KAISER PERMANENTE®

Added*Choice*® POS BENEFITS AND SERVICES

	Tier 1 Provider Network MEMBER PAYS	Tier 2† Provider Network MEMBER PAYS	Tier 3† Provider Network MEMBER PAYS
Prosper PC 70% 1500 Low RX effective 1/1/2010			
Deductible (Calendar Year, Single/Family) • Tiers 1 and 2 cross accumulate	$1,000/$2,000[3]	$1,500/$3,000[3]	$2,000/$4,000[3]
Coinsurance	None	30%	50%
Out-of-Pocket Maximum (Calendar Year, Single/Family) • Tiers 1 and 2 cross accumulate	$1,000/$2,000	$2,000/$4,000	$5,000/$10,000
Lifetime Maximum	None	$2,000,000[1]	$2,000,000[1]
OUTPATIENT CARE			
Office Visits—Primary Care Physician	$15 copay	$25 copay[3]	50% after deductible
Office Visits—Specialist	$35 copay	$50 copay[3]	50% after deductible
• Vision exams through affiliated providers are covered under Tier 1 copayment	$35 copay[3]	Covered under Tier 1	Covered under Tier 1
Outpatient Surgery	No Charge after deductible	30% after deductible	50% after deductible
Urgent Care Office Visits	$45 copay	30% after deductible	50% after deductible
• Laboratory and diagnostic testing, X-rays	No Charge after deductible	30% after deductible	50% after deductible
Physical, Speech and Occupational Therapy	No Charge after deductible[3] Limited to 20 visits per therapy per calendar year	30% after deductible Limited to 20 visits per therapy per calendar year[1]	50% after deductible Limited to 20 visits per therapy per calendar year[1]
PREVENTIVE SERVICES			
Preventive Adult Physical primary care exam	No Charge	$25 copay[3] Limited to 1 routine visit per calendar year[1]	50% after deductible Limited to 1 routine visit per calendar year[1]
Preventive Well Child Care primary care exam	No Charge	$25 copay[3] Limited to $500 per calendar year[1]	50% after deductible Limited to $500 per calendar year[1]
Preventive Mammogram and PAP screening	No Charge	30% after deductible	50% after deductible
Preventive Lab and X-ray screenings	No Charge	30% after deductible	50% after deductible
LABORATORY AND RADIOLOGICAL SERVICES			
• Laboratory and diagnostic testing, X-rays	No Charge after deductible	30% after deductible	50% after deductible
• Allergy treatment	$5 copay	30% after deductible Limited to $1,000 per calendar year[1]	50% after deductible Limited to $1,000 per calendar year[1]
HOSPITAL INPATIENT CARE			
Inpatient Services	No Charge after deductible	30% after deductible	50% after deductible
EMERGENCY SERVICES (Fee waived if admitted)			
Emergent use of an Emergency Room[2]	$150 copay	Emergencies treated at providers in this Tier are covered at the Tier 1 benefit level	Emergencies treated at providers in this Tier are covered at the Tier 1 benefit level
Non-emergent use of an Emergency Room	See Tiers 2 and 3	$150[3] per visit then 30% after deductible	$150[3] per visit then 50% after deductible
AMBULANCE SERVICES			
• Only when required by medical condition and transportation in any other vehicle would endanger your health	$50 copay	30% after deductible $1,000 per calendar year[1]	50% after deductible $1,000 per calendar year[1]
BIOLOGICALLY BASED MENTAL ILLNESSES			
Inpatient Services (does not include residential services)	No Charge after deductible	30% after deductible	50% after deductible
Outpatient Services	$35 copay	$50 copay	50% after deductible
MENTAL HEALTH			
Inpatient Services (does not include residential services)	No Charge after deductible	30% after deductible	50% after deductible
Outpatient Services	$35 copay	$50 copay	50% after deductible

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CHEMICAL DEPENDENCY & ALCOHOL RELATED SERVICES			
Inpatient-Specialized Hospital (does not include residential services)	No Charge after deductible	30% after deductible	50% after deductible
Outpatient	$35 copay	$50 copay	50% after deductible
TRANSPLANTS			
Inpatient-including follow-up care	No Charge after deductible	Covered under Tier 1	Covered under Tier 1
Outpatient-including follow-up care	$35 copay	Covered under Tier 1	Covered under Tier 1
ALTERNATE CARE			
Home Health Services	No Charge after deductible	30% after deductible	50%[3] after deductible
Hospice Home Care/Respite Care	No Charge after deductible	30% after deductible	50%[3] after deductible
Skilled Nursing Facility	No Charge after deductible 100 day maximum	30% after deductible Limited to $1,000[1]	50%[3] after deductible Limited to $1,000[1]
DURABLE MEDICAL EQUIPMENT (DME), EXTERNAL PROSTHETICS AND ORTHOTICS			
• durable medical equipment and devices	20%	30% after deductible Limited to $2,000[1]	50% after deductible Limited to $2,000[1]
CHIROPRACTIC SERVICES			
Chiropractic services covered at Tier 1 when provided by American Specialty Health providers	$25 copay[3] Limited to 20 visits per calendar year	30% after deductible Limited to 20 visits per calendar year[1]	50% after deductible Limited to 20 visits per calendar year[1]
EXTENDED DEPENDENT COVERAGE • Dependents are covered up to age 23 at the end of the month • Full-Time Students are covered up to age 23 at the end of the month			
PRESCRIPTION DRUGS **Pharmacies** Whether your physician is in Tier 1, 2, or 3, we encourage you to have your prescription filled at a Tier 1 KP or Affiliated Pharmacy if the drug is listed on the Kaiser Permanente preferred drug list. This will allow you to take advantage of the most cost effective price.	**KP and Affiliated Pharmacies** Pharmacies located in one of the 10 Kaiser Permanente medical facilities in Northeast Ohio; and dozens of independent pharmacies that contract with Kaiser. For a current list of all pharmacies, refer to the provider directory included with enrollment materials, or visit kp.org.	**Participating** This network includes nearly 60,000 pharmacies* nationwide including large drugstore chains and independently owned pharmacies such as Costco, Drug Mart, Giant Eagle, Kmart, Marc's, Rite Aid, Target, Wal-Mart, Walgreens and more. *Kaiser Permanente contracts with the MedImpact Medcare Pharmacy Network	**Non Participating** Any Pharmacy that is not in tier 1 or Tier 2 is considered Tier 3 (out-of-network) Whether your drug is listed on the preferred drug list or not, you will be charged the actual cost of the medication.
Formulary Prescription medications included on the Kaiser Permanente preferred drug list	$15 generic/$40 brand	See Nonformulary	Not Covered
Nonformulary Prescription Medications not included on the Kaiser Permanente preferred drug list.	$30 generic/$60 brand	$30 generic/$60 brand	Not Covered
Mail order is handled through the Kaiser Permanente Direct Mail service only.			
62-day supply formulary medication	1x formulary copay	Not Covered	Not Covered
90-day supply nonformulary medication	2x nonformulary copay	Not Covered	Not Covered

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	Tier 1 Provider Network	Tier 2† Provider Network	Tier 3† Provider Network
	MEMBER PAYS	MEMBER PAYS	MEMBER PAYS

† Payments are based upon the Maximum Allowable Charge (MAC) for covered services. Maximum Allowable Charge is the lesser of the Negotiated Rate, the Usual, Customary and Reasonable Charge or the Actual Billed Charge. The Member is responsible for any charges that exceed MAC for out-of-network services.

[1]Combined Tier 2 and Tier 3 maximum benefit.

[2]Services for emergencies are covered at any emergency room at the Tier 1 benefit level. Emergency medical services that do not meet Tier 1 definition are eligible for coverage at the appropriate Tier 2 or Tier 3 coinsurance level of benefits provided through Kaiser Permanente Insurance Company (KPIC). Emergency Room surcharge fees are not covered by KPIC.

[3]Amount is not subject to, nor does it contribute toward satisfaction of the Out-of-Pocket Maximum for specified Tier.

GENERAL EXCLUSIONS

This summary of benefits contains highlights only. This is not a contract. Specific benefits, exclusions and limitations are contained in the Group Agreement we have with your employer and the *Evidence of Coverage* (EOC) and *Certificate of Insurance* (COI) you will receive when you become a member. For specific questions about coverage, existing Members may call our Customer Relations Department at (216) 621-7100 or toll-free at 1-800-686-7100. New Members may call a Kaiser Permanente Representative at (216) 479-5770 or toll-free at 1-800-400-1907. Our TTY line is (216) 635-4444 for the hearing impaired.

Plan Deductibles do not contribute to the satisfaction of the Tier 1, Tier 2, and Tier 3 Out-of-Pocket Maximums, unless otherwise noted. Copayments and per visit deductibles are not subject to, nor do they contribute toward satisfaction of the Tier 2 and 3 Deductibles or Out-of-Pocket Maximums. Plan Deductibles do not cross accumulate across Tiers 1, 2, or 3, unless otherwise stated.

Group Exclusions and Limitations within Tier 1: Services not medically necessary; services and supplies not approved by an Ohio Permanente Medical Group physician or an affiliated physician; services that are the financial responsibility of an employer or services that a government agency is required by law to provide; services provided under any Workers' Compensation or employer's liability law; certain physical examinations, cardiac rehabilitation, custodial or intermediate care, long-term rehabilitative services, including physical, speech and occupational therapy; artificial conception: services other than artificial insemination, for conception by artificial means, including but not limited to in vitro fertilization, ovum transplants, gamete intrafallopian transfer, zygote intrafallopian transfer; services related to the procurement and storage of donor semen and storage; services related to sexual reassignment; services to reverse voluntary, surgically induced infertility; experimental and investigational procedures, non-human and artificial organs and their implantation; specialized behavioral modification programs for chronic conditions; alternative medical services including acupuncture, naturopathy, and massage therapy; hypnotherapy and hypnotic anesthesia; cosmetic surgery and services.

Group Exclusions and Limitations within Tier 2 and Tier 3: Hearing and vision exams, treatment for involuntary infertility, emergency services as defined by Kaiser Permanente Tier 1, transplants and transplant related services, durable medical equipment, prosthetic devices and orthotic appliances. Certain services may be subject to precertification. Kaiser Permanente Insurance Company, (KPIC), will make no payment for treatment, confinement or supplies to the extent such treatment services or supplies were provided arranged, paid for or payable by Kaiser Foundation Health Plan of Ohio.

Basic Coverage Information: Any person may cancel coverage within 72 hours after having signed the agreement or offer to enroll in the plan. Cancellation occurs when written notice of cancellation is given to Kaiser Permanente or its agents or representatives. The notice of cancellation shall be considered given when the prospective subscriber mails a letter to Kaiser Permanente.

Added Choice® is jointly underwritten by Kaiser Foundation Health Plan of Ohio and Kaiser Permanente Insurance Company (KPIC). This benefit chart is a summary only. Details on benefit coverage are contained in the *Evidence of Coverage* (EOC) and *Certificate of Insurance* (COI) you will receive when you become a member. The EOC and COI are the binding documents between Health Plan and its Members. In the case of a conflict between this benefit chart and the EOC or COI, the EOC and COI will prevail. Precertification is required for some services provided by Preferred Provider Organization and Out-of-Network providers. Details are contained in the COI. For specific questions about coverage, Existing Members should call our Customer Relations Department at (216) 621-7100 or toll-free at 1-800-686-7100. New Members should call a Kaiser Permanente Representative at (216) 479-5770 or toll-free 1-800-400-1907. Our TTY line is (216) 635-4444 for the hearing impaired.