

PLAN OVERVIEW

HMO plans • Balance plans • Now plans • HSA-qualified plans

FEATURES AT A GLANCE

HMO PLANS

FEATURES	PREMIER PLAN	PLAN 500	PLAN 1000
Annual deductible (individual/family)	None	\$500/\$1,500	\$1,000/\$3,000
Out-of-pocket maximum (coinsurance) (individual/family)	Not applicable	\$2,000/\$6,000	\$2,000/\$6,000
Lifetime benefit maximum¹	Unlimited	Unlimited	Unlimited
BENEFITS			
Benefits shown with copays are not subject to the deductible. Benefits shown with coinsurance are subject to the deductible.			
OFFICE SERVICES			
Primary care office visit	\$30 per visit	\$30 per visit	\$30 per visit
Specialist office visit	\$50 per visit	\$50 per visit	\$50 per visit
Preventive screenings²	No charge	No charge	No charge
PHARMACY SERVICES (30-day supply) 90-day supply available through mail order for many prescription drugs			
Pharmacy deductible (individual/family)	\$200/\$600	\$200/\$600	\$200/\$600
Prescription drugs—generic (Kaiser Permanente pharmacy/network pharmacy)	\$15/\$21	\$15/\$21	\$15/\$21
Prescription drugs—brand (Kaiser Permanente pharmacy/network pharmacy)	\$30/\$36	\$30/\$36	\$30/\$36
OUTPATIENT SERVICES			
Laboratory and radiology services	No charge	No charge	No charge
High-tech radiology (MRI, CT, etc.)	\$100	30% coinsurance	30% coinsurance
Outpatient surgery facility	\$100	30% coinsurance	30% coinsurance
Hospital outpatient facility	\$100	30% coinsurance	30% coinsurance
Physician/Other professional charges	No charge	30% coinsurance	30% coinsurance
INPATIENT SERVICES			
Inpatient hospital (facility charge)	\$500 per admission	30% coinsurance	30% coinsurance
Physician/Other professional charges	No charge	30% coinsurance	30% coinsurance
Inpatient mental health facility (30 days per calendar year)	\$500 per admission	30% coinsurance	30% coinsurance
MATERNITY SERVICES			
Maternity (obstetrician/midwife) ³	\$1,000	\$1,000	\$1,000
Maternity (hospital delivery) ³	\$2,000	\$2,000	\$2,000
EMERGENCY SERVICES			
Emergency Room (copay waived if admitted)	\$150 per visit	\$150 per visit	\$150 per visit
After-hours urgent care	\$60 per visit	\$60 per visit	\$60 per visit
Ambulance	\$150 per trip	\$150 per trip	\$150 per trip
OTHER SERVICES			
Rehabilitation therapies (Physical/Occupational) (20 visits per year combined)	\$50	30% coinsurance	30% coinsurance
Vision exam	\$50	\$50	\$50

Note: Benefits with a copay are not subject to the deductible. Benefits with coinsurance are subject to the deductible.

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PLAN 2000	PLAN 3000	PLAN 5000	FEATURES
\$2,000/\$6,000	\$3,000/\$9,000	\$5,000/\$15,000	Annual deductible (individual/family)
\$2,000/\$6,000	\$2,000/\$6,000	\$2,000/\$6,000	Out-of-pocket maximum (coinsurance) (individual/family)
Unlimited	Unlimited	Unlimited	Lifetime benefit maximum ¹
Benefits shown with copays are not subject to the deductible. Benefits shown with coinsurance are subject to the deductible.			BENEFITS
			OFFICE SERVICES
\$30 per visit	\$30 per visit	\$30 per visit	Primary care office visit
\$50 per visit	\$50 per visit	\$50 per visit	Specialist office visit
No charge	No charge	No charge	Preventive screenings ²
90-day supply available through mail order for many prescription drugs			PHARMACY SERVICES (30-day supply)
\$200/\$600	\$200/\$600	\$500/\$1,500	Pharmacy deductible (individual/family)
\$15/\$21	\$15/\$21	\$15/\$21	Prescription drugs—generic (Kaiser Permanente pharmacy/network pharmacy)
\$30/\$36	\$30/\$36	\$30/\$36	Prescription drugs—brand (Kaiser Permanente pharmacy/network pharmacy)
			OUTPATIENT SERVICES
No charge	No charge	No charge	Laboratory and radiology services
30% coinsurance	30% coinsurance	30% coinsurance	High-tech radiology (MRI, CT, etc.)
30% coinsurance	30% coinsurance	30% coinsurance	Outpatient surgery facility
30% coinsurance	30% coinsurance	30% coinsurance	Hospital outpatient facility
30% coinsurance	30% coinsurance	30% coinsurance	Physician/Other professional charges
			INPATIENT SERVICES
30% coinsurance	30% coinsurance	30% coinsurance	Inpatient hospital (facility charge)
30% coinsurance	30% coinsurance	30% coinsurance	Physician/Other professional charges
30% coinsurance	30% coinsurance	30% coinsurance	Inpatient mental health facility (30 days per calendar year)
			MATERNITY SERVICES
\$1,000	\$1,000	\$1,000	Maternity (obstetrician/midwife) ³
\$2,000	\$2,000	\$2,000	Maternity (hospital delivery) ³
			EMERGENCY SERVICES
\$150 per visit	\$150 per visit	\$150 per visit	Emergency Room (copay waived if admitted)
\$60 per visit	\$60 per visit	\$60 per visit	After-hours urgent care
\$150 per trip	\$150 per trip	\$150 per trip	Ambulance
			OTHER SERVICES
30% coinsurance	30% coinsurance	30% coinsurance	Rehabilitation therapies (Physical/Occupational) (20 visits per year combined)
\$50	\$50	\$50	Vision exam

¹Some benefits may have limitations.

²Office visit copay may apply. Well-child visit: no charge up to age 2

³Maternity charges for members are for Ob/Gyn and/or midwife services (pre/postnatal and delivery) and for inpatient facility charge. Other charges may apply for other professional services.

FEATURES AT A GLANCE

BALANCE HMO PLANS Individual coverage only

FEATURES	BALANCE 2000	BALANCE 3000	BALANCE 5000
Annual deductible	\$2,000	\$3,000	\$5,000
Out-of-pocket maximum (coinsurance)	\$5,000	\$6,000	\$10,000
Lifetime benefit maximum¹	\$3 million	\$3 million	\$3 million
BENEFITS	Benefits shown with copays are not subject to the deductible. Benefits shown with coinsurance are subject to the deductible.		
OFFICE SERVICES			
Primary care office visit	\$40 per visit	\$40 per visit	\$40 per visit
Specialist office visit	\$50 per visit	\$50 per visit	\$50 per visit
Preventive screenings²	No charge	No charge	No charge
PHARMACY SERVICES (30-day supply) 90-day supply available through mail order for many prescription drugs			
Pharmacy deductible (brand drugs only)	\$500	\$500	\$500
Prescription drugs—generic (Kaiser Permanente pharmacy/network pharmacy)	\$20/\$30	\$20/\$30	\$20/\$30
Prescription drugs—brand (Kaiser Permanente pharmacy/network pharmacy)	\$40/\$50 (after drug deductible)	\$40/\$50 (after drug deductible)	\$40/\$50 (after drug deductible)
OUTPATIENT SERVICES			
Laboratory and radiology services	30% coinsurance	30% coinsurance	30% coinsurance
High-tech radiology (MRI, CT, etc.)	30% coinsurance	30% coinsurance	30% coinsurance
Outpatient surgery facility	30% coinsurance	30% coinsurance	30% coinsurance
Hospital outpatient facility	30% coinsurance	30% coinsurance	30% coinsurance
Physician/Other professional charges	30% coinsurance	30% coinsurance	30% coinsurance
INPATIENT SERVICES			
Inpatient hospital (facility charge)	30% coinsurance	30% coinsurance	30% coinsurance
Physician/Other professional charges	30% coinsurance	30% coinsurance	30% coinsurance
Inpatient mental health facility (30 days per calendar year)	30% coinsurance	30% coinsurance	30% coinsurance
MATERNITY SERVICES			
Maternity (obstetrician/midwife)	No coverage	No coverage	No coverage
Maternity (hospital delivery)	No coverage	No coverage	No coverage
EMERGENCY SERVICES			
Emergency Room (copay waived if admitted)	\$150 per visit	\$150 per visit	\$150 per visit
After-hours urgent care	\$60 per visit	\$60 per visit	\$60 per visit
Ambulance	\$150 per trip	\$150 per trip	\$150 per trip
OTHER SERVICES			
Rehabilitation therapies (Physical/Occupational) (20 visits per year combined)	30% coinsurance	30% coinsurance	30% coinsurance
Vision exam	No coverage	No coverage	No coverage

Note: Benefits with a copay are not subject to the deductible. Benefits with coinsurance are subject to the deductible.

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BALANCE 7500	BALANCE 10000	FEATURES
\$7,500	\$10,000	Annual deductible
\$10,000	\$10,000	Out-of-pocket maximum (coinsurance)
\$3 million	\$3 million	Lifetime benefit maximum¹
Benefits shown with copays are not subject to the deductible. Benefits shown with coinsurance are subject to the deductible.		BENEFITS
		OFFICE SERVICES
\$40 per visit	\$40 per visit	Primary care office visit
\$50 per visit	\$50 per visit	Specialist office visit
No charge	No charge	Preventive screenings²
90-day supply available through mail order for many prescription drugs		PHARMACY SERVICES (30-day supply)
\$500	\$500	Pharmacy deductible (brand drugs only)
\$20/\$30	\$20/\$30	Prescription drugs—generic (Kaiser Permanente pharmacy/network pharmacy)
\$40/\$50 (after drug deductible)	\$40/\$50 (after drug deductible)	Prescription drugs—brand (Kaiser Permanente pharmacy/network pharmacy)
		OUTPATIENT SERVICES
30% coinsurance	30% coinsurance	Laboratory and radiology services
30% coinsurance	30% coinsurance	High-tech radiology (MRI, CT, etc.)
30% coinsurance	30% coinsurance	Outpatient surgery facility
30% coinsurance	30% coinsurance	Hospital outpatient facility
30% coinsurance	30% coinsurance	Physician/Other professional charges
		INPATIENT SERVICES
30% coinsurance	30% coinsurance	Inpatient hospital (facility charge)
30% coinsurance	30% coinsurance	Physician/Other professional charges
30% coinsurance	30% coinsurance	Inpatient mental health facility (30 days per calendar year)
		MATERNITY SERVICES
No coverage	No coverage	Maternity (obstetrician/midwife)
No coverage	No coverage	Maternity (hospital delivery)
		EMERGENCY SERVICES
\$150 per visit	\$150 per visit	Emergency Room (copay waived if admitted)
\$60 per visit	\$60 per visit	After-hours urgent care
\$150 per trip	\$150 per trip	Ambulance
		OTHER SERVICES
30% coinsurance	30% coinsurance	Rehabilitation therapies (Physical/Occupational) (20 visits per year combined)
No coverage	No coverage	Vision exam

¹Some benefits may have limitations.

²Deductible does not apply. Office visit copay may apply.

FEATURES AT A GLANCE

BALANCE WITH HSA OPTION PLANS

Individual coverage only

This is a summary description and is not intended to replace the *Evidence of Coverage*, which contains the complete provisions of this coverage. Some services require preauthorization. Applicants are subject to medical review.

FEATURES	BALANCE HSA 1200	BALANCE HSA 2000
Annual deductible	\$1,200	\$2,000
Out-of-pocket maximum	\$1,200	\$4,000
Lifetime benefit maximum	\$3 million	\$3 million
Coinsurance	No charge (after deductible)	20% coinsurance (after deductible)
Preventive care visits	\$15 office visit copay	\$15 office visit copay
Preventive care services	No charge	No charge
All other covered services	No charge (after deductible)	20% coinsurance (after deductible)

Note: Benefits with a copay are not subject to the deductible. Benefits with coinsurance are subject to the deductible.



FEATURES AT A GLANCE

NOW PLANS

This is a summary description and is not intended to replace the *Evidence of Coverage*, which contains the complete provisions of this coverage. Some services require preauthorization. Applicants are subject to medical review.

FEATURES	NOW 2000	NOW 4000	NOW 6000	NOW 10000
Annual deductible (individual/family)	\$2,000 /\$6,000	\$4,000 /\$12,000	\$6,000/\$18,000	\$10,000/\$30,000
Out-of-pocket maximum (coinsurance) (individual/family)	\$5,000/\$9,000	\$5,000/\$9,000	\$5,000/\$9,000	\$5,000/\$9,000
Lifetime benefit maximum ¹	\$6 million	\$6 million	\$6 million	\$6 million
BENEFITS	Benefits shown with copays are not subject to the deductible. Benefits shown with coinsurance are subject to the deductible.			
OFFICE SERVICES				
Primary care office visit	\$40 per visit	\$40 per visit	\$40 per visit	\$40 per visit
Specialist office visit	\$60 per visit	\$60 per visit	\$60 per visit	\$60 per visit
Preventive screenings ²	No charge	No charge	No charge	No charge
PHARMACY SERVICES				
Prescription drugs	No coverage ³	No coverage ³	No coverage ³	No coverage ³
OUTPATIENT SERVICES Kaiser Permanente medical centers/non-Kaiser Permanente facilities				
Laboratory and radiology services	No charge/ 30% coinsurance	No charge/ 30% coinsurance	No charge/ 30% coinsurance	No charge/ 30% coinsurance
High-tech radiology (MRI, CT, etc.)	30% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance
Outpatient surgery facility	30% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance
Hospital outpatient facility	30% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance
Physician/Other professional charges	30% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance
INPATIENT SERVICES				
Inpatient hospital (facility charge)	30% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance
Physician/Other professional charges	30% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance
Inpatient mental health facility (30 days per calendar year)	30% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance
MATERNITY SERVICES				
Maternity (obstetrician/midwife) ⁴	\$1,500	\$1,500	\$1,500	\$1,500
Maternity (hospital delivery) ⁴	\$3,000	\$3,000	\$3,000	\$3,000
EMERGENCY SERVICES				
Emergency Room (copay waived if admitted)	\$250 per visit	\$250 per visit	\$250 per visit	\$250 per visit
After-hours urgent care	\$70 per visit	\$70 per visit	\$70 per visit	\$70 per visit
Ambulance	\$250 per trip	\$250 per trip	\$250 per trip	\$250 per trip
OTHER SERVICES				
Rehabilitation therapies (Physical/Occupational) (20 visits per year combined)	30% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance
Vision exam	\$60	\$60	\$60	\$60

Note: Benefits with a copay are not subject to the deductible. Benefits with coinsurance are subject to the deductible.

¹Some benefits may have limitations.

²Office visit copay may apply. Well-child visit: no charge up to age 2

³Some exceptions may apply as set out in the *Evidence of Coverage* or as required by law.

⁴Maternity charges for members are for Ob/Gyn and/or midwife services (pre/postnatal and delivery) and for inpatient hospital charge. Other charges will apply for other professional services both inpatient and outpatient.

FEATURES AT A GLANCE

NOW PLUS PLANS with prescription drug coverage

FEATURES	NOW PREMIER PLUS	NOW 500 PLUS	NOW 1000 PLUS	NOW 2000 PLUS
Annual deductible (individual/family)	None	\$500/\$1,500	\$1,000/\$3,000	\$2,000/\$6,000
Out-of-pocket maximum (coinsurance) (individual/family)	None	\$2,000/\$6,000	\$2,000/\$6,000	\$5,000/\$9,000
Lifetime benefit maximum¹	Unlimited	\$6 million	\$6 million	\$6 million
BENEFITS	Benefits shown with copays are not subject to the deductible. Benefits shown with coinsurance are subject to the deductible.			
OFFICE SERVICES				
Primary care office visit	\$30 per visit	\$40 per visit	\$40 per visit	\$40 per visit
Specialist office visit	\$50 per visit	\$60 per visit	\$60 per visit	\$60 per visit
Preventive screenings²	No charge	No charge	No charge	No charge
PHARMACY SERVICES (30-day supply) 90-day supply available through mail order for most prescriptions				
Pharmacy deductible (brand drugs only) (individual/family)	\$200/\$600	\$300/\$600	\$300/\$600	\$300/\$600
Prescription drugs—generic (Kaiser Permanente pharmacy/network pharmacy)	\$15/\$21	\$15/\$21	\$15/\$21	\$15/\$21
Prescription drugs—brand (Kaiser Permanente pharmacy/network pharmacy)	\$40/\$46	\$40/\$46	\$40/\$46	\$40/\$46
OUTPATIENT SERVICES Kaiser Permanente medical centers/non-Kaiser Permanente facilities				
Laboratory and radiology services	No charge/\$100	No charge/30% coinsurance	No charge/30% coinsurance	No charge/30% coinsurance
High-tech radiology (MRI, CT, etc.)	\$50/\$100	30% coinsurance	30% coinsurance	30% coinsurance
Outpatient surgery facility	\$100	30% coinsurance	30% coinsurance	30% coinsurance
Hospital outpatient facility	\$100	30% coinsurance	30% coinsurance	30% coinsurance
Physician/Other professional charges	No charge	30% coinsurance	30% coinsurance	30% coinsurance
INPATIENT SERVICES				
Inpatient hospital (facility charge)	\$500 per admission	30% coinsurance	30% coinsurance	30% coinsurance
Physician/Other professional charges	No charge	30% coinsurance	30% coinsurance	30% coinsurance
Inpatient mental health facility (30 days per calendar year)	\$500 per admission	30% coinsurance	30% coinsurance	30% coinsurance
MATERNITY SERVICES				
Maternity (obstetrician/midwife) ³	\$1,000	\$1,500	\$1,500	\$1,500
Maternity (hospital delivery) ³	\$2,000	\$3,000	\$3,000	\$3,000
EMERGENCY SERVICES				
Emergency Room (copay waived if admitted)	\$150 per visit	\$250 per visit	\$250 per visit	\$250 per visit
After-hours urgent care	\$60 per visit	\$70 per visit	\$70 per visit	\$70 per visit
Ambulance	\$150 per trip	\$250 per trip	\$250 per trip	\$250 per trip
OTHER SERVICES				
Rehabilitation therapies (Physical/Occupational) (20 visits per year combined)	\$50	30% coinsurance	30% coinsurance	30% coinsurance
Vision exam	\$50	\$60	\$60	\$60

Note: Benefits with a copay are not subject to the deductible. Benefits with coinsurance are subject to the deductible.

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NOW 4000 PLUS	NOW 6000 PLUS	NOW 10000 PLUS	FEATURES
\$4,000/\$12,000	\$6,000/\$18,000	\$10,000/\$30,000	Annual deductible (individual/family)
\$5,000/\$9,000	\$5,000/\$9,000	\$5,000/\$9,000	Out-of-pocket maximum (coinsurance) (individual/family)
\$6 million	\$6 million	\$6 million	Lifetime benefit maximum ¹
Benefits shown with copays are not subject to the deductible. Benefits shown with coinsurance are subject to the deductible.			BENEFITS
			OFFICE SERVICES
\$40 per visit	\$40 per visit	\$40 per visit	Primary care office visit
\$60 per visit	\$60 per visit	\$60 per visit	Specialist office visit
No charge	No charge	No charge	Preventive screenings ²
90-day supply available through mail order for most prescriptions			PHARMACY SERVICES (30-day supply)
\$300/\$600	\$300/\$600	\$300/\$600	Pharmacy deductible (brand drugs only) (individual/family)
\$15/\$21	\$15/\$21	\$15/\$21	Prescription drugs—generic (Kaiser Permanente pharmacy/network pharmacy)
\$40/\$46	\$40/\$46	\$40/\$46	Prescription drugs—brand (Kaiser Permanente pharmacy/network pharmacy)
Kaiser Permanente medical centers/non-Kaiser Permanente facilities			OUTPATIENT SERVICES
No charge/30% coinsurance	No charge/30% coinsurance	No charge/30% coinsurance	Laboratory and radiology services
30% coinsurance	30% coinsurance	30% coinsurance	High-tech radiology (MRI, CT, etc.)
30% coinsurance	30% coinsurance	30% coinsurance	Outpatient surgery facility
30% coinsurance	30% coinsurance	30% coinsurance	Hospital outpatient facility
30% coinsurance	30% coinsurance	30% coinsurance	Physician/Other professional charges
			INPATIENT SERVICES
30% coinsurance	30% coinsurance	30% coinsurance	Inpatient hospital (facility charge)
30% coinsurance	30% coinsurance	30% coinsurance	Physician/Other professional charges
30% coinsurance	30% coinsurance	30% coinsurance	Inpatient mental health facility (30 days per calendar year)
			MATERNITY SERVICES
\$1,500	\$1,500	\$1,500	Maternity (obstetrician/midwife) ³
\$3,000	\$3,000	\$3,000	Maternity (hospital delivery) ³
			EMERGENCY SERVICES
\$250 per visit	\$250 per visit	\$250 per visit	Emergency Room (copay waived if admitted)
\$70 per visit	\$70 per visit	\$70 per visit	After-hours urgent care
\$250 per trip	\$250 per trip	\$250 per trip	Ambulance
			OTHER SERVICES
30% coinsurance	30% coinsurance	30% coinsurance	Rehabilitation therapies (Physical/Occupational) (20 visits per year combined)
\$60	\$60	\$60	Vision exam

¹Some benefits may have limitations.

²Office visit copay may apply. Well-child visit: no charge up to age 2

³Maternity charges for members are for Ob/Gyn and/or midwife services (pre/postnatal and delivery) and for inpatient hospital charge. Other charges will apply for other professional services both inpatient and outpatient.

FEATURES AT A GLANCE

HMO PLANS WITH HSA OPTION

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SELF-ONLY PLANS	HSA Option 3500/100% Self	HSA Option 5000/100% Self	HSA Option 3500/80% Self
Annual deductible	\$3,500	\$5,000	\$3,500
Out-of-pocket maximum	\$3,500	\$5,000	\$5,000
Coinsurance	No charge (after deductible)	No charge (after deductible)	20% coinsurance (after deductible)
Maximum benefit while covered	Unlimited	Unlimited	Unlimited
Preventive care visits	\$15 office copay	\$15 office copay	\$15 office copay
Preventive care services	No charge	No charge	No charge
All other covered services	No charge (after deductible)	No charge (after deductible)	20% coinsurance (after deductible)

FAMILY PLANS (2+)	HSA Option 3500/100% Family	HSA Option 5000/100% Family	HSA Option 3500/80% Family	HSA Option 5000/80% Family
Annual deductible	\$3,500	\$5,000	\$3,500	\$5,000
Out-of-pocket maximum	\$3,500	\$5,000	\$7,500	\$9,000
Coinsurance	No charge (after deductible)	No charge (after deductible)	20% coinsurance (after deductible)	20% coinsurance (after deductible)
Maximum benefit while covered	Unlimited	Unlimited	Unlimited	Unlimited
Preventive care visits	\$15 office copay	\$15 office copay	\$15 office copay	\$15 office copay
Preventive care services	No charge	No charge	No charge	No charge
All other covered services	No charge (after deductible)	No charge (after deductible)	20% coinsurance (after deductible)	20% coinsurance (after deductible)

Note: Benefits with a copay are not subject to the deductible. Benefits with coinsurance are subject to the deductible.



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