$250 copay per day (after deductible)	\$500 copay per day (after deductible)
<b>Maternity</b> Coverage varies. For details, please consult the plan's <i>Membership Agreement</i> .			
Maternity care	Covered		
<b>Emergency and urgent care</b>			
Emergency Department visit (waived if admitted)	\$100 copay (after deductible)		\$150 copay (after deductible)
Urgent care visit	\$20 copay	\$25 copay	\$30 copay
Ambulance service	\$150 copay (after deductible)		
<b>Prescription drugs</b>			
Plan pharmacy (up to a 30-day supply)	Generic: \$10 copay/Brand: \$35 copay		
Mail-order (up to a 100-day supply)	Generic: \$20 copay/Brand: \$70 copay		

This is a summary of the most frequently asked-about benefits and their copayments and coinsurance. For more information on benefits, copayments, and coinsurance, please refer to the *Disclosure Form* enclosed in this kit. Detailed information about your plan is included in the *Membership Agreement* or *Certificate of Insurance*, which will be mailed to you upon acceptance or upon request.

		<b>NEW!</b>	<b>NEW!</b>
	<b>40/2000</b>	<b>40/3000 NM<sup>1</sup></b>	<b>50/5000 NM<sup>1</sup></b>
<b>FEATURES</b>			
Individual plan annual deductible (subscriber only)	\$2,000	\$3,000	\$5,000
Family plan annual deductible (individual/family)	\$2,000/\$4,000	No dependent coverage	
Individual plan annual out-of-pocket maximum (subscriber only)	\$4,000	\$6,000	\$7,500
Family plan annual out-of-pocket maximum (individual/family)	\$4,000/\$8,000	No dependent coverage	
Lifetime benefit maximum	None	\$5 million	
<b>BENEFITS SERVICES NOT SUBJECT TO DEDUCTIBLE UNLESS OTHERWISE INDICATED</b>			
<b>Preventive care</b>			
Immunizations	No charge		
Routine physical exam	\$40 copay	\$50 copay	
Well-child visit (0–23 months)	\$40 copay	\$30 copay	
Well-woman visit	\$40 copay	\$50 copay	
Mammogram	\$10 copay		
<b>Outpatient services (per visit or procedure)</b>			
Primary care/Specialty office visit	\$40 copay	\$50 copay (after deductible)	
Most X-rays and lab tests	\$10 copay (after deductible)		
MRI, CT, and PET	\$50 copay (after deductible)		
Outpatient surgery	\$250 copay (after deductible)	20% coinsurance (after deductible)	30% coinsurance (after deductible)
<b>Inpatient hospital care</b>			
Room and board, surgery, anesthesia, X-rays, lab tests, and medications	\$500 copay per day (after deductible)	20% coinsurance (after deductible)	30% coinsurance (after deductible)
<b>Maternity</b> Coverage varies. For details, please consult the plan's <i>Membership Agreement</i> or <i>Certificate of Insurance</i> .			
Maternity care	Covered	Not covered	
<b>Emergency and urgent care</b>			
Emergency Department visit (waived if admitted)	\$150 copay (after deductible)		
Urgent care visit	\$40 copay	\$50 copay (after deductible)	
Ambulance service	\$150 copay (after deductible)		
<b>Prescription drugs</b>			
Plan pharmacy (up to a 30-day supply)	Generic: \$10 copay/Brand: \$35 copay		Not covered
Mail-order (up to a 100-day supply)	Generic: \$20 copay/Brand: \$70 copay		Not covered

Note: For services subject to a deductible, you will have to pay health care expenses out of pocket until you meet your deductible. For information describing the benefits and limitations, cost-sharing amounts, premiums, and dental plans, please review the details in your enrollment material. To request a copy of the *Membership Agreement* or *Certificate of Insurance* for a particular plan, please call us at 1-800-464-4000 or contact your broker.

<sup>1</sup> These plans are offered by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc.

# Benefit highlights

	0/1500 WITH HSA	0/2700 WITH HSA	30/2700 WITH HSA
<b>FEATURES</b>			
Individual plan annual deductible (subscriber only)	\$1,500	\$2,700	
Family plan annual deductible (individual/family)	\$3,000/\$3,000	\$5,450/\$5,450	
Individual plan annual out-of-pocket-maximum (subscriber only)	\$3,000	\$5,000	\$5,250
Family plan annual out-of-pocket-maximum (individual/family)	\$6,000/\$6,000	\$10,000/\$10,000	\$10,500/\$10,500
Lifetime benefit maximum	None		
<b>BENEFITS SERVICES NOT SUBJECT TO DEDUCTIBLE UNLESS OTHERWISE INDICATED</b>			
<b>Preventive care</b>			
Immunizations	No charge		
Routine physical exam	No charge		\$30 copay
Well-child visit (0–23 months)	No charge		\$10 copay
Well-woman visit	No charge		\$30 copay
Mammogram	\$10 copay		
<b>Outpatient services (per visit or procedure)</b>			
Primary care/Specialty office visit	No charge (after deductible)		\$30 copay (after deductible)
Most X-rays and lab tests	\$10 copay (after deductible)		
MRI, CT, and PET	\$50 copay (after deductible)		
Outpatient surgery	\$150 copay (after deductible)	\$200 copay (after deductible)	30% coinsurance (after deductible)
<b>Inpatient hospital care</b>			
Room and board, surgery, anesthesia, X-rays, lab tests, and medication	\$300 copay per day (after deductible)	\$400 copay per day (after deductible)	30% coinsurance (after deductible)
<b>Maternity</b> Coverage varies. For details, please consult the plan's <i>Membership Agreement</i> .			
Maternity care	Covered		
<b>Emergency and urgent care</b>			
Emergency Department visit (waived if admitted)	\$100 copay (after deductible)		30% coinsurance (after deductible)
Urgent care visit	No charge (after deductible)		\$30 copay (after deductible)
Ambulance service	\$100 copay (after deductible)		
<b>Prescription drugs</b>			
Plan pharmacy (up to a 30-day supply)	Generic: \$10 copay/Brand: \$35 copay (after deductible)		Not covered
Mail-order (up to a 100-day supply)	Generic: \$20 copay/Brand: \$70 copay (after deductible)		Not covered

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	<b>NEW!</b> 40/4000 NM WITH HSA <sup>1</sup>	<b>NEW!</b> 0/5000 WM WITH HSA <sup>1</sup>
<b>FEATURES</b>		
Individual plan annual deductible (subscriber only)	\$4,000	\$5,000
Family plan annual deductible (individual/family)	No dependent coverage	
Individual plan annual out-of-pocket maximum (subscriber only)	\$5,600	\$5,000
Family plan annual out-of-pocket maximum (individual/family)	No dependent coverage	
Lifetime benefit maximum	\$5 million	
<b>BENEFITS SERVICES NOT SUBJECT TO DEDUCTIBLE UNLESS OTHERWISE INDICATED</b>		
<b>Preventive care</b>		
Immunizations	No charge	
Routine physical exam	\$40 copay	No charge
Well-child visit (0–23 months)	\$30 copay	No charge
Well-woman visit	\$40 copay	No charge
Mammogram	\$10 copay	No charge
<b>Outpatient services (per visit or procedure)</b>		
Primary care/Specialty office visit	\$40 copay (after deductible)	No charge (after deductible)
Most X-rays and lab tests	\$10 copay (after deductible)	No charge (after deductible)
MRI, CT, and PET	\$50 copay (after deductible)	No charge (after deductible)
Outpatient surgery	30% coinsurance (after deductible)	No charge (after deductible)
<b>Inpatient hospital care</b>		
Room and board, surgery, anesthesia, X-rays, lab tests, and medication	30% coinsurance (after deductible)	No charge (after deductible)
<b>Maternity</b> Coverage varies. For details, please consult the plan's <i>Certificate of Insurance</i> .		
Maternity care	Not covered	Covered (after deductible)
<b>Emergency and urgent care</b>		
Emergency Department visit (waived if admitted)	\$150 copay (after deductible)	No charge (after deductible)
Urgent care visit	\$40 copay (after deductible)	No charge (after deductible)
Ambulance service	\$150 copay (after deductible)	No charge (after deductible)
<b>Prescription drugs</b>		
Plan pharmacy (up to a 30-day supply)	Generic: \$10 copay/Brand: \$35 copay (after deductible)	No charge (after deductible)
Mail-order (up to a 100-day supply)	Generic: \$20 copay/Brand: \$70 copay (after deductible)	No charge (after deductible)

Note: For services subject to a deductible, you will have to pay health care expenses out of pocket until you meet your deductible. For information describing the benefits and limitations, cost-sharing amounts, premiums, and dental plans, please review the details in your enrollment material. To request a copy of the *Membership Agreement* or *Certificate of Insurance* for a particular plan, please call us at 1-800-464-4000 or contact your broker.

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