

KAISER MEDICAL BENEFITS COMPARISON		
	Low Option HMO	High Option HMO
* Services marked with an asterisk are different than Blue Shields benefit levels.		
Medical Plan		
Annual Deductible	None	None
Lifetime Maximum	None	None
Annual Co-Pay Maximum*	\$1,500 individual, \$3,000 family	\$1,500 individual \$3,000 family
Hospital Care		
Inpatient *	\$500 per admission*	\$100 per admission
Outpatient*	\$20 copay per procedure/visit*	\$15 copay per procedure/visit*
Emergency Room Copay waived if admitted.	\$100 copay, no coverage for non-emergency	\$50 copay, no coverage for non-emergency
Urgent Care	\$20 copay	\$15 copay
Skilled Nursing *	No copay for up to 100 days per benefit period*	No copay for up to 100 days per benefit period
Physician Care		
Office Visits (includes specialists)	\$20 copay	\$15 copay
Hospital Visits (physician services)	No charge	No charge
Periodic Health Evaluation	\$20 copay per visit	\$15 copay per visit
X-Ray & Lab Services	No charge	No charge
Outpatient Rehabilitation Therapy	\$20 copay per visit	\$15 copay per visit
Immunizations*	No copay*	No copay*
Home Health Care Services (Visit limitations where applicable are combined for network and non-network services)*	No copay per home visit when prescribed by a Plan physician (services limited to inside the Service Area); limit of three 2-hour visits per day, 100 visits per year*	No copay per home visit when prescribed by a Plan physician (services limited to inside the Service Area); limit of three 2-hour visits per day, 100 visits per year*
Chiropractic*	Not covered	Not covered*
Prosthetics/Orthotics*	No charge when deemed medically necessary and prescribed by a Plan physician*	No charge when deemed medically necessary and prescribed by a Plan physician*
Durable Medical Equipment (unlimited benefits based on medical necessity)*	No charge per covered item. Must be in accordance with DME formulary guidelines.*	No charge per covered item. Must be in accordance with DME formulary guidelines.*
Acupuncture*	\$20 copay per visit. Covered as alternative to standard treatment as determined by a Plan MD; primarily a component of a multidisciplinary chronic pain management program.*	\$15 copay per visit. Covered as alternative to standard treatment as determined by a Plan MD; primarily a component of a multidisciplinary chronic pain management program.*
Mental Health		
Severe Disorders-Inpatient*	\$500 copay per admission. No day limit.*	\$100 copay per admission. No day limit.
Severe Disorders-Outpatient*	Individual: \$20; Group: \$10 copay per visit. No visit limit.*	Individual: \$15; Group: \$7 copay per visit. No visit limit.*
Non-Severe Disorders-Inpatient*	\$500 copay per admission, up to 30 days per calendar year.*	\$100 copay per admission, up to 30 days per calendar year.
Non-Severe Disorders-Outpatient*	Individual: \$20; Group: \$10 copay per visit, up to 20 visits per calendar year.*	Individual: \$15; Group: \$7 copay per visit, up to 20 visits per calendar year.*
Chem. Dependency Rehab-Outpatient*	Individual: \$20; Group: \$5 copay per visit. No outpatient visit limit.*	Individual: \$15; Group: \$5 copay per visit. No outpatient visit limit.*
Detoxification-Inpatient (Detoxification only)*	\$500 copay per admission; Transitional Residential Recovery Service (TRRS) in a non-medical setting; \$100 copay per admission, up to 60 days per calendar year, but no more than 120 days in any 5 consecutive calendar year period.*	\$100 copay per admission; Transitional Residential Recovery Service (TRRS) in a non-medical setting; \$100 copay per admission, up to 60 days per calendar year, but no more than 120 days in any 5 consecutive calendar year period.*
Prescription Drugs		
Retail: Generic/Brand*	\$10 generic / \$35 brand copay per prescription. No non-formulary coverage. Up to 30- day supply. When medically necessary, prescribed by a Plan physician, and obtained at Plan pharmacies.*	\$10 generic / \$30 brand copay per prescription. No non-formulary coverage. Up to 30- day supply. When medically necessary, prescribed by a Plan physician, and obtained at Plan pharmacies.*
Mail Order: Generic/Brand*	\$20 generic / \$70 brand copay per prescription. Up to 100 day supply. When medically necessary, prescribed by a Plan physician, and obtained through Plan mail order.*	\$20 generic / \$60 brand copay per prescription. Up to 100 day supply. When medically necessary, prescribed by a Plan physician, and obtained through Plan mail order.*
Vision		
Screening (Routine Preventive performed by PCP, excludes refractions)	\$20 copay per exam.	\$15 copay per exam.
Eyewear (Lens, Frame)	Not covered	Not covered

Zip Codes eligible for Kaiser coverage:

93001 93007 93033 93043 93002 93009 93034 93044,
93005 93031 9304193006 93032 93042

93003 93022 93035 93060 93004 93030 93036 93061