



good health is no secret

WELCOME TO KAISER PERMANENTE

Benefit highlights

	\$35 COPAYMENT PLAN WITH RX	\$40 COPAYMENT PLAN WITH RX
FEATURES		
Individual plan annual deductible (subscriber only)		None
Family plan annual deductible (individual/family)		None
Individual plan annual out-of-pocket maximum (subscriber only)		\$3,000
Family plan annual out-of-pocket maximum (individual/family)		\$3,000/\$7,500
Lifetime benefit maximum		None
BENEFITS		
Preventive care		
Immunizations		No charge
Adult preventive care exam		No charge
Well-child visit		No charge
Well-woman visit		No charge
Adult preventive care screening		No charge
Colorectal cancer screening		No charge
Outpatient services (per visit or procedure)		
Primary care/Specialty care office visit	\$35 copay/\$50 copay	\$40 copay/\$60 copay
Ambulatory surgery		\$200 copay
Diagnostic lab and X-ray		No charge
Therapeutic X-ray	\$50 copay	\$60 copay
Inpatient hospital care		
Hospital care and professional visits		30% coinsurance
Maternity		
Prenatal care/Delivery and inpatient well-baby care		Not covered
Emergency and urgent care		
Emergency room visit (waived if admitted)		\$200 copay
Nonroutine care	\$35 copay	\$40 copay
After-hours care		\$100 copay
Ambulance service		30% coinsurance (up to \$700 per trip)
Prescription drugs		
	Rx subject to \$200 drug deductible unless otherwise indicated ¹	
Pharmacy (up to a 30-day supply)	Generic: \$5 copay (not subject to drug deductible)/Brand: \$30 copay	
Mail-order (up to a 90-day supply)	Generic: \$10 copay (not subject to drug deductible)/Brand: \$60 copay	

This is only a summary. For more detailed information, refer to the *Health Benefit Plan Description Form*, which you may obtain by calling 1-800-634-4579. Once you become a member, you will receive your *Membership Agreement*, which can be used to determine the exact terms and conditions of your coverage.

¹The drug deductible does not apply to the out-of-pocket maximum. There are different copays and coinsurance for nonpreferred and specialty drugs. See the *Membership Agreement* for specific details.

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Benefit highlights

	\$1,000 DEDUCTIBLE PLAN (80%) with Rx	\$1,500 DEDUCTIBLE PLAN (80%) with Rx	\$2,000 DEDUCTIBLE PLAN (70%) with Rx
Features			
Individual plan annual deductible (subscriber only) ¹	\$1,000	\$1,500	\$2,000
Family plan annual deductible (individual/family) ^{1,2}	\$1,000/\$3,000	\$1,500/\$4,500	\$2,000/\$6,000
Individual plan annual out-of-pocket maximum (subscriber only)	\$4,000	\$6,000	\$5,000
Family plan annual out-of-pocket maximum (individual/family) ²	\$4,000/\$8,000	\$6,000/\$12,000	\$5,000/\$10,000
Lifetime benefit maximum	None		
Benefits			
Services not subject to deductible unless otherwise indicated			
Preventive care			
Immunizations	No charge		
Adult preventive care exam	No charge		
Well-child visit	No charge		
Well-woman visit	No charge		
Adult preventive care screening	No charge		
Colorectal cancer screening	No charge		
Outpatient services (per visit or procedure)			
Primary care/Specialty care office visit	\$30 copay/\$50 copay		
Ambulatory surgery	20% coinsurance (after deductible)	30% coinsurance (after deductible)	
Diagnostic lab	No charge		
Therapeutic and diagnostic X-ray	20% coinsurance (after deductible)	30% coinsurance (after deductible)	
Inpatient hospital care			
Hospital care and professional visits	20% coinsurance (after deductible)	30% coinsurance (after deductible)	
Maternity			
Prenatal care/Delivery and inpatient well-baby care	Not covered		
Emergency and urgent care			
Emergency room visit (waived if admitted)	20% coinsurance (after deductible)	30% coinsurance (after deductible)	
Nonroutine care	\$30 copay		
After-hours care	\$75 copay		
Ambulance service	20% coinsurance (up to \$500 per trip)	30% coinsurance (up to \$500 per trip)	
Prescription drugs			
Rx subject to \$200 drug deductible unless otherwise indicated			
Pharmacy (up to a 30-day supply) ³	Generic: \$5 copay (not subject to drug deductible) Brand: \$30 copay	Generic: \$15 copay Brand: \$30 copay	
Mail-order (up to a 90-day supply) ³	Generic: \$10 copay (not subject to drug deductible) Brand: \$60 copay	Generic: \$30 copay Brand: \$60 copay	

¹In deductible plans, the deductible does not apply to the out-of-pocket maximum.

²For families in a deductible plan, individual family members are responsible for meeting the family deductible and out-of-pocket maximum only up to the individual deductible and out-of-pocket maximum amount, until the family out-of-pocket maximum is met.

³The drug deductible does not apply to the medical deductible or the out-of-pocket maximum. There are different copays and coinsurance for nonpreferred and specialty drugs. See the *Membership Agreement* for specific details.

Benefit highlights

	\$2,000 HSA-QUALIFIED DEDUCTIBLE HMO PLAN (80%)	\$2,000 HSA-QUALIFIED DEDUCTIBLE HMO PLAN (100%)	\$2,500 HSA-QUALIFIED DEDUCTIBLE HMO PLAN (100%)
Features			
Individual plan annual deductible (subscriber only) ¹	\$2,000		\$2,500
Family plan annual deductible (individual/family) ^{1,2}	\$4,000/\$4,000		\$5,000/\$5,000
Individual plan annual out-of-pocket maximum (subscriber only)	\$5,000	\$2,000	\$2,500
Family plan annual out-of-pocket maximum (individual/family) ²	\$10,000/\$10,000	\$4,000/\$4,000	\$5,000/\$5,000
Lifetime benefit maximum	None		
Benefits Services not subject to deductible unless otherwise indicated			
Preventive care			
Immunizations	No charge		
Adult preventive care exam	No charge		
Well-child visit	No charge		
Well-woman visit	No charge		
Adult preventive care screening	No charge		
Colorectal cancer screening	No charge		
Outpatient services (per visit or procedure)			
Primary care/Specialty care office visit	20% coinsurance (after deductible)	No charge (after deductible)	
Ambulatory surgery	20% coinsurance (after deductible)	No charge (after deductible)	
Diagnostic lab	20% coinsurance (after deductible)	No charge (after deductible)	
Therapeutic and diagnostic X-ray	20% coinsurance (after deductible)	No charge (after deductible)	
Inpatient hospital care			
Hospital care and professional visits	20% coinsurance (after deductible)	No charge (after deductible)	
Maternity			
Prenatal care/Delivery and inpatient well-baby care	Not covered		
Emergency and urgent care			
Emergency room visit (waived if admitted)	20% coinsurance (after deductible)	No charge (after deductible)	
Nonroutine care	20% coinsurance (after deductible)	No charge (after deductible)	
After-hours care	20% coinsurance (after deductible)	No charge (after deductible)	
Ambulance service	20% coinsurance (after deductible)	No charge (after deductible)	
Prescription drugs			
Pharmacy (up to a 30-day supply) ³	Not covered	No charge (after deductible)	
Mail-order (up to a 90-day supply) ³	Not covered	No charge (after deductible)	

¹In HSA-qualified deductible HMO plans, the deductible does apply to the out-of-pocket maximum.

²For family memberships in an HSA-qualified deductible HMO plan, the individual deductible and out-of-pocket maximum do not apply. The family deductible and out-of-pocket maximum can be met by a combination of family members.

³See the *Membership Agreement* for specific details.

	\$3,000 HSA-QUALIFIED DEDUCTIBLE HMO PLAN (100%)	\$4,000 HSA-QUALIFIED DEDUCTIBLE HMO PLAN (100%)	\$5,000 HSA-QUALIFIED DEDUCTIBLE HMO PLAN (100%)
Features			
Individual plan annual deductible (subscriber only) ¹	\$3,000	\$4,000	\$5,000
Family plan annual deductible (individual/family) ^{1,2}	\$6,000/\$6,000	\$8,000/\$8,000	\$10,000/\$10,000
Individual plan annual out-of-pocket maximum (subscriber only)	\$3,000	\$4,000	\$5,000
Family plan annual out-of-pocket maximum (individual/family) ²	\$6,000/\$6,000	\$8,000/\$8,000	\$10,000/\$10,000
Lifetime benefit maximum	None		
Benefits Services not subject to deductible unless otherwise indicated			
Preventive care			
Immunizations	No charge		
Adult preventive care exam	No charge		
Well-child visit	No charge		
Well-woman visit	No charge		
Adult preventive care screening	No charge		
Colorectal cancer screening	No charge		
Outpatient services (per visit or procedure)			
Primary care/Specialty care office visit	No charge (after deductible)		
Ambulatory surgery	No charge (after deductible)		
Diagnostic lab	No charge (after deductible)		
Therapeutic and diagnostic X-ray	No charge (after deductible)		
Inpatient hospital care			
Hospital care and professional visits	No charge (after deductible)		
Maternity			
Prenatal care/Delivery and inpatient well-baby care	Not covered		
Emergency and urgent care			
Emergency room visit (waived if admitted)	No charge (after deductible)		
Nonroutine care	No charge (after deductible)		
After-hours care	No charge (after deductible)		
Ambulance service	No charge (after deductible)		
Prescription drugs			
Pharmacy (up to a 30-day supply) ³	No charge (after deductible)		
Mail-order (up to a 90-day supply) ³	No charge (after deductible)		

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