PLAN FINDER

I WANT TO BE ABLE TO VISIT MY DOCTOR REGULARLY, so a plan with **no deductible** and **fixed copayments** for office visits is best for me. I'm willing to pay a **higher** monthly rate for a plan that offers broad coverage and predictable out-of-pocket costs.

DEFINITIONS

Coinsurance
In a deductible plan, this is a percentage of charges you must pay when you receive a prescription or covered service.

Copayment
This is a fixed dollar amount you pay for certain supplies and services.

Deductible
In plans with a medical and/or pharmacy deductible, this is the set amount you must pay in a calendar year for certain services or supplies before Kaiser Permanente begins to cover them at the copayment or coinsurance amount.

Generic and brand
Generic medications are less expensive but chemically identical copies of their *brand-name* equivalents.

HSA (health savings account)
This is a savings account intended to be used for health care expenses. HSAs have certain tax advantages as well as certain restrictions. Kaiser Permanente does not offer HSAs—they must be set up separately through a financial institution.

Out-of-pocket maximum
This is the most you would have to pay for certain covered health care services in a calendar year.

Preventive care
Preventive care services include well-child visits from 0 to 23 months, scheduled prenatal care, and vaccines (immunizations).

See "Understanding Health Care Terms," page 8, for more detailed information.

COPAYMENT PLANS

Moderate monthly rate Predictable out-of-pocket costs	Higher monthly rate Predictable out-of-pocket costs
$50 Copayment Plan	**$25 Copayment Plan**
• Annual out-of-pocket maximum: $3,500/individual or $7,000/family	• Annual out-of-pocket maximum: $2,500/individual or $5,000/family
• No medical deductible	• No medical deductible
• Office visit: $50 per visit	• Office visit: $25 per visit
• Most lab and X-rays: $10 per encounter	• Most lab and X-rays: $10 per encounter
• Hospital care: $500 per day	• Hospital care: $200 per day
• Emergency services: $150 per visit	• Emergency services: $100 per visit
• Prescription drugs: – Most prescription drugs not covered	• Prescription drugs: – $10 generic – $35 brand

COPAYMENT PLANS – FEATURES AT A GLANCE

This is a summary of the most frequently asked-about benefits and their copayments and coinsurance. For more information on benefits, copayments, and coinsurance, please refer to the *Disclosure Form* enclosed with this booklet. Detailed information about your plan is included in the *Membership Agreement*, which will be mailed to you upon acceptance.

FEATURES	$50 COPAYMENT PLAN	$25 COPAYMENT PLAN
Medical calendar-year deductible		
Individual	None	None
Family	None	None
Annual out-of-pocket maximum		
Individual	$3,500	$2,500
Family	$7,000	$5,000
Lifetime benefit maximum	None	None
PROFESSIONAL SERVICES (PLAN PROVIDER OFFICE VISITS)		
Primary and specialty care visits (includes routine and urgent care appointments)	$50 per visit	$25 per visit
Well-child visits from 0 to 23 months	$15 per visit	No charge
Family planning visits	$50 per visit	$25 per visit
Scheduled prenatal care and first postpartum visit	$15 per visit	No charge
Eye exams	$50 per visit	$25 per visit
Hearing tests	$50 per visit	$25 per visit
Physical, occupational, and speech therapy visits	$50 per visit	$25 per visit
OUTPATIENT SERVICES		
Outpatient surgery	$250 per procedure	$100 per procedure
Allergy injection visits	$5 per visit	$5 per visit
Vaccines (immunizations)	No charge	No charge
Most X-rays and lab tests	$10 per encounter	$10 per encounter
Health education		
Individual visits	$50 per visit	$25 per visit
Group visits	No charge	No charge
HOSPITALIZATION SERVICES		
Room and board, surgery, anesthesia, X-rays, lab tests, and medications	$500 per day	$200 per day
EMERGENCY HEALTH COVERAGE		
Emergency Department visits	$150 per visit (waived if admitted directly to the hospital)	$100 per visit (waived if admitted directly to the hospital)
AMBULANCE SERVICES		
Emergency ambulance services	$300 per trip	$100 per trip

COPAYMENT PLANS – FEATURES AT A GLANCE

FEATURES	$50 COPAYMENT PLAN	$25 COPAYMENT PLAN
PRESCRIPTION DRUG COVERAGE		
Covered items in accord with our drug formulary when obtained at Plan pharmacies	Most prescription drugs are not covered.	
Generic drugs		$10 up to a 30-day supply
Brand-name drugs		$35 up to a 30-day supply
Mail-order program		$20 generic/$70 brand for 100-day supply of most maintenance drugs
DURABLE MEDICAL EQUIPMENT (DME)		
DME used in the home in accord with our DME formulary	Not covered	Not covered
Prosthetic and orthotic devices	No charge	No charge
MENTAL HEALTH SERVICES		
Inpatient psychiatric care	$500 per day (up to 30 days per calendar year)	$200 per day (up to 30 days per calendar year)
Outpatient visits		
Individual visits	$50 per visit (up to 20 individual/group visits per calendar year)	$25 per visit (up to 20 individual/group visits per calendar year)
Group therapy visits	$25 per visit (up to 20 individual/group visits per calendar year)	$12 per visit (up to 20 individual/group visits per calendar year)
	Up to 20 additional group therapy visits that meet Medical Group criteria in the same calendar year	Up to 20 additional group therapy visits that meet Medical Group criteria in the same calendar year
Note: Visit and day limits do not apply to severe mental illness and serious emotional disturbances of children as described in the "Benefits and Cost Sharing" section of the *Membership Agreement*.		
CHEMICAL DEPENDENCY SERVICES		
Inpatient detoxification	$500 per day	$200 per day
Outpatient individual therapy visits	$50 per visit	$25 per visit
Outpatient group therapy visits	$5 per visit	$5 per visit
Transitional residential recovery services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission	$100 per admission
HOME HEALTH SERVICES		
Home health care (up to 100 two-hour visits per calendar year)	No charge	No charge
OTHER		
Skilled nursing facility care	No charge (up to 100 days per benefit period)	No charge (up to 100 days per benefit period)
Hospice care	No charge	No charge