KAISER PERMANENTE

December 1, 2016 - November 30, 2017

BENEFIT	Platinum 90 0/20 HMO
Lifetime Maximum	Unlimited
Calendar Year Deductible : Individual / Family	None
Calendar Year Max Out-of-Pocket: Individual / Family	$4,000 / $8,000 (Embedded)
Office Visit	$20 (Primary) $40 (Specialty)
Most Laboratory Tests	$20 Copay
Most X-rays & Diagnostics	$40 Copay
MRI/CT/PET	$150 Copay
Preventive Care Exam	$0 Copay
Hospitalization	$290 per Day (Days 1-5) per Admission
Outpatient Surgery	$290 Copay per Procedure
Emergency Room	$150 Copay (waived if admitted directly to hospital)
Urgent Care Center	$20 Copay
Maternity:	
Inpatient	$290 per Day (Days 1-5) per Admission
Prenatal/First Postpartum Visit	$0 Copay
Mental Health:	
Inpatient	$290 per Day (Days 1-5) per Admission
Outpatient	$20 Copay
Substance Abuse: Inpatient Detox Only	$290 per Day (Days 1-5) per Admission
Prescriptions:	(Up to a 30-Day Supply)
Generic	$5 Copay
Deductible (Brand Name)	None
Brand	$15 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 Visit	$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)	$175 allowance
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. Age Dependents: may remain on coverage up to age 26.
Open Enrollment	November 1st - November 30th

Over

KAISER PERMANENTE

December 1, 2016 - November 30, 2017

BENEFIT	Gold 80 0/35 HMO	Gold 80 500/30 HMO
Lifetime Maximum	Unlimited	Unlimited
Calendar Year Deductible : Individual / Family	None	$500 / $1,000 (1)
Calendar Year Max Out-of-Pocket: Individual / Family	$6,200 / $12,400	$6,250 / $12,500
Office Visit	$35 (Primary) $55 (Specialty)	$30 Copay
Most Laboratory Tests	$35 Copay	$20 Copay
Most X-rays & Diagnostics	$50 Copay	$20 Copay
MRI/CT/PET	$250 Copay	$250 Copay
Preventive Care Exam	$0 Copay	$0 Copay
Hospitalization	$655 per Day (Days 1-5) per Admission	$600 per Day (Days 1-5) per Admission After Deductible
Outpatient Surgery	$655 Copay per Procedure	$600 Copay per Procedure After Deductible
Emergency Room	$250 Copay (waived if admitted directly to hospital)	$250 Copay After Deductible (waived if admitted directly to hospital)
Urgent Care Center	$35 Copay	$30 Copay
Maternity:		
Inpatient	$655 per Day (Days 1-5) per Admission	$600 per Day (Days 1-5) per Admission After Deductible
Prenatal/First Postpartum Visit	$0 Copay	$0 Copay
Mental Health:		
Inpatient	$655 per Day (Days 1-5) per Admission	$600 per Day (Days 1-5) per Admission After Deductible
Outpatient	$35 copay	$30 copay
Substance Abuse: Inpatient Detox Only	$655 per Day (Days 1-5) per Admission	$600 per Day (Days 1-5) per Admission After Deductible
Prescriptions:	(Up to a 30-Day Supply)	(Up to a 30-Day Supply)
Generic	$15 Copay	$15 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 Visit	$0 Copay	$0 Copay
Cleaning & Exam	$0 Copay	$0 Copay
Periodontics	$85 - $350 Copay Depending on Procedure	$85 - $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

(1) This plan has an embedded deductible and out-of-pocket maximum. Each family member will begin paying copayments or coinsurance after meeting his or her individual deductible, or whenthe 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

December 1, 2016 - November 30, 2017

BENEFITS	Silver 70 1000/50 HMO	Silver 70 1500/45 HMO
Lifetime Maximum	Unlimited	Unlimited
Calendar Year Deductible: Individual/family	$1,000 / $2,000 (1)	$1,500 / $3,000 (1)
Calendar Year Max Out-of-Pocket: Individual/family	$6,500 / $13,000 (1)	$6,500 / $13,000 (1)
Office Visit	$50 Copay	$45 Primary / $70 Specialty Copay
Most Laboratory Tests	$40 Copay	$35 Copay
Most X-rays & Diagnostics	$40 Copay	$65 Copay
MRI/CT/PET	30% After Deductible	$250 Copay
Preventive Care Exam	$0 Copay	$0 Copay
Hospitalization	30% After Deductible	20% After Deductible
Outpatient Surgery	30% After Deductible	20 % (Deductible Waived)
Emergency Room	30% After Deductible	$300 Copay After Deductible (waived if admitted directly to hospital)
Urgent Care Center	$50 Copay	$45 Copay
Maternity:		
Inpatient	30% After Deductible	20% After Deductible
Prenatal/Prenatal Care	$0 Copay	$0 Copay
Mental Health:		
Inpatient	30% After Deductible	20% After Deductible
Outpatient	$50 Copay	$45 Copay
Substance Abuse: Inpatient Detox Only	30% After Deductible	20% After Deductible
Prescriptions:	(Up to a 30-Day Supply)	(Up to a 30-Day Supply)
Generic	$25 Copay	$15 Copay
Deductible (Brand Name)	None	$250 Brand Name Deductible
Brand	$50 Copay	$55 Copay (After $250 drug 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	$20 Copay	$0 Copay
Cleaning & Exam	$0 Copay	$0 Copay
Periodontics	$85 - $350 Copay Depending on Procedure	$85 - $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

(1) This plan has an embedded deductible and out-of-pocket maximum. Each family member will begin paying copayments or coinsurance after meeting his or her individual deductible, or whenthe 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

December 1, 2016 - November 30, 2017

MAPPED FROM		Silver 70 HSA 1500/20 OR Bronze 60 HSA 3500/30
BENEFITS	Bronze 60 6000/70 HMO	Bronze 60 HSA 4500/40% HMO
Lifetime Maximum	Unlimited	Unlimited
Calendar Year Deductible: Individual/family	$6,000 / $12,000 (1)	$4,500 / $9,000 (1)
Calendar Year Max Out-of-Pocket: Individual/family	$6,500 / $13,000 (1)	$6,500 / $13,000 (1)
Office Visit	$70 Primary - After Deductible $90 Specialist - After dedictible	40% After Deductible
Most Laboratory Tests	$40	40% After Deductible
Most X-rays & Diagnostics	100% (up to out-of-pocket maximum)	40% After Deductible
MRI/CT/PET	100% (up to out-of-pocket maximum)	40% After Deductible
Preventive Care Exam	$0 Copay	$0 Copay
Hospitalization	100% (up to out-of-pocket maximum)	40% After Deductible
Outpatient Surgery	100% (up to out-of-pocket maximum)	40% After Deductible
Emergency Room	100% (up to out-of-pocket maximum)	40% After Deductible
Urgent Care Center	$70 After Deductible	40% After Deductible
Maternity:		
Inpatient	100% (up to out-of-pocket maximum)	40% After Deductible
Prenatal/Prenatal Care	$0	$0
Mental Health:		
Inpatient	100% (up to out-of-pocket maximum)	40% After Deductible
Outpatient	$70 After Deductible	40% After Deductible
Substance Abuse:		
Inpatient Detox Only	100% (up to out-of-pocket maximum)	40% After Deductible
Prescriptions:	(Up to a 30-Day Supply)	(Up to a 100-Day Supply)
Generic	100% per prescription up to $500 maximum After $500 drug deductible	40% After Plan Deductible
Deductible	$500	Subject to Plan Deductible (1)
Brand	100% per prescription up to $500 maximum After $500 drug deductible	40% After Plan 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	$20 Copay
Cleaning & Exam	$0 Copay	$0 Copay
Periodontics	$85 - $350 Copay Depending on Procedure	$85 - $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

(1) This plan has an embedded deductible and out-of-pocket maximum. Each family member will begin paying copayments or coinsurance after meeting his or her individual deductible, or whenthe 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.