

HMO PLANS

BENEFITS SUMMARIES

KAISER PERMANENTE CHOICE SOLUTION

A CHOICE Administrators® Program

MEDICAL BENEFITS	HMO 10	HMO 30	HMO 20/\$1000
	Member pays	Member pays	Member pays
Deductible: Individual / Family	No deductible	No deductible	\$1,000 / \$2,000 (applies to out of pocket max.) ⁽¹⁾
Annual Out-of-Pocket Maximum Individual / Family ⁽¹⁾	\$1,500 / \$3,000	\$3,000 / \$6,000	\$3,500 / \$7,000
OFFICE VISITS	\$10 copay	\$30 copay	\$20 copay ⁽⁶⁾
LAB AND X-RAY	\$10 copay per encounter ⁽⁴⁾	\$10 copay per encounter ⁽⁴⁾	\$10 copay after deductible ⁽³⁾
HOSPITAL CARE	\$200 copay per day	\$400 copay per day	20% after deductible
Emergency Room	\$50 copay per visit (waived if admitted to hospital)	\$100 copay per visit (waived if admitted to hospital)	20% after deductible
Rx BENEFITS (Pharmacy and Mail Order)⁽²⁾			
Prescription – Generic	\$10 copay	\$10 copay	\$10 copay
Prescription – Brand Name	\$20 copay	\$30 copay after \$100 brand prescription deductible	\$30 copay
ADDITIONAL BENEFITS			
Maternity (Prenatal Care)	No Charge	No Charge	No Charge
Outpatient Surgery	\$100 copay per procedure	\$250 copay per procedure	20% after deductible
Home Health Care (max. 100 two-hour visits per calendar year)	No Charge (max. 3 visits in one day)	No Charge (max. 3 visits in one day)	No Charge ⁽⁶⁾ (max. 3 visits in one day)
Skilled Nursing Facility (up to 100 days per benefit period)	\$200 copay per admission	\$400 copay per admission	20% after deductible
Ambulance Services	\$50 copay per trip	\$100 copay per trip	\$150 copay per trip after deductible
Mental Health Services In the Medical Office	\$10 copay (individual visit) \$5 copay (group visit)	\$30 copay (individual visit) \$15 copay (group visit)	\$20 copay (individual visit) ⁽⁶⁾ \$10 copay (group visit) ⁽⁶⁾
In the Hospital	\$200 copay per day	\$400 copay per day	20% after deductible
Chemical Dependency Services In the Medical Office	\$10 copay (individual visit) \$5 copay (group visit)	\$30 copay (individual visit) \$5 copay (group visit)	\$20 copay (individual visit) ⁽⁶⁾ \$5 copay (group visit) ⁽⁶⁾
In the Hospital (detoxification only)	\$200 copay per day	\$400 copay per day	20% after deductible

¹ The Annual Out-of-Pocket Maximum is the limit to the total amount that an individual or family must pay for certain Services in a Calendar Year (as discussed in the Evidence of Coverage). There are some benefits that do not apply toward the deductible. Amounts you pay for covered services subject to the deductible, and some other services as described under "Deductibles" in the Evidence of Coverage, apply toward the annual out-of-pocket maximum.

² Prescription drugs covered in accord with the Kaiser Permanente formulary when prescribed by a Plan Physician and obtained at Plan Pharmacies. A few drugs have different Copay; please refer to the Evidence of Coverage for detailed information about prescription drug Copay.

³ \$10 Copay per encounter (except that MRI, CT, and PET are \$50 Copay per procedure) after Deductible.

⁴ \$10 copay per encounter (except that MRI, CT, and PET are \$50 per procedure).

⁵ The deductible does not apply to the following plan provider office visits: Physician office visits, Adult preventive screening, Well-Child preventive care visits, Family planning visits, Scheduled prenatal care and first postpartum visit, Eye exams, Hearing tests, Allergy testing, Health education, Home Health Care, Mental Health.

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KP5234A.8.10



PPO PLAN

BENEFITS SUMMARY

KAISER PERMANENTE CHOICE SOLUTION A CHOICE Administrators® Program

PPO 30 / \$500

MEDICAL BENEFITS	Participating Network Providers Member pays	Non-Participating Network Providers Member pays
Deductible: Individual / Family	\$500/\$1,500 ⁽¹⁾	\$750/\$2,250 ⁽¹⁾
OFFICE VISITS	\$30 copay ⁽⁵⁾⁽⁹⁾	50% after deductible
LAB AND X-RAY	20% after deductible ⁽⁵⁾⁽⁹⁾	50% after deductible
HOSPITAL CARE	20% after \$250 deductible per admission ⁽⁴⁾	50% after \$500 deductible per admission ⁽⁴⁾
Emergency Room	20% after deductible	20% after deductible
RX BENEFITS		
Prescription – Generic	\$15 copay ⁽⁵⁾⁽⁷⁾ (if obtained at participating pharmacies)	Not covered (if obtained at non-participating pharmacies)
Prescription – Brand	\$40 copay ⁽⁵⁾⁽⁷⁾ after \$250 deductible (if obtained at participating pharmacies)	Not covered (if obtained at non-participating pharmacies)
Prescription – Most Non- Formulary	\$60 copay ⁽⁵⁾⁽⁷⁾ after \$250 deductible (if obtained at participating pharmacies)	Not covered (if obtained at non-participating pharmacies)
Prescription – Mail Order	2x the corresponding single copay per prescription, up to 100 day supply	Not covered (if obtained at non-participating pharmacies)
ADDITIONAL BENEFITS		
Maternity (Prenatal Care)	20% after deductible	50% after deductible
Chiropractic	\$15 copay 20 combined visits \$50 allowance for chiro appliance annually	N/A
Annual Out-of-Pocket Maximum: Individual / Family	\$2,000 / \$6,000 ⁽²⁾	\$6,000 / \$18,000 ⁽²⁾
Maximum Benefit while insured	Unlimited	\$5,000,000 ⁽³⁾
Outpatient Surgery	20% after deductible	50% after deductible
Home Health Care (up to 100 combined 2-hour visits per calendar year)	20% ⁽¹⁰⁾ after deductible	20% ⁽¹⁰⁾ after deductible
Skilled Nursing Facility Care (up to 100 days per benefit period)	20% after \$250 deductible per admission ⁽⁴⁾ combined maximum 60 visits per calendar year	50% after \$500 deductible per admission ⁽⁴⁾ combined maximum 60 visits per calendar year
Ambulance Services	40% ⁽⁶⁾ after deductible	40% ⁽⁶⁾ after deductible
Mental Health Services		
In the Medical Office – Severe mental illness ⁽⁸⁾	\$30 copay ⁽⁵⁾⁽⁹⁾	50% after deductible
In the Hospital – Severe mental illness ⁽⁸⁾	20% after \$250 deductible per admission ⁽⁴⁾	50% after \$500 deductible per admission ⁽⁴⁾
In the Medical Office – All other covered mental illness	\$30 copay ⁽⁵⁾⁽⁹⁾	50% after deductible
In the Hospital – All other covered mental illness	20% after \$250 deductible per admission ⁽⁴⁾	50% after \$500 deductible per admission ⁽⁴⁾
Chemical Dependency Services		
In the Medical Office	\$30 copay ⁽⁵⁾⁽⁹⁾	50% after deductible
In the Hospital (detoxification only)	20% after \$250 deductible per admission ⁽⁴⁾	50% after \$500 deductible per admission ⁽⁴⁾

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This chart only describes a summary of benefits. For a complete understanding of benefits, please read this summary in conjunction with the Kaiser Permanente Insurance Company Certificate of Insurance, which contains a complete explanation of benefits, exclusions, and limitations. The information provided in this chart is not intended for use as a Summary Plan Description, nor is it designed to serve as the Certificate of Insurance.

The PPO Insurance Plan is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, Inc.

Footnotes

- ⁽¹⁾ Covered Charges applied to satisfy Deductibles at the Participating Provider level will not be applied towards satisfaction of Deductibles at the Non-Participating Provider level. Likewise, Covered Charges applied to satisfy Deductibles at the Non-Participating Provider level will not be applied towards satisfaction of the Deductibles at the Participating Provider Level.
- ⁽²⁾ Covered Charges incurred toward satisfaction of the Out-of-Pocket Maximum at the Non-Participating Providers tier will accumulate toward satisfaction of the Out-of-Pocket Maximum at the Participating Providers tier. Covered Charges incurred toward satisfaction of the Out-of-Pocket Maximum at the Participating Providers tier will not accumulate toward satisfaction of the Out-of-Pocket Maximum at the Non-Participating Providers tier.
- ⁽³⁾ Maximum benefit while insured for services provided by Non-Participating Providers.
- ⁽⁴⁾ Per admission inpatient deductibles do not contribute toward the Calendar Year Deductible or the Out-of-Pocket Maximum.
- ⁽⁵⁾ Exempt from deductibles.
- ⁽⁶⁾ The Participating Provider Network does not contract for ambulance coverage. Therefore, medically necessary non-emergency ambulance service is payable at the Non-Participating Providers level. Non-emergency ambulance coverage is limited to a maximum of \$2,000 per calendar year for all KPIC-covered services.
- ⁽⁷⁾ MedCare Pharmacy copays are not subject to, nor do they contribute toward satisfaction of, the Calendar Year Deductible or the Out-of-Pocket Maximum. Select prescription drugs are excluded from this coverage.
- ⁽⁸⁾ Severe Mental Illness is limited to the following: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.
- ⁽⁹⁾ Deductibles, including the Calendar Year Deductible, Coinsurance and Copayments do not apply to Preventive Benefits required under the Patient Protection Affordable Care Act (PPACA) provided by PHCS Providers.
- ⁽¹⁰⁾ Combined maximum deductibles of \$50 per calendar year.

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Participating Providers and Non-Participating Providers exclusions and limitations

Unless specifically covered under the Group Policy, expenses incurred in connection with the following services are excluded: Charges, services, or care that are provided or reimbursed by Kaiser Foundation Health Plan, Inc. (KFHP); not medically necessary; in excess of the Maximum Allowable Charge; not available in the United States; for personal comfort; not completed in accordance with the Physician's orders. Emergency Department facility fees or charges for nonemergency weekend (Friday through Sunday) hospital admissions. Charges arising from work or that can be covered under workers' compensation or any similar law, or for which the Group Policyholder or Member is required by law to maintain alternative insurance or coverage. Charges for military service related conditions or where care is provided at government expense. Services or care provided in a Member's home, by a family member, or by a resident of the household. Dental care and dental X-rays, appliances, or orthodontia, including surgery on the jawbone, unless due to injury to natural teeth. Cosmetic services; plastic surgery; sex transformation; sexual dysfunction; surrogacy arrangements; biotechnology drugs or diagnostics; nonprescription drugs or medicines; treatment, procedures, or drugs Kaiser Permanente Insurance Company (KPIC) determines to be experimental or investigational. Education, counseling, therapy, or care for learning deficiencies or behavioral problems. Services, care, or treatment of or in connection with obesity or weight management. Services, care, or treatment of or in connection with craniomandibular or temporomandibular joint disorders, unless for medically necessary surgical treatment of the disorder. Services, care, or treatment of or in connection with musculoskeletal therapy; health education; biofeedback; hypnotherapy; immunizations; medical social services; hearing exams, aids, or therapy; radial keratotomy or similar procedures; reversal of sterilization; or routine foot care. Services or care required by a court of law or for insurance, travel, employment, school, camp, government licensing, or similar purposes. Transplants, including donor costs. Custodial care; care in an intermediate care facility; maintenance therapy for rehabilitation; or living or transportation expenses. Services or supplies necessary to treat an injury to which a contributing cause was a Member's: commission of or attempt to commit a felony; engagement in an illegal occupation; intoxication or being under the influence of a narcotic, unless administered by a Physician. Services of a private-duty nurse. Vision care, including routine exams, eye refractions, orthoptics, glasses, contact lenses, or fittings. Drugs and medicines for the purpose of smoking cessation. Services for which no charge is normally made in the absence of insurance.

Pending Regulatory Approval

POS PLAN

BENEFITS SUMMARIES

KAISER PERMANENTE CHOICE SOLUTION A CHOICE Administrators® Program

POS 20 / \$1,000

MEDICAL BENEFITS	HMO	PHCS Providers (PPO)	Non-Participating Providers (out-of-network)
	Member pays	Member pays	Member pays
Deductible: Individual / Family	No deductible	\$1,000 / \$3,000 ⁽¹⁾	\$1,000 / \$3,000 ⁽¹⁾
OFFICE VISITS	\$20 copay	\$30 copay	40% ⁽¹⁰⁾ after deductible
LAB AND X-RAY	No Charge	20% after deductible	40% ⁽¹⁰⁾ after deductible
HOSPITAL CARE	\$250 copay per admission	20% after \$250 deductible per admission ⁽⁴⁾	40% (Max per day \$1,000)
Emergency Room	\$100 copay ⁽⁵⁾ per visit (waived if admitted to hospital)	\$100 copay ⁽¹¹⁾ per visit, regardless of facility / hospital accessed	\$100 copay ⁽¹¹⁾ per visit, regardless of facility / hospital accessed
Rx BENEFIT⁽⁸⁾ (9)			
Prescription – Generic	\$10 copay	\$20 copay (if obtained at participating pharmacies) ⁽⁶⁾⁽⁷⁾	Not covered (if obtained at non-participating pharmacies)
Prescription – Brand	\$30 copay	\$40 copay after \$250 Brand deductible (if obtained at participating pharmacies) ⁽⁶⁾⁽⁷⁾	Not covered (if obtained at non-participating pharmacies)
Prescription – Most Non-Formulary	\$40 copay	\$50 copay after \$250 deductible (if obtained at participating pharmacies) ⁽⁶⁾⁽⁷⁾	Not covered (if obtained at non-participating pharmacies)
Prescription – Mail Order	Generic - \$10 copay (1-30 days) \$20 copay (31-100 days) Brand - \$30 copay (1-30 days) \$60 copay (31-100 days)	Not Covered	Not Covered (if obtained at non-participating pharmacies)
ADDITIONAL BENEFITS			
Maternity (Prenatal Care)	No Charge	20% after deductible	40% ⁽¹⁰⁾ after deductible
Annual Out-of-Pocket Maximum: Individual / Family	\$1,500 / \$3,000	\$3,000 / \$9,000 ⁽²⁾	\$4,500 / \$13,500 ⁽²⁾
Maximum Benefit while insured	Unlimited	\$2,000,000 ⁽³⁾	\$2,000,000 ⁽³⁾
Outpatient Surgery	\$100 copay per procedure	20% after deductible	40% ⁽¹⁰⁾ after deductible
Home Health Care (up to 100 2-hour visits per calendar year)	No charge	20% after deductible (Combined maximum deductible of \$50 per calendar year)	20% after deductible (Combined maximum deductible of \$50 per calendar year)
Skilled Nursing Facility (up to 100 days per benefit period)	\$250 copay per admission	20% after \$250 deductible per admission (Combined maximum 60 visits per calendar year)	40% after \$500 deductible per admission (Combined maximum 60 visits per calendar year)
Ambulance Services	\$50 copay per trip	\$50 ⁽¹¹⁾ copay per trip	\$50 ⁽¹¹⁾ copay per trip
Mental Health Services			
In the Medical Office	\$20 copay (individual visit) \$10 copay (group visit)	\$30 copay	40% after deductible
In the Hospital	\$250 copay per admission	20% after \$250 deductible per admission	40% (Max per day \$1,000)
Chemical Dependency Services			
In the Medical Office	\$20 copay (individual visit) \$5 copay (group visit)	\$30 copay	40% after deductible
In the Hospital	\$250 copay per admission (detoxification only)	20% after \$250 deductible per admission	40% (Max per day \$1,000)

See footnotes on last page

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This chart only describes a summary of benefits. For a complete understanding of benefits, please read this summary in conjunction with the Kaiser Permanente Insurance Company (KPIC) Certificate of Insurance, which contains a complete explanation of benefits, exclusions, and limitations. The information provided in this Benefit Summary is not intended for use as a Summary Plan Description, nor is it designed to serve as the Certificate of Insurance.

The POS Insurance Plan is jointly underwritten by Kaiser Foundation Health Plan, Inc. (KFHP) and Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, Inc. KFHP underwrites the HMO Providers tier, and KPIC underwrites the Participating and Non-Participating Providers tiers.

Footnotes

- ⁽¹⁾ Deductibles do not count toward satisfying the Out-of-Pocket Maximum.
- ⁽²⁾ Covered Charges incurred toward satisfaction of the Out-of-Pocket Maximum at the Non-Participating Providers tier will accumulate toward satisfaction of the Out-of-Pocket Maximum at the Participating Providers tier. Covered Charges incurred toward satisfaction of the Out-of-Pocket Maximum at the Participating Providers tier will not accumulate toward satisfaction of the Out-of-Pocket Maximum at the Non-Participating Providers tier.
- ⁽³⁾ Maximum benefit amount while insured is combined for services provided by Participating Providers and Non-Participating Providers.
- ⁽⁴⁾ Per admission deductibles do not contribute to the Calendar Year Deductible or the Out-of-Pocket Maximum.
- ⁽⁵⁾ Emergency medical services are covered by Kaiser Foundation Health Plan, Inc. Non-emergency medical services received in an emergency care setting that are not covered as a Health Plan benefit may be eligible for coverage by KPIC. Emergency Department surcharge fees are not covered by KPIC.
- ⁽⁶⁾ Participating Pharmacies are Albertsons, Kmart, Longs, Raley's, Rite Aid, Safeway, Sav-on, Vons, and Walgreens.
- ⁽⁷⁾ Pharmacy copays and deductibles are not subject to, nor do they contribute toward satisfaction of, the Calendar Year Deductible or the Out-of-Pocket Maximum. Select prescription medications are excluded from coverage.
- ⁽⁸⁾ Non-formulary prescriptions are underwritten by Kaiser Permanente Insurance Company.
- ⁽⁹⁾ Prescription drugs covered in accord with the Kaiser Permanente formulary when prescribed by a Plan Physician and obtained at Plan Pharmacies. A few drugs have different copays; please refer to the Evidence of Coverage for detailed information about prescription drug copays.
- ⁽¹⁰⁾ Payments are based upon the Maximum Allowable Charge for Covered Services. The Maximum Allowable Charge may be less than the amount actually billed by the provider. Covered Persons are responsible for payment of any amounts in excess of the Maximum Allowable Charge for a Covered Service. Maximum Allowable Charge is the lesser of: the Usual, Customary, and Reasonable Charges; the Negotiated Rate; and the Actual Billed Charges for Covered Services.
- ⁽¹¹⁾ Emergency visits and ambulance for emergency medical conditions are covered as an HMO benefit for services received at any provider. Copayments paid for Emergency visits and ambulance for emergency medical conditions are not subject to, nor do they contribute towards, satisfaction of either the Calendar Year Deductible or the Out-of-Pocket Maximum.

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Participating Providers and Non-Participating Providers exclusions and limitations

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HSA-QUALIFIED PLANS

BENEFIT SUMMARIES

KAISER PERMANENTE CHOICE SOLUTION

A CHOICE Administrators® Program

MEDICAL BENEFITS	HDHP 1900*	HDHP 2700*
	Member Pays	Member Pays
Deductible Individual / Family ⁽¹⁾	\$1,900 / \$3,800	\$2,700 / \$5,400
Annual Out-of-Pocket Maximum: Individual / Family ⁽²⁾	\$3,400 / \$6,800	\$5,000 / \$10,000
PREVENTIVE CARE⁽⁴⁾		
Routine Physical	\$0 no deductible	\$30 per visit no deductible
OFFICE VISITS	\$0 per visit after deductible	\$30 copay after deductible
LAB AND X-RAY-OUTPATIENT	\$0 after deductible	\$10 per encounter after deductible
LAB AND X-RAY-MRI/CT/PET	\$50 per procedure after deductible	\$50 per procedure after deductible
HOSPITAL CARE	\$300/per day after deductible	20% per admission after deductible
Emergency Room	\$100 per visit after deductible	20% per visit after deductible
RX BENEFITS⁽³⁾		
Prescription – Generic	\$10 copay after deductible	\$10 copay after deductible
Prescription – Brand	\$30 copay after deductible	\$30 copay after deductible
Prescription – Mail Order–Generic	\$10 copay after deductible (1-30 days)	\$10 copay after deductible (1-30 days)
	\$20 copay after deductible (31-100 days)	\$20 copay after deductible (31-100 days)
Mail Order–Brand	\$30 copay after deductible (1-30 days)	\$30 copay after deductible (1-30 days)
	\$60 copay after deductible (31-100 days)	\$60 copay after deductible (31-100 days)
ADDITIONAL BENEFITS		
Maternity (Prenatal Care)	\$0 no deductible	\$0 no deductible
2nd Surgical Opinion	\$0 per visit after deductible	\$30 copay after deductible
Outpatient Surgery	\$150 per procedure after deductible	20% after deductible
Home Health Care (Max. 100 two-hour visits per year)	\$0 per visit after deductible	\$0 per visit after deductible
Skilled Nursing Facility Care (100-day limit per benefit period)	Extended Care-\$0 per admission after deductible	Extended Care-20% per admission after deductible
Ambulance Services	\$100 per trip after deductible	20% per trip after deductible
Mental Health Services		
Doctor Fees	\$0 per visit after deductible	\$30 copay per visit after deductible
Hospital Care	\$300 per day after deductible	20% per admission after deductible
Chemical Dependency Services		
In the Medical Office	\$0 per visit after deductible	\$30 per visit after deductible
In the Hospital	\$300 per day after deductible	20% per admission after deductible

*HSA - Qualified High Deductible Health Plan

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HSA-QUALIFIED PLANS

The High Deductible Health Plans are underwritten by Kaiser Foundation Health Plan (KFHP).

Footnotes

- ⁽¹⁾ For Self enrollment coverage, the entire Individual Annual Deductible must be met before copay or coinsurance is applied for the individual member. For Family coverage, the entire Family Annual Deductible must be met before copay or coinsurance is applied for any individual family member. For Plan 2700, the family deductible contains an embedded individual deductible, meaning any member of the family never satisfies more than the individual deductible.
- ⁽²⁾ The Annual Out-of-Pocket maximum is the limit to the total amount that an individual or family must pay for certain Services in a Calendar Year (as discussed in the *Evidence of Coverage*). For Self enrollment coverage, the entire Individual Annual Out-of-Pocket maximum must be met before the limit is applied for the individual member. For Family coverage, the entire Family Annual Out-of-Pocket maximum must be met before the limit is applied for any individual family member.
- ⁽³⁾ Prescription drugs covered in accord with the Kaiser Permanente formulary when prescribed by a Plan Physician and obtained at Plan Pharmacies. A few drugs have different copay; please refer to the *Evidence of Coverage* for detailed information about prescription drug copay.
- ⁽⁴⁾ Pursuant to recent federal law changes, certain preventive services are not subject to these or any copayments. Please see your *Evidence of Coverage*.

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