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# **Kaiser Permanente**

for Individuals and Families

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Plans & Benefits | Colorado



# PLANS & BENEFITS

Use this brochure to compare plans  
and choose the one that's best for you.

## IN THIS BROCHURE

- Benefit highlights

# BENEFIT HIGHLIGHTS

## Deductible plans

	KP 1500/30/Rx	KP 2000/30/Rx	KP 3000/30/Rx	KP 4000/30/Rx	KP 5000/30
<b>Features</b>					
Annual deductible (individual/family) <sup>1,2</sup>	\$1,500/\$4,500	\$2,000/\$6,000	\$3,000/\$9,000	\$4,000/\$12,000	\$5,000/\$15,000
Annual out-of-pocket maximum (individual/family) <sup>2</sup>	\$3,750/\$7,500	\$5,000/\$10,000	\$7,500/\$15,000	\$10,000/\$20,000	\$5,000/\$10,000
<b>Benefits</b> <span style="float: right;">Services not subject to deductible unless otherwise indicated</span>					
<b>Preventive care</b>					
Immunizations	No charge				
Adult preventive care exam	No charge				
Well-child visit	No charge				
Well-woman visit	No charge				
Adult preventive screening	No charge				
Colorectal cancer screening	No charge				
<b>Outpatient services (per visit or procedure)</b>					
Primary care/Specialty care office visit	\$30 copay/\$50 copay				
Ambulatory surgery	30% coinsurance (after deductible)				
Diagnostic lab (in a medical office or contracted free-standing facility)	No charge				
Therapeutic and diagnostic X-ray	30% coinsurance (after deductible)				
<b>Inpatient hospital care</b>					
Hospital care and professional visits	30% coinsurance (after deductible)				
<b>Maternity</b>					
Routine prenatal care visit	\$30 copay				
Delivery and inpatient well-baby care	30% coinsurance (after deductible)				
<b>Emergency and urgent care</b>					
Emergency room visit	30% coinsurance (after deductible)				
Nonroutine care	\$30 copay				
After-hours care	\$75 copay				
Ambulance service	30% coinsurance (up to \$500 per trip)				
<b>Prescription drugs</b>					
Pharmacy (up to a 30-day supply filled at a Kaiser Permanente pharmacy) <sup>3</sup>	Generic: \$15 copay/Brand: \$30 copay				Not covered
Mail-order (up to a 90-day supply) <sup>3</sup>	Generic: \$30 copay/Brand: \$60 copay				Not covered

<sup>1</sup>In deductible plans, the deductible does not apply to the out-of-pocket maximum. In HSA-qualified deductible HMO plans, the deductible does apply to the out-of-pocket maximum.

<sup>2</sup>For families in a deductible plan, individual family members are responsible for meeting the family deductible and out-of-pocket maximum only up to the individual deductible and out-of-pocket maximum amount, until the family out-of-pocket maximum is met. For family memberships in an HSA-qualified deductible HMO plan, the individual deductible and out-of-pocket maximum do not apply. The family deductible and out-of-pocket maximum can be met by a combination of family members.

<sup>3</sup>There are different copays and coinsurance for nonpreferred and specialty drugs. See the *Membership Agreement* for specific details.

## HSA-qualified deductible HMO plans

	KP HSA 2000/20/Rx	KP HSA 2500/20/Rx	KP HSA 3000/20/Rx
<b>Features</b>			
Annual deductible (individual/family) <sup>1,2</sup>	\$2,000/\$4,000	\$2,500/\$5,000	\$3,000/\$6,000
Annual out-of-pocket maximum (individual/family) <sup>2</sup>	\$4,000/\$8,000	\$5,000/\$10,000	\$5,950/\$11,900
<b>Benefits</b> <span style="float: right;">Services not subject to deductible unless otherwise indicated</span>			
<b>Preventive care</b>			
Immunizations		No charge	
Adult preventive care exam		No charge	
Well-child visit		No charge	
Well-woman visit		No charge	
Adult preventive screening		No charge	
Colorectal cancer screening		No charge	
<b>Outpatient services (per visit or procedure)</b>			
Primary care/Specialty care office visit		20% coinsurance (after deductible)	
Ambulatory surgery		20% coinsurance (after deductible)	
Diagnostic lab (in a medical office or contracted free-standing facility)		20% coinsurance (after deductible)	
Therapeutic and diagnostic X-ray		20% coinsurance (after deductible)	
<b>Inpatient hospital care</b>			
Hospital care and professional visits		20% coinsurance (after deductible)	
<b>Maternity</b>			
Routine prenatal care visit		20% coinsurance (after deductible)	
Delivery and inpatient well-baby care		20% coinsurance (after deductible)	
<b>Emergency and urgent care</b>			
Emergency room visit		20% coinsurance (after deductible)	
Nonroutine care		20% coinsurance (after deductible)	
After-hours care		20% coinsurance (after deductible)	
Ambulance service		20% coinsurance (after deductible)	
<b>Prescription drugs</b>			
Pharmacy (up to a 30-day supply filled at a Kaiser Permanente pharmacy) <sup>3</sup>		Generic: \$15 copay/Brand: \$30 copay (after deductible)	
Mail-order (up to a 90-day supply) <sup>3</sup>		Generic: \$30 copay/Brand: \$60 copay (after deductible)	

This is only a summary. For more detailed information, refer to the *Health Benefit Plan Description Form*, which you may obtain by calling 1-800-634-4579. Once you become a member, you will receive your *Membership Agreement*, which can be used to determine the exact terms and conditions of your coverage.

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