KAISER PERMANENTE

Effective Date	December 1, 2015 - November 30, 2016	
MAPPED FROM	$15 Copay Plan OR $20 Copay Plan	$30 Copay Plan OR $50 Copay Plan
BENEFIT	Platinum 90 0/20 HMO	Gold 80 0/30 HMO
Lifetime Maximum	Unlimited	Unlimited
Calendar Year Deductible : Individual / Family	None	None
Calendar Year Max Out-of-Pocket: Individual / Family	$4,000 / $8,000	$6,250 / $12,500
Office Visit	$20 (Primary) $40 (Specialty)	$30 (Primary) $50 (Specialty)
Most Laboratory Tests	$20 Copay	$30 Copay
Most X-rays & Diagnostics	$40 Copay	$50 Copay
MRI/CT/PET	$150 Copay	$250 Copay
Preventive Care Exam	$0 Copay	$0 Copay
Hospitalization	$250 per Day (Days 1-5) per Admission	$600 per Day (Days 1-5) per Admission
Outpatient Surgery	$250 Copay per Procedure	$600 Copay per Procedure
Emergency Room	$150 Copay	$250 Copay
Urgent Care Center	$20 Copay	$30 Copay
Maternity:		
Inpatient	$250 per Day (Days 1-5) per Admission	$600 per Day (Days 1-5) per Admission
Prenatal/First Postpartum Visit	$0 Copay	$0 Copay
Mental Health:		
Inpatient	$250 per Day (Days 1-5) per Admission	$600 per Day (Days 1-5) per Admission
Outpatient	$20 Copay	$30 copay
Substance Abuse:		
Inpatient Detox Only	$250 per Day (Days 1-5) per Admission	$600 per Day (Days 1-5) per Admission
Prescriptions:	(Up to a 30-Day Supply)	(Up to a 30-Day Supply)
Generic	$5 Copay	$19 Copay
Deductible (Brand Name)	None	None
Brand	$15 Copay	$50 Copay
Pediatric Dental & Vision (Up to age 19)		
Deductible / Waiting Period	$0 Deductible & No Waiting Periods	$0 Deductible & No Waiting Periods
Annual Out-of-Pocket Maximum	$350 per Child / $700 Multichild	$350 per Child / $700 Multichild
Office Visit	$0 Copay	$0 Copay
Cleaning & Exam	$0 Copay	$0 Copay
Periodontics	$0 - $350 Copay Depending on Procedure	$0 - $350 Copay Depending on Procedure
Restorative	$25 - $350 Copay Depending on Procedure	$25 - $350 Copay Depending on Procedure
Endodontics	$85 - $300 Copay Depending on Procedure	$85 - $300 Copay Depending on Procedure
Prosthodontics	$65 - $350 Copay Depending on Procedure	$65 - $350 Copay Depending on Procedure
Orthodontics (Medically Necessary)	$350 Copay	$350 Copay
Pediatric Vision (Up to age 19) Includes Exam and Eyewear	One standard pair of frames & lenses or contact lenses per calendar year	One standard pair of frames & lenses or contact lenses per calendar year
Adult Vision Exam	$0 Copay	$0 Copay
Adult Optical (Eyewear)	Not Covered	Not Covered
Provider Restrictions	Kaiser	

Eligibility Guidelines - GUARANTEED ISSUE

Kaiser Members & Dependents	New Members: May join the 1st of the month following 30 days of membership. Qualifying Events: you may join within 30 days after you have a loss of coverage, marriage, birth or adoption. Over Age Dependents: may remain on coverage up to age 26.
Open Enrollment	November 1st - November 30th

KAISER PERMANENTE

Effective Date	December 1, 2015 - November 30, 2016	
MAPPED FROM	$30/1000 Plan OR $30/1500 Plan	$40/2000 Plan
BENEFITS	Gold 80 500/30 HMO	Silver 70 1000/40 HMO
Lifetime Maximum	Unlimited	Unlimited
Calendar Year Deductible: Individual/family	$500 / $1,000 (1)	$1,000 / $2,000 (1)
Calendar Year Max Out-of-Pocket: (4) Individual/family	$6,250 / $12,500	$6,250 / $12,500
Office Visit	$30 Copay	$40 Copay
Most Laboratory Tests	$20 Copay	$30 Copay
Most X-rays & Diagnostics	$20 Copay	$40 Copay
MRI/CT/PET	$250 Copay	30% After Deductible
Preventive Care Exam	$0 Copay	$0 Copay
Hospitalization	$600 per Day (Days 1-5) per Admission After Deductible	30% After Deductible
Outpatient Surgery	$600 per Procedure After Deductible	30% After Deductible
Emergency Room	$250 Copay After Deductible	30% After Deductible
Urgent Care Center	$30 Copay	$40 Copay
Maternity:		
Inpatient	$600 per Day (Days 1-5) per Admission After Deductible	30% After Deductible
Prenatal/First Postpartum Visit	$0 Copay	$0 Copay
Mental Health:		
Inpatient	$600 per Day (Days 1-5) per Admission After Deductible	30% After Deductible
Outpatient	$30 Copay	$40 Copay
Substance Abuse:		
Inpatient Detox Only	$600 per Day (Days 1-5) per Admission After Deductible	30% After Deductible
Prescriptions:	(Up to a 30-Day Supply)	(Up to a 30-Day Supply)
Generic	$20 Copay	$25 Copay
Deductible (Brand Name)	None	None
Brand	$50 Copay	$50 Copay
Pediatric Dental & Vision (Up to age 19)		
Deductible / Waiting Period	$0 Deductible & No Waiting Periods	$0 Deductible & No Waiting Periods
Annual Out-of-Pocket Maximum	$350 per Child / $700 Multichild	$350 per Child / $700 Multichild
Office visits	$0 Copay	$0 Copay
Cleaning & Exam	$0 Copay	$0 Copay
Periodontics	$0 - $350 Copay Depending on Procedure	$0 - $350 Copay Depending on Procedure
Restorative	$25 - $350 Copay Depending on Procedure	$25 - $350 Copay Depending on Procedure
Endodontics	$85 - $300 Copay Depending on Procedure	$85 - $300 Copay Depending on Procedure
Prosthodontics	$65 - $350 Copay Depending on Procedure	$65 - $350 Copay Depending on Procedure
Orthodontics (medically necessary)	$350 Copay	$350 Copay
Pediatric Vision (Up to age 19) Includes Exam and Eyewear	One standard pair of frames & lenses or contact lenses per calendar year	One standard pair of frames & lenses or contact lenses per calendar year
Adult Vision Exam	$0 Copay	$0 Copay
Adult Optical (Eyewear)	Not Covered	Not Covered
Provider Restrictions	Kaiser	

Eligibility Guidelines - GUARANTEED ISSUE

Kaiser Members & Dependents Open Enrollment	New Members: May join the 1st of the month following 30 days of membership. Qualifying Events: you may join November 1st - November 30th

(1) This plan carries an embedded deductible. Each family member becomes eligible after meeting the individual deductible, or when the family deductible is satisfied. Individual family members are no longer subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of pocket maximum is met.

KAISER PERMANENTE

Effective Date	December 1, 2015 - November 30, 2016
MAPPED FROM	NEW PLAN EFFECTIVE DECEMBER 1ST
BENEFITS	Silver 70 1500/45 HMO
Lifetime Maximum	Unlimited
Calendar Year Deductible: Individual/family	 $1,500 / $3,000 (1)
Calendar Year Max Out-of-Pocket: (4) Individual/family	 $6,250 / $12,500
Office Visit	$45 Primary / $65 Specialty Copay
Most Laboratory Tests	$45 Copay
Most X-rays & Diagnostics	$65 Copay
MRI/CT/PET	$250 Copay
Preventive Care Exam	$0 Copay
Hospitalization	20% After Deductible
Outpatient Surgery	20 % After Deductible
Emergency Room	$250 Copay After Deductible
Urgent Care Center	$45 Copay
Maternity: Inpatient Prenatal/First Postpartum Visit	 20% After Deductible $0 Copay
Mental Health: Inpatient Outpatient	 20% After Deductible $45 Copay
Substance Abuse: Inpatient Detox Only	 20% After Deductible
Prescriptions: Generic Deductible (Brand Name) Brand	(Up to a 30-Day Supply) $15 Copay $500 $50 Copay
Pediatric Dental & Vision (Up to age 19)	
Deductible / Waiting Period	$0 Deductible & No Waiting Periods
Annual Out-of-Pocket Maximum	$350 per Child / $700 Multichild
Office visits	$0 Copay
Cleaning & Exam	$0 Copay
Periodontics	$85 - $350 Copay Depending on Procedure
Restorative	$25 - $350 Copay Depending on Procedure
Endodontics	$85 - $300 Copay Depending on Procedure
Prosthodontics	$65 - $350 Copay Depending on Procedure
Orthodontics (medically necessary)	$350 Copay
Pediatric Vision (Up to age 19) Includes Exam and Eyewear	One standard pair of frames & lenses or contact lenses per calendar year
Adult Vision Exam	$0 Copay
Adult Optical (Eyewear)	Not Covered
Provider Restrictions	Kaiser

Eligibility Guidelines - GUARANTEED ISSUE	
Kaiser Members & Dependents	New Members: May join the 1st of the month following 30 days of membership. Qualifying Events: you may join within 30 days after you have a loss of coverage, marriage, birth or adoption. Over Age Dependents: may remain on coverage up to age 26.
Open Enrollment	November 1st - November 30th

(1) This plan carries an embedded deductible. Each family member becomes eligible after meeting the individual deductible, or when the family deductible is satisfied. Individual family members are no longer subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of pocket maximum is met.

KAISER PERMANENTE

Effective Date	December 1, 2015 - November 30, 2016	
MAPPED FROM	$0/2000 HSA Plan OR $0/2700 HSA Plan	$30/3000 HSA Plan
BENEFITS	Silver 70 HSA 1500/20% HMO	Bronze 60 HSA 3500/30 HMO
Lifetime Maximum	Unlimited	Unlimited
Calendar Year Deductible:		
Individual / Family	$1,500 / $3,000 (1)	$3,500 / $7,000 (2)
Calendar Year Max Out-of-Pocket: (4)		
Individual / Family	$6,250 / $12,500	$6,250 / $12,500
Office Visit	20% After Deductible	$30 Copay After Deductible
Most Laboratory Tests	20% After Deductible	$30 Copay After Deductible
Most X-rays & Diagnostics	20% After Deductible	$30 Copay After Deductible
MRI/CT/PET	20% After Deductible	30% After Deductible
Preventive Care Exam	$0 Copay	$0 Copay
Hospitalization	20% After Deductible	30% After Deductible
Outpatient Surgery	20% per Procedure After Deductible	30% per Procedure After Deductible
Emergency Room	20% After Deductible	30% After Deductible
Urgent Care Center	20% After Deductible	$30 Copay After Deductible
Maternity:		
Inpatient	20% After Deductible	30% After Deductible
Prenatal/First Postpartum Visit	No Charge / 0% After Deductible	No Charge / 0% After Deductible
Mental Health:		
Inpatient	20% After Deductible	30% After Deductible
Outpatient	20% After Deductible	$30 Copay After Deductible
Substance Abuse:		
Inpatient Detox Only	20% After Deductible	30% After Deductible
Prescriptions:	(Up to a 100-Day Supply)	(Up to a 30-Day Supply)
Generic	20% After Deductible	$15 Copay After Deductible
Deductible (Brand Name)	Subject to Plan Deductible (1)	Subject to Plan Deductible (2)
Brand	20% After Deductible	$40 Copay After Deductible
Pediatric Dental (Up to age 19)		
Deductible / Waiting Period	$0 Deductible & No Waiting Periods	$0 Deductible & No Waiting Periods
Annual Out-of-Pocket Maximum	$350 per Child / $700 Multichild	$350 per Child / $700 Multichild
Office visits	$0 Copay	$0 Copay
Cleaning & Exam	$0 Copay	$0 Copay
Periodontics	$0 - $350 Copay Depending on Procedure	$0 - $350 Copay Depending on Procedure
Restorative	$25 - $350 Copay Depending on Procedure	$25 - $350 Copay Depending on Procedure
Endodontics	$85 - $300 Copay Depending on Procedure	$85 - $300 Copay Depending on Procedure
Prosthodontics	$65 - $350 Copay Depending on Procedure	$65 - $350 Copay Depending on Procedure
Orthodontics (Medically Necessary)	$350 Copay	$350 Copay
Pediatric Vision (Up to age 19) Includes Exam and Eyewear	One standard pair of frame & lenses or contact lenses per calendar year	One standard pair of frame & lenses or contact lenses per calendar year
Adult Vision Exam	$0 Copay	$0 Copay
Adult Optical (Eyewear)	Not Covered	Not Covered
Provider Restrictions	Kaiser	

Eligibility Guidelines - GUARANTEED ISSUE

Kaiser Members & Dependents	New Members: May join the 1st of the month following 30 days of membership. Qualifying Events: you may join within 30 days after you have a loss of coverage, marriage, birth or adoption. Over Age Dependents: may remain on coverage up to age 26.
Open Enrollment	November 1st - November 30th

(1) This plan carries an aggregate deductible. The entire family deductible must be met before copayments apply for individual family members. Also, the entire family out-of-pocket maximum must be reached before individual family members are no longer subject to cost sharing.

(2) This plan carries an embedded deductible. Each family member becomes eligible after meeting the individual deductible, or when the family deductible is satisfied. Individual family members are no longer subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of pocket maximum is met.

KAISER PERMANENTE

Effective Date	December 1, 2015 - November 30, 2016	
MAPPED FROM	NEW PLANS EFFECTIVE DECEMBER 1ST	
BENEFITS	Bronze 60 5000/60 HMO	Bronze 60 HSA 4500/40% HMO
Lifetime Maximum	Unlimited	Unlimited
Calendar Year Deductible:		
Individual/family	$5,000 / $10,000 (2)	$4,500 / $9,000 (1)
Calendar Year Max Out-of-Pocket: (4)		
Individual/family	$6,250 / $12,500	$6,250 / $12,500
Office Visit	$60 Primary (3) / $70 Specialist (After Deductible)	40% After Deductible
Most Laboratory Tests	30% After Deductible	40% After Deductible
Most X-rays & Diagnostics	30% After Deductible	40% After Deductible
MRI/CT/PET	30% After Deductible	40% After Deductible
Preventive Care Exam	$0 Copay	$0 Copay
Hospitalization	30% After Deductible	40% After Deductible
Outpatient Surgery	30% per Procedure After Deductible	40% After Deductible
Emergency Room	$300 Copay After Deductible	40% After Deductible
Urgent Care Center	$60 Copay (3)	40% After Deductible
Maternity:		
Inpatient	30% After Deductible	40% After Deductible
Prenatal/First Postpartum Visit	No Charge	No Charge / 0% After Deductible
Mental Health:		
Inpatient	30% After Deductible	40% After Deductible
Outpatient	$60 Copay (3)	40% After Deductible
Substance Abuse:		
Inpatient Detox Only	30% After Deductible	40% After Deductible
Prescriptions:	(Up to a 30-Day Supply)	(Up to a 30-Day Supply)
Generic	$15 Copay After Deductible	40% After Deductible
Deductible (Brand Name)	Subject to Plan Deductible (2)	Subject to Plan Deductible (1)
Brand	$50 Copay After Deductible	40% After Deductible
Pediatric Dental & Vision (Up to age 19)		
Deductible / Waiting Period	$0 Deductible & No Waiting Periods	$0 Deductible & No Waiting Periods
Annual Out-of-Pocket Maximum	$350 per Child / $700 Multichild	$350 per Child / $700 Multichild
Office visits	$0 Copay	$0 Copay
Cleaning & Exam	$0 Copay	$0 Copay
Periodontics	$0 - $350 Copay Depending on Procedure	$0 - $350 Copay Depending on Procedure
Restorative	$25 - $350 Copay Depending on Procedure	$25 - $350 Copay Depending on Procedure
Endodontics	$85 - $300 Copay Depending on Procedure	$85 - $300 Copay Depending on Procedure
Prosthodontics	$65 - $350 Copay Depending on Procedure	$65 - $350 Copay Depending on Procedure
Orthodontics (medically necessary)	$350 Copay	$350 Copay
Pediatric Vision (Up to age 19)	One standard pair of frames & lenses or	One standard pair of frames & lenses or
Includes Exam and Eyewear	contact lenses per calendar year	contact lenses per calendar year
Adult Vision Exam	$0 Copay	$0 Copay
Adult Optical (Eyewear)	Not Covered	Not Covered
Provider Restrictions	Kaiser	

Eligibility Guidelines - GUARANTEED ISSUE	
Kaiser Members & Dependents	New Members: May join the 1st of the month following 30 days of membership. Qualifying Events: you may join within 30 days after you have a loss of coverage, marriage, birth or adoption. Over Age Dependents: may remain on coverage up to age 26.
Open Enrollment	November 1st - November 30th

(1) This plan carries an aggregate deductible. The entire family deductible must be met before copayments apply for individual family members. Also, the entire family out-of-pocket maximum must be reached before individual family members are no longer subject to cost sharing.

(2) This plan carries an embedded deductible. Each family member becomes eligible after meeting the individual deductible, or when the family deductible is satisfied. Individual family members are no longer subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of pocket maximum is

(3) Deductible waived for first three visits combined for non-preventive primary care, urgent care and individual mental/behavioral health and substance use disorder services.