

Understanding the plans: benefit highlights

The charts on the next few pages show you a sample of each plan’s benefits. Review the diagram below to help you understand how to read those charts.

Here’s a quick look at how to use the chart

	KP Offered through Kaiser Permanente
Plan type	Deductible
Features	
Annual medical deductible (individual/family)	\$4,000/\$8,000
Annual out-of-pocket maximum (individual/family)	\$8,200/\$16,400
Benefits	
Preventive care	
Routine physical exam, mammograms, etc.	No charge
Outpatient services (per visit or procedure)	
Primary care office visit	\$40
Specialty care office visit	\$80
Most X-rays	\$85
Most lab tests	\$40
MRI, CT, PET	\$325
Outpatient surgery	20%
Mental health visit	\$40
Inpatient hospital care	
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	20% after deductible
Maternity	
Routine prenatal care visit, first postpartum visit	No charge
Delivery and inpatient well-baby care	20% after deductible
Emergency and urgent care	
Emergency Department visit	\$400
Urgent care visit	\$40
Prescription drugs (up to a 30-day supply)	
Generic	\$16 after \$300 pharmacy deductible
Preferred brand	\$60 after \$300 pharmacy deductible
Non-preferred brand	\$60 after \$300 pharmacy deductible
Specialty	20% after \$300 pharmacy deductible, up to \$250 per prescription
Whole health	
Healthy services	Optical promotions kp2020.org

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Annual deductible
You need to pay this amount before your plan starts helping you pay for most covered services. Under this sample plan, you’d pay the full charges for covered services until you reach \$4,000 for yourself or \$8,000 for your family. Then you’d start paying copays or coinsurance.

Annual out-of-pocket maximum
This is the most you’ll pay for care during the calendar year before your plan starts paying 100% for most covered services. In this example, you’d never pay more than \$8,200 for yourself and no more than \$16,400 for your family for your copays, coinsurance, and deductible in a calendar year.

Preventive care at no charge
Most preventive care services—including routine physical exams and mammograms—are covered at no charge. Plus, they’re not subject to the deductible.

Covered before you reach the deductible
With some services, you’ll only pay a copay or coinsurance, regardless of whether you’ve reached your deductible. Under this plan, primary care visits are covered at a \$40 copay—even before you meet your deductible. With our Silver deductible plans, primary care, specialty care, and urgent care visits all are covered before you reach the deductible.

Coinsurance
After reaching your deductible, this is a percentage of the charges that you may pay for covered services. Here, you’d pay 20% of the cost per day for your inpatient hospital care after you reach your deductible. Your plan would pay the rest for the remainder of the calendar year.

Copay
This is the set amount you pay for covered services, usually after you reach your deductible. In this example, you’d pay a \$40 copay for urgent care visits, whether or not you have met your deductible.

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E Offered through the health benefit exchange, Covered California

Financial assistance options with lower copays, coinsurance, and deductibles are available for certain plans, and for Native Alaskans and American Indians on CoveredCA.com.

	KP E Kaiser Permanente - Bronze 60 HDHP HMO	KP E Kaiser Permanente - Bronze 60 HMO	KP Kaiser Permanente - Bronze 60 HMO 8200/0%
Plan type	HSA-qualified	Deductible	Deductible
Features			
Annual medical deductible (individual/family)	\$7,000/\$14,000	\$6,300/\$12,600	\$8,200/\$16,400
Annual out-of-pocket maximum (individual/family)	\$7,000/\$14,000	\$8,200/\$16,400	\$8,200/\$16,400
Benefits			
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	No charge after deductible	\$65 after deductible*	No charge after deductible
Specialty care office visit	No charge after deductible	\$95 after deductible*	No charge after deductible
Most X-rays	No charge after deductible	40% after deductible	No charge after deductible
Most lab tests	No charge after deductible	\$40	No charge after deductible
MRI, CT, PET	No charge after deductible	40% after deductible	No charge after deductible
Outpatient surgery	No charge after deductible	40% after deductible	No charge after deductible
Mental health visit	No charge after deductible	\$65 after deductible*	No charge after deductible
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	No charge after deductible	40% after deductible	No charge after deductible
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	No charge after deductible	40% after deductible	No charge after deductible
Emergency and urgent care			
Emergency Department visit	No charge after deductible	40% after deductible	No charge after deductible
Urgent care visit	No charge after deductible	\$65 after deductible*	No charge after deductible
Prescription drugs (up to a 30-day supply)			
Generic	No charge after deductible	\$18 after \$500 pharmacy deductible†	\$20†
Preferred brand	No charge after deductible	40% after \$500 pharmacy deductible, up to \$500 per prescription	No charge after deductible
Non-preferred brand	No charge after deductible	40% after \$500 pharmacy deductible, up to \$500 per prescription	No charge after deductible
Specialty	No charge after deductible	40% after \$500 pharmacy deductible, up to \$500 per prescription	No charge after deductible
Whole health			
Healthy services	Optical promotions*** kp2020.org	Optical promotions*** kp2020.org	Optical promotions*** kp2020.org

* The Kaiser Permanente Bronze 60 HMO plan includes three office visits for the benefit copay before you reach your deductible. Office visits include primary, specialty, urgent, or outpatient mental health and substance use care.

† Mail order: Up to a 100-day supply of qualified prescriptions for the cost of a 60-day supply.

** After 5 days, there is no charge for covered services related to the admission.

†† Only applicants younger than age 30, or applicants age 30 and older who provide a certificate from Covered California demonstrating hardship or lack of affordable coverage, may purchase a Minimum Coverage HMO plan.

‡‡ The Kaiser Permanente Minimum Coverage HMO plan includes three office visits at no charge before you reach your deductible. Office visits include primary, urgent, or outpatient mental health care.

*** Optical promotions and other services shown may be provided by groups other than Kaiser Permanente, and aren't offered or guaranteed under your coverage. Additional fees you pay won't count toward your deductible or out-of-pocket maximum.

This plan summary is intended to highlight the most frequently asked about benefits, copays, coinsurance, and deductibles. For services subject to the deductible, you'll have to pay health care expenses out of pocket until you meet your deductible. Most deductibles, copays, and coinsurance contribute to the annual out-of-pocket maximum. Please refer to the *Combined Membership Agreement, Evidence of Coverage, and Disclosure Form (EOC)* for complete details on your plan or for specific limitations and exclusions. To request a copy of the EOC, please visit kp.org/plandocuments, call us at 1-800-464-4000, or contact your broker.

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	E Kaiser Permanente - Silver 70 HMO	KP Kaiser Permanente - Silver 70 HMO Off Exchange	KP Kaiser Permanente - Silver 70 HMO 2500/45	KP Kaiser Permanente - Silver 70 HDHP HMO 3250/20%
Plan type	Deductible	Deductible	Deductible	HSA-qualified
Features				
Annual medical deductible (individual/family)	\$4,000/\$8,000	\$4,000/\$8,000	\$2,500/\$5,000	\$3,250/\$6,500
Annual out-of-pocket maximum (individual/family)	\$8,200/\$16,400	\$8,200/\$16,400	\$8,200/\$16,400	\$7,000/\$14,000
Benefits				
Preventive care				
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)				
Primary care office visit	\$40	\$40	\$45	20% after deductible
Specialty care office visit	\$80	\$80	\$75	20% after deductible
Most X-rays	\$85	\$85	\$70 after deductible	20% after deductible
Most lab tests	\$40	\$40	\$25 after deductible	20% after deductible
MRI, CT, PET	\$325	\$325	\$350 after deductible	20% after deductible
Outpatient surgery	20%	20%	35% after deductible	20% after deductible
Mental health visit	\$40	\$40	\$45	20% after deductible
Inpatient hospital care				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	20% after deductible	20% after deductible	35% after deductible	20% after deductible
Maternity				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	20% after deductible	20% after deductible	35% after deductible	20% after deductible
Emergency and urgent care				
Emergency Department visit	\$400	\$400	\$350 after deductible	20% after deductible
Urgent care visit	\$40	\$40	\$45	20% after deductible
Prescription drugs (up to a 30-day supply)				
Generic	\$16 after \$300 pharmacy deductible [†]	\$16 after \$300 pharmacy deductible [†]	\$20 [†]	20% after deductible, up to \$250 per prescription
Preferred brand	\$60 after \$300 pharmacy deductible [†]	\$60 after \$300 pharmacy deductible [†]	\$65 after \$350 pharmacy deductible [†]	20% after deductible, up to \$250 per prescription
Non-preferred brand	\$60 after \$300 pharmacy deductible [†]	\$60 after \$300 pharmacy deductible [†]	\$65 after \$350 pharmacy deductible [†]	20% after deductible, up to \$250 per prescription
Specialty	20% after \$300 pharmacy deductible, up to \$250 per prescription	20% after \$300 pharmacy deductible, up to \$250 per prescription	35% after \$350 pharmacy deductible, up to \$250 per prescription	20% after deductible, up to \$250 per prescription
Whole health				
Healthy services	Optical promotions*** kp2020.org	Optical promotions*** kp2020.org	Optical promotions*** kp2020.org	Optical promotions*** kp2020.org

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	KP E Kaiser Permanente - Gold 80 HMO Coinsurance	KP E Kaiser Permanente - Gold 80 HMO	KP E Kaiser Permanente - Platinum 90 HMO	KP E Kaiser Permanente - Minimum Coverage HMO ^{††}
Plan type	Copay	Copay	Copay	Deductible
Features				
Annual medical deductible (individual/family)	None/None	None/None	None/None	\$8,550/\$17,100
Annual out-of-pocket maximum (individual/family)	\$8,200/\$16,400	\$8,200/\$16,400	\$4,500/\$9,000	\$8,550/\$17,100
Benefits				
Preventive care				
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)				
Primary care office visit	\$35	\$35	\$15	First 3 office visits no charge. ^{††} Additional visits no charge after deductible
Specialty care office visit	\$65	\$65	\$30	No charge after deductible
Most X-rays	\$75	\$75	\$30	No charge after deductible
Most lab tests	\$40	\$40	\$15	No charge after deductible
MRI, CT, PET	20%	\$150	\$75	No charge after deductible
Outpatient surgery	20%	\$340	\$125	No charge after deductible
Mental health visit	\$35	\$35	\$15	First 3 office visits no charge. ^{††} Additional visits no charge after deductible
Inpatient hospital care				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	20%	\$600 per day up to 5 days ^{**}	\$250 per day up to 5 days ^{**}	No charge after deductible
Maternity				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	20%	\$600 per day up to 5 days ^{**}	\$250 per day up to 5 days ^{**}	No charge after deductible
Emergency and urgent care				
Emergency Department visit	\$350	\$350	\$150	No charge after deductible
Urgent care visit	\$35	\$35	\$15	First 3 office visits no charge. ^{††} Additional visits no charge after deductible
Prescription drugs (up to a 30-day supply)				
Generic	\$15 [‡]	\$15 [‡]	\$5 [‡]	No charge after deductible
Preferred brand	\$55 [‡]	\$55 [‡]	\$15 [‡]	No charge after deductible
Non-preferred brand	\$55 [‡]	\$55 [‡]	\$15 [‡]	No charge after deductible
Specialty	20% up to \$250 per prescription	20% up to \$250 per prescription	10% up to \$250 per prescription	No charge after deductible
Whole health				
Healthy services	Optical promotions ^{***} kp2020.org	Optical promotions ^{***} kp2020.org	Optical promotions ^{***} kp2020.org	Optical promotions ^{***} kp2020.org

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Cost Share Reduction (CSR) Plans

You must qualify for and enroll in the CSR plans on this page through Covered California.

	E Kaiser Permanente - Silver 73 HMO	E Kaiser Permanente - Silver 87 HMO	E Kaiser Permanente - Silver 94 HMO
Plan type	Deductible	Deductible	Deductible
Features			
Annual medical deductible (individual/family)	\$3,700/\$7,400	\$1,400/\$2,800	\$75/\$150
Annual out-of-pocket maximum (individual/family)	\$6,500/\$13,000	\$2,850/\$5,700	\$1,000/\$2,000
Benefits			
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	\$35	\$15	\$5
Specialty care office visit	\$75	\$25	\$8
Most X-rays	\$85	\$40	\$8
Most lab tests	\$40	\$20	\$8
MRI, CT, PET	\$325	\$100	\$50
Outpatient surgery	20%	15%	10%
Mental health visit	\$35	\$15	\$5
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	20% after deductible	15% after deductible	10% after deductible
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	20% after deductible	15% after deductible	10% after deductible
Emergency and urgent care			
Emergency Department visit	\$400	\$150	\$50
Urgent care visit	\$35	\$15	\$5
Prescription drugs (up to a 30-day supply)			
Generic	\$16 after \$275 pharmacy deductible [†]	\$5 [†]	\$3 [†]
Preferred brand	\$55 after \$275 pharmacy deductible [†]	\$25 after \$100 pharmacy deductible [†]	\$10 [†]
Non-preferred brand	\$55 after \$275 pharmacy deductible [†]	\$25 after \$100 pharmacy deductible [†]	\$10 [†]
Specialty	20% after \$275 pharmacy deductible, up to \$250 per prescription	15% after \$100 pharmacy deductible, up to \$150 per prescription	10%, up to \$150 per prescription
Whole health			
Healthy services	Optical promotions*** kp2020.org	Optical promotions*** kp2020.org	Optical promotions*** kp2020.org

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