2009 KAISER PERMANENTE PLAN OVERVIEW

FEATURES	PLAN 20	PLAN 25	PLAN 500/1000	PLAN 1000/2000	PLAN 1500/3000	PLAN 2500/5000	PLAN 5000/10000
Annual deductible Individual/Family	None	None	$500/$1,000	$1,000/$2,000	$1,500/$3,000	$2,500/$5,000	$5,000/$10,000
Primary care office visits **Specialty care office visits**	$20 $45	$25 $45	$15 $25	$25 $35	$25 $35	No charge after deductible	No charge after deductible
Prenatal office visits	No charge	No charge	No charge	No charge	No charge	No charge after deductible	No charge after deductible
Preventive exams	$20 primary $45 specialty	$25 primary $45 specialty	No charge	No charge	No charge	$15	$15
Laboratory and diagnostic tests, X-rays	No charge	No charge	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	No charge after deductible	No charge after deductible
Covered formulary drugs	$20 generic $40 brand	$25 generic $45 brand (after $200 drug deductible)	$15 generic $45 brand	$15 generic $45 brand	$15 generic $45 brand	No charge after deductible	No charge after deductible
Outpatient surgery	$100 per visit	$250 per visit	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	No charge after deductible	No charge after deductible
Hospital inpatient care	$500 per admission	$750 per admission	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	No charge after deductible	No charge after deductible
Ambulance service	$125 per trip	$125 per trip	$125 per trip after deductible	$125 per trip after deductible	$125 per trip after deductible	No charge after deductible	No charge after deductible
Emergency services (copay waived if admitted)	$125 per visit	$125 per visit	$125 per visit	$125 per visit	$125 per visit	No charge after deductible	No charge after deductible
Urgent care services (at Kaiser Permanente or contracted facilities)	$45 per visit	$45 per visit	$45 per visit	$45 per visit	$45 per visit	No charge after deductible	No charge after deductible
Vision services (provided by Spectera® Inc., at United Optical stores)	Covered	Covered	Covered	Covered	Covered	Not covered	Not covered
Preventive dental care (by Delta Dental of Ohio)	Covered	Covered	Covered	Covered	Covered	Covered	Covered

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HAVE A QUESTION? **CALL THE INDIVIDUAL & FAMILY PLANS SALES CENTER** 1-877-252-1849

This overview of benefits contains highlights only. This is not a contract. Specific benefits, exclusions, and limitations are contained in the *Evidence of Coverage* which you will receive upon acceptance. Charges not subject to deductible unless otherwise indicated.

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KAISER PERMANENTE®