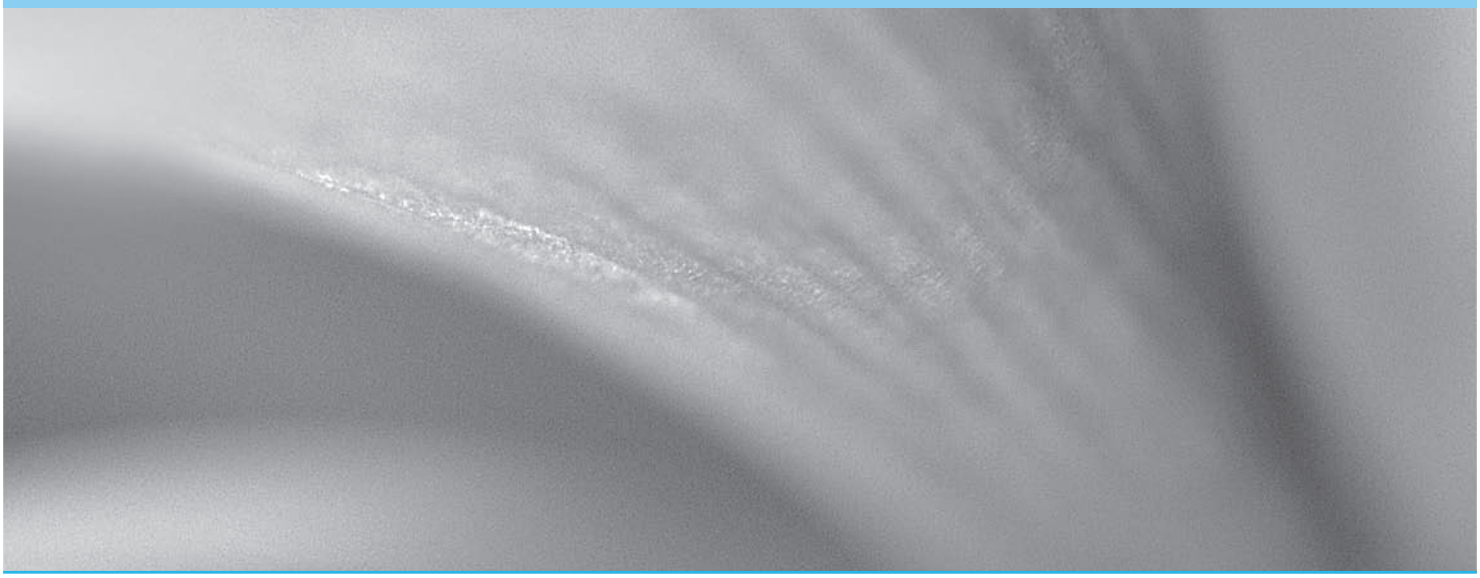
FEATURES AT A GLANCE

Deductible plans • HSA-qualified deductible HMO plans • Copayment plans



QUESTIONS? CALL US. **WE HAVE ANSWERS.**

1-800-678-0470

KAISER PERMANENTE®

FEATURES AT A GLANCE

DEDUCTIBLE PLANS

DEDUCTIBLE PLANS

HSA-QUALIFIED DEDUCTIBLE HMO PLANS

Features	$1,000 Deductible Plan (80%) with Rx	$1,500 Deductible Plan (80%) with Rx	$2,000 Deductible Plan (70%) with Rx	$2,000 Deductible Plan (70%)	$3,000 Deductible Plan (70%) with Rx	$5,000 Deductible Plan (60%) with Rx	$5,000 Deductible Plan (70%)	$2,000 HSA-Qualified Deductible HMO Plan (80%)	$2,000 HSA-Qualified Deductible HMO Plan (100%)	$2,500 HSA-Qualified Deductible HMO Plan (100%)	$3,000 HSA-Qualified Deductible HMO Plan (100%)	$4,000 HSA-Qualified Deductible HMO Plan (100%)	$5,000 HSA-Qualified Deductible HMO Plan (100%)
Annual medical deductible[1]													
Individual/Family	$1,000/$3,000	$1,500/$4,500	$2,000/$6,000	$2,000/$6,000	$3,000/$9,000	$5,000	$5,000/$15,000	$2,000/$4,000	$2,000/$4,000	$2,500/$5,000	$3,000/$6,000	$4,000/$8,000	$5,000/$10,000
Maximums													
Annual out-of-pocket maximum Individual/Family	$4,000/$8,000	$6,000/$12,000	$5,000/$10,000	$5,000/$10,000	$9,000/$18,000	$15,000	$5,000/$10,000	$5,000/$10,000	$2,000/$4,000	$2,500/$5,000	$3,000/$6,000	$4,000/$8,000	$5,000/$10,000
Lifetime maximum paid by the Plan for all care	No lifetime maximum	No lifetime maximum	No lifetime maximum	No lifetime maximum	No lifetime maximum	No lifetime maximum	No lifetime maximum	No lifetime maximum	No lifetime maximum	No lifetime maximum	No lifetime maximum	No lifetime maximum	No lifetime maximum
Benefits (All benefits are subject to the deductible unless otherwise noted.)									(All benefits are subject to the deductible unless otherwise noted.)				
Routine medical office visits													
Primary care visit	$30[2]	$30[2]	$30[2]	$30[2]	$30[2]	$10[2]	$30[2]	20% coinsurance	No charge	No charge	No charge	No charge	No charge
Specialty care visit	$50[2]	$50[2]	$50[2]	$50[2]	$50[2]	$40[2]	$50[2]	20% coinsurance	No charge	No charge	No charge	No charge	No charge
Preventive services[2,3]	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Maternity													
Prenatal/Delivery and inpatient well-baby care	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Prescription drugs													
Pharmacy (up to 30-day supply)	$5 generic (not subject to drug deductible). After $200 drug deductible: $30 brand-name/$50 nonpreferred/ 20% coinsurance for specialty drugs[4]	$5 generic (not subject to drug deductible). After $200 drug deductible: $30 brand-name/$50 nonpreferred/ 20% coinsurance for specialty drugs[4]	After $200 drug deductible: $15 generic/$30 brand-name/ 50% nonpreferred[4]	Not covered	$5 generic (not subject to drug deductible). After $200 drug deductible: $30 brand-name/$50 nonpreferred/ 20% coinsurance for specialty drugs[4]	$5 generic (not subject to drug deductible). After $200 drug deductible: $30 brand-name/$50 nonpreferred/ 20% coinsurance for specialty drugs[4]	Not covered	Not covered	No charge	No charge	No charge	No charge	No charge
Mail-order (up to 90-day supply)	$10 generic (not subject to drug deductible). After $200 drug deductible: $60 brand-name/$100 nonpreferred/ 20% coinsurance for specialty drugs[4]	$10 generic (not subject to drug deductible). After $200 drug deductible: $60 brand-name/$100 nonpreferred/ 20% coinsurance for specialty drugs[4]	After $200 drug deductible: $30 generic/$60 brand-name/ 50% nonpreferred[4]	Not covered	$10 generic (not subject to drug deductible). After $200 drug deductible: $60 brand-name/$100 nonpreferred/ 20% coinsurance for specialty drugs[4]	$10 generic (not subject to drug deductible). After $200 drug deductible: $60 brand-name/$100 nonpreferred/ 20% coinsurance for specialty drugs[4]	Not covered	Not covered	No charge	No charge	No charge	No charge	No charge
Inpatient hospital													
Hospital care	20% coinsurance per admission	20% coinsurance per admission	30% coinsurance per admission	30% coinsurance per admission	30% coinsurance per admission	40% coinsurance per admission	30% coinsurance per admission	20% coinsurance per admission	No charge per admission	No charge per admission	No charge per admission	No charge per admission	No charge per admission
Inpatient professional visits	20% coinsurance	20% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance	40% coinsurance	30% coinsurance	20% coinsurance	No charge	No charge	No charge	No charge	No charge
Outpatient													
Ambulatory surgery	20% coinsurance per admission	20% coinsurance per admission	30% coinsurance per admission	30% coinsurance per admission	30% coinsurance per admission	40% coinsurance per admission	30% coinsurance per admission	20% coinsurance per admission	No charge per admission	No charge per admission	No charge per admission	No charge per admission	No charge per admission
Laboratory and X-ray													
Diagnostic lab	No charge[2]	No charge[2]	No charge[2]	No charge[2]	No charge[2]	No charge[2]	No charge[2]	20% coinsurance	No charge	No charge	No charge	No charge	No charge
Therapeutic and diagnostic X-ray	20% coinsurance	20% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance	Therapeutic $40[2]/Diagnostic no charge[2]	30% coinsurance	20% coinsurance	No charge	No charge	No charge	No charge	No charge
Emergency and urgent care													
Emergency room visits (at a designated Kaiser Permanente emergency room or a non-Plan emergency room)	20% coinsurance	20% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance	$300[2]	30% coinsurance	20% coinsurance	No charge	No charge	No charge	No charge	No charge
Ambulance	20% coinsurance (up to a maximum of $500 per trip)[2]	20% coinsurance (up to a maximum of $500 per trip)[2]	30% coinsurance (up to a maximum of $500 per trip)[2]	30% coinsurance (up to a maximum of $500 per trip)[2]	30% coinsurance (up to a maximum of $500 per trip)[2]	40% coinsurance (up to a maximum of $700 per trip)[2]	30% coinsurance (up to a maximum of $500 per trip)[2]	20% coinsurance	No charge	No charge	No charge	No charge	No charge
Nonroutine care (per visit at a Kaiser Permanente medical office or non-Plan facility outside the service area during office hours)	$30[2]	$30[2]	$30[2]	$30[2]	$30[2]	$10[2]	$30[2]	20% coinsurance	No charge	No charge	No charge	No charge	No charge
After-hours care (per after-hours visit at a designated Kaiser Permanente after-hours medical office)	$75[2]	$75[2]	$75[2]	$75[2]	$75[2]	$75[2]	$75[2]	20% coinsurance	No charge	No charge	No charge	No charge	No charge

All benefits are subject to the annual medical deductible unless otherwise noted. Preventive services are not subject to annual medical deductible. Prescription drugs are not subject to the annual medical deductible but may be subject to an annual drug deductible.

Deductible plans:
[1]The deductible does not apply toward the out-of-pocket maximum.
[2]Not subject to medical deductible
[3]Preventive services include adult preventive care exams, adult preventive care screenings, well-woman care, immunizations, and well-child care.
[4]Drug deductible does not apply to the medical deductible or out-of-pocket maximum. The 20 percent coinsurance for specialty drugs includes self-injectables up to a maximum of $250 per drug dispensed and applies to all deductible plans with Rx except the $2,000 Deductible Plan (70%) with Rx.

Important note: This is only a summary. For more detailed information, refer to the *Health 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.

All benefits are subject to the annual medical deductible unless otherwise noted. Preventive services are not subject to annual medical deductible.

HSA-qualified deductible HMO plans only:
[1]The deductible applies toward the out-of-pocket maximum.
[2]Not subject to medical deductible
[3]Preventive services include adult preventive care exams, adult preventive care screenings, well-woman care, immunizations, and well-child care.

Features	$30 Copayment Plan	$35 Copayment Plan with Rx	$40 Copayment Plan with Rx
Annual deductible			
Individual/Family	None	None	None
Maximums			
Annual out-of-pocket maximum Individual/Family	$3,000/$7,500	$3,000/$7,500	$3,000/$7,500
Lifetime maximum paid by the Plan for all care	No lifetime maximum	No lifetime maximum	No lifetime maximum
Benefits			
Routine medical office visits			
Primary care visit	$30	$35	$40
Specialty care visit	$40	$50	$60
Preventive services[1]	No charge	No charge	No charge
Maternity			
Prenatal/Delivery and inpatient well-baby care	Not covered	Not covered	Not covered
Prescription drugs[2]			
Pharmacy (up to 30-day supply)	Not covered	$5 generic (not subject to drug deductible). After $200 drug deductible: $30 brand-name/$50 nonpreferred/ 20% coinsurance for specialty drugs[2]	$5 generic (not subject to drug deductible). After $200 drug deductible: $30 brand-name/$50 nonpreferred/ 20% coinsurance for specialty drugs[2]
Mail-order (up to 90-day supply)	Not covered	$10 generic (not subject to drug deductible). After $200 drug deductible: $60 brand-name/$100 nonpreferred/ 20% coinsurance for specialty drugs[2]	$10 generic (not subject to drug deductible). After $200 drug deductible: $60 brand-name/$100 nonpreferred/ 20% coinsurance for specialty drugs[2]
Inpatient hospital			
Hospital care	20% coinsurance per admission	30% coinsurance per admission	30% coinsurance per admission
Inpatient professional visits	20% coinsurance	30% coinsurance	30% coinsurance
Outpatient			
Ambulatory surgery	$150	$200	$200
Laboratory and X-ray			
Diagnostic lab and X-ray	No charge	No charge	No charge
Therapeutic X-ray	$40	$50	$60
Emergency and urgent care			
Emergency room visits (at a designated Kaiser Permanente emergency room or a non-Plan emergency room)[3]	$150	$200	$200
Ambulance	20% coinsurance (up to a maximum of $500 per trip)	30% coinsurance (up to a maximum of $700 per trip)	30% coinsurance (up to a maximum of $700 per trip)
Nonroutine care (per visit at a Kaiser Permanente medical office or non-Plan facility outside the service area during office hours)	$30	$35	$40
After-hours care (per after-hours visit at a designated Kaiser Permanente after-hours medical office)	$75	$100	$100

Copayment plans:
[1]Preventive services include adult preventive care exams, adult preventive care screenings, well-woman care, immunizations, and well-child care.
[2]Drug deductible does not apply to generic drugs. The 20 percent coinsurance for specialty drugs includes self-injectables up to a maximum of $250 per drug dispensed.
[3]Waived if admitted as an inpatient

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