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2025

AVAILABLE KAISER PLAN OPTIONS

These medical plans are fully insured and underwritten by Kaiser Permanente. This is a summary only. Any errors or omissions are unintentional. Plan Handbooks are available by request.

DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS	COPAY B
Deductible per Calendar Year	None
Maximum out-of-pocket per Calendar Year *(Includes deductible, coinsurance, and prescription copays)*	$1,500 Single $3,000 Family

BENEFIT FEATURES	Covered Person Pays
Preventive Care Services: Routine well-baby care, physical examinations, health screenings, and immunizations	No charge
OFFICE VISITS	**Covered Person Pays**
Primary Care	$5 first 3 visits*, then $20
Specialty Care	$30 per visit
Urgent Care	$40 per visit
PROFESSIONAL VISITS	**Covered Person Pays**
Outpatient laboratory, radiology, and diagnostic procedures	$20 per department visit
CT, MRI, PET scans	$50 per department visit
Outpatient surgery	$50 copay
Maternity care	No charge, applicable copays for lab & x-ray
Therapeutic injections including allergy shots	$10 copay *(separate office visit copay may apply)*
HOSPITAL/FACILITY SERVICES	**Covered Person Pays**
Inpatient services	$200/day up to $1,000/admission
Outpatient physical, speech and occupational therapies *(20 visits/therapy/calendar year)*	$30 per visit
Outpatient mental/behavioral health & chemical dependency services	$5 first 3 visits*, then $20
Emergency room visit	$200 per visit *(waived if admitted)*
Skilled Nursing Facility – *Up to 100 days/Calendar Year*	No charge
OTHER SERVICES	**Covered Person Pays**
Ambulance (per transport)	$75 copay
Home health care – 130 visits/Calendar Year	No charge
Hospice	No charge
Durable medical equipment and supplies	20% coinsurance

**First three visits combined primary care and mental health*

PRESCRIPTION MEDICATION BENEFIT	COPAY PLAN B
Generic	$10
Preferred Brand	$20
Non-Preferred Brand	$40
Specialty Generic	$40
Mail order *(up to 90-day supply)*	2x copay
Administered medications, including injections *(all outpatient settings)*	20% coinsurance

DEDUCTIBLE A	DEDUCTIBLE B	HDHP-1
$250 Single $750 Family	$500 Single $1,500 Family	$1,700 Single $3,400 Family
$2,000 Single $6,000 Family	$3,000 Single $9,000 Family	$3,400 Single $6,800 Family

Covered Person Pays		
No charge	No charge	No charge
Covered Person Pays		
$5 first 3 visits*, then $15	$5 first 3 visits*, then $20	After deductible $5 first 3 visits*, then 20%
$25 per visit	$30 per visit	20% after deductible
$35 per visit	$40 per visit	20% after deductible
Covered Person Pays		
$15 per department visit	$20 per department visit	20% after deductible
$15 per department visit	$50 per department visit	20% after deductible
20% after deductible	20% after deductible	10% after deductible
No charge, applicable copays for lab & x-ray	No charge, applicable copays for lab & x-ray	No charge, applicable copays for lab & x-ray
$10 per visit may apply *(no deductible)*	$10 per visit may apply *(no deductible)*	20% after deductible
Covered Person Pays		
20% after deductible	20% after deductible	20% after deductible
$25 per visit	$30 per visit	20% after deductible
$5 first 3 visits*, then $15	$5 first 3 visits*, then $20	After deductible $5 first 3 visits*, then 20%
20% after deductible	20% after deductible	20% after deductible
20% after deductible	20% after deductible	20% after deductible
Covered Person Pays		
20% after deductible	20% after deductible	20% after deductible
20% after deductible	20% after deductible	20% after deductible
No charge	No charge	No charge
20% after deductible	20% after deductible	20% after deductible

DEDUCTIBLE A	DEDUCTIBLE B	HDHP-1
$10	$10	20% after deductible
$20	$20	
$20	$40	
$20	$40	
2x copay	2x copay	
$0	20% after deductible	20% after deductible

OTHER SERVICES PROVIDED BY KAISER PERMANENTE

Bariatric Surgery: *Bariatric surgery may be covered to treat morbid obesity if the covered person meets specified medical criteria, subject to inpatient hospital cost share.*
Healthy Lifestyle Programs: *Individualized online programs that provide encouragement and information about specific health conditions: back pain, chronic conditions, depression, insomnia, nutrition, smoking cessation, stress, and weight management.*
BeyondWell: *A comprehensive well-being solution for members that integrates wellness activities, goals, rewards, and challenges into a single location for a holistic wellness offering.*
Prenatal and Pregnancy Services
Appointment Alternatives • Advice Nurse Line available 24/7 • Virtual Care doctor appointment by computer or mobile device • Email Your Doctor by secure email
Case and Disease Management: *Supports and educates members with serious illnesses, chronic conditions, or injuries.*

ADDITIONAL PLAN RIDERS

The following benefits can be added to all Kaiser Plans for an additional cost, unless otherwise noted. These riders are selected on the group level, not at the individual employee level.

ALTERNATIVE CARE RIDER
Must use Complimentary Healthcare Plan Providers and does not count towards out-of-pocket maximum

BENEFIT	COPAY & DEDUCTIBLE PLANS	HDHP-1
Acupuncture Services (up to 12 visits per year)	$20 copay per visit	After deductible, $20 copay per visit
Chiropractic Services (up to 20 visits per year)	$20 copay per visit	After deductible, $20 copay per visit
Massage Therapy (up to 12 visits per year)	$25 copay per visit	After deductible, $25 copay per visit

HEARING AID RIDER
For participants over the age of 18. State mandated coverage applies to children 18 years and younger. Hearing exam is included in medical plan benefit under office visit.

BENEFIT	COPAY PLAN B	DEDUCTIBLE A & B	HDHP-1
Hearing Examination	$30 copay	$25 copay	20% After Deductible
Hearing Aids Benefit	$1,500 allowance for each hearing aid per ear every 3 years.		

KAISER VISION RIDER
State mandated coverage applies to children 18 and younger.

BENEFIT	COPAY PLAN B	DEDUCTIBLE A	DEDUCTIBLE B	HDHP-1
Eye Exam	$20 copay	$15 copay	$20 copay	20% After Deductible
Lenses and Frames	$150 allowance to be applied to one prescription for lenses and frames per calendar year.			
Elective Contact Lenses	$150 allowance to be applied toward one prescription of contact lenses in lieu of lenses and frames per calendar year.			