

# 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.) <sup>(1)</sup>
Annual Out-of-Pocket Maximum: Individual / Family <sup>(1)</sup>	\$1,500 / \$3,000	\$3,000 / \$6,000	\$3,500 / \$7,000
<b>OFFICE VISITS</b>	\$10 copay	\$30 copay	\$20 copay <sup>(6)</sup>
<b>LAB AND X-RAY</b>	\$10 copay per encounter <sup>(5)</sup>	\$10 copay per encounter <sup>(5)</sup>	\$10 copay after deductible <sup>(4)</sup>
<b>HOSPITAL CARE</b>	\$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
<b>Rx BENEFITS (Pharmacy and Mail Order)<sup>(2)</sup></b>			
Prescription – Generic	\$10 copay	\$10 copay	\$10 copay
Prescription – Brand Name	\$20 copay	\$30 copay after \$100 brand prescription deductible	\$30 copay
<b>ADDITIONAL BENEFITS</b>			
Maternity (Prenatal Care)	\$10 copay	\$15 copay	\$10 copay <sup>(6)</sup>
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 <sup>(6)</sup> (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 <sup>(3)</sup>	\$10 copay (individual visit) \$5 copay (group visit)	\$30 copay (individual visit) \$15 copay (group visit)	\$20 copay (individual visit) <sup>(6)</sup> \$10 copay (group visit) <sup>(6)</sup> (20 visits per calendar year)
In the Hospital	\$200 copay per day	\$400 copay per day	20% after deductible (30 days per calendar year)
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) <sup>(6)</sup> \$5 copay (group visit) <sup>(6)</sup>
In the Hospital (detoxification only)	\$200 copay per day	\$400 copay per day	20% after deductible

<sup>1</sup> 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.

<sup>2</sup> 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.

<sup>3</sup> Visit or day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the Evidence of Coverage.

<sup>4</sup> \$10 Copay per encounter (except that MRI, CT, and PET are \$50 Copay per procedure) after Deductible.

<sup>5</sup> \$10 copay per encounter (except that MRI, CT, and PET are \$50 per procedure)

<sup>6</sup> 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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# PPO PLANS

## 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 <sup>(1)</sup>	\$750/\$2,250 <sup>(1)</sup>
<b>OFFICE VISITS</b>	\$30 copay <sup>(5)</sup>	50% after deductible
<b>LAB AND X-RAY</b>	20% after deductible	50% after deductible
<b>HOSPITAL CARE</b>	20% after \$250 deductible per admission <sup>(4)</sup>	50% after \$500 deductible per admission <sup>(4)</sup>
Emergency Room	20% after deductible	20% after deductible
<b>RX BENEFITS</b>		
Prescription – Generic	\$15 copay <sup>(7)</sup> (if obtained at participating pharmacies)	Not covered (if obtained at non-participating pharmacies)
Prescription – Brand	\$40 copay <sup>(7)</sup> after \$250 deductible (if obtained at participating pharmacies)	Not covered (if obtained at non-participating pharmacies)
Prescription – Most Non-Formulary	\$60 copay <sup>(7)</sup> (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)
<b>ADDITIONAL BENEFITS</b>		
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 <sup>(2)</sup>	\$6,000 / \$18,000 <sup>(2)</sup>
Maximum Benefit while insured	\$5,000,000 <sup>(3)</sup>	\$5,000,000 <sup>(3)</sup>
Outpatient Surgery	20% after deductible	50% after deductible
Home Health Care (up to 100 combined 2-hour visits per calendar year)	20% <sup>(10)</sup> after deductible	20% <sup>(10)</sup> after deductible
Skilled Nursing Facility Care (up to 100 days per benefit period)	20% after \$250 deductible per admission <sup>(4)</sup> combined maximum 60 visits per calendar year	50% after \$500 deductible per admission <sup>(4)</sup> combined maximum 60 visits per calendar year
Ambulance Services	40% <sup>(6)</sup> after deductible	40% <sup>(6)</sup> after deductible
<b>Mental Health Services</b>		
In the Medical Office – Severe mental illness <sup>(8)</sup>	\$30 copay <sup>(5)</sup>	50% after deductible
In the Hospital – Severe mental illness <sup>(8)</sup>	20% after \$250 deductible per admission <sup>(4)</sup>	50% after \$500 deductible per admission <sup>(4)</sup>
In the Medical Office – All other covered mental illness	\$30 after deductible	50% after deductible
In the Hospital – All other covered mental illness	20% after \$250 deductible per admission <sup>(4)</sup>	50% after \$500 deductible per admission <sup>(4)</sup>
<b>Chemical Dependency Services<sup>(9)</sup></b>		
In the Medical Office	\$30 after deductible	50% after deductible
In the Hospital (detoxification only)	20% after \$250 deductible per admission <sup>(4)</sup>	50% after \$500 deductible per admission <sup>(4)</sup>

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# PPO PLANS

## BENEFITS SUMMARY

## KAISER PERMANENTE CHOICE SOLUTION A CHOICE Administrators® Program

PPO HSA 2200*		
MEDICAL BENEFITS	Participating Network Providers Member pays	Non-Participating Network Providers Member pays
Deductible: Individual / Family	\$2,200 / \$4,400 <sup>(1)</sup>	\$3,200 / \$6,400 <sup>(1)</sup>
<b>OFFICE VISITS</b>	\$40 after deductible	50% after deductible
<b>LAB AND X-RAY – OUTPATIENT</b>	30% after deductible	50% after deductible
<b>HOSPITAL CARE</b>	30% after deductible	50% (\$600 Max per day) after deductible
Emergency Room	30% (\$100 copay per visit) after deductible	30% (\$100 copay per visit) after deductible
<b>RX BENEFITS</b>		
Prescription – Generic	\$15 copay <sup>(7)</sup> after deductible (if obtained at participating pharmacies)	Not covered (if obtained at non-participating pharmacies)
Prescription – Brand	\$35 copay <sup>(7)</sup> after deductible (if obtained at participating pharmacies)	Not covered (if obtained at non-participating pharmacies)
Prescription – Mail Order – Generic	2x the corresponding single copay per prescription, up to 100 day supply	Not covered (if obtained at non-participating pharmacies)
Prescription – Mail Order – Brand	2x the corresponding single copay per prescription, up to 100 day supply	Not covered (if obtained at non-participating pharmacies)
<b>ADDITIONAL BENEFITS</b>		
Maternity (Prenatal Care)	20% after deductible	50% after deductible
Annual Out-of-Pocket Maximum: Individual / Family	\$4,000 / \$8,000 <sup>(2)</sup>	\$8,000 / \$16,000 <sup>(2)</sup>
Maximum Benefit while insured	\$5,000,000 <sup>(3)</sup>	\$5,000,000 <sup>(3)</sup>
Outpatient Surgery	30% after deductible	50% (\$400 Max. per procedure) after deductible
Home Health Care (up to 100 combined 2-hour visits per calendar year)	20% after deductible	20% after deductible
Skilled Nursing Facility Care (Up to 100 days per benefit period)	30% (combined Max. 60 visits per calendar year) after deductible	50% (combined Max. 60 visits per calendar year) after deductible
Ambulance Services	50% <sup>(6)</sup> after deductible	50% <sup>(6)</sup> after deductible
Mental Health Services		
In the Medical Office – Severe mental illness <sup>(8)</sup>	\$40 after deductible	50% after deductible
In the Hospital – Severe mental illness <sup>(8)</sup>	30% after deductible	50% (\$600 Max per day) after deductible
In the Medical Office – All other covered mental illness	\$40 after deductible	50% after deductible
In the Hospital – All other covered mental illness	30% after deductible	50% (\$600 max per day) after deductible
Chemical Dependency Services <sup>(9)</sup>		
In the Medical Office	\$40 after deductible	50% after deductible
In the Hospital	30% after deductible	50% (\$600 max per day) after deductible

\*HSA - Qualified High Deductible Health Plan

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# PPO PLANS

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

- <sup>(1)</sup> Calendar Year Deductible amounts are combined for services provided by Participating Providers and Non-Participating Providers. Deductibles do not count toward satisfying the Out-of-Pocket Maximum.
- <sup>(2)</sup> 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.
- <sup>(3)</sup> Maximum benefit amount while insured is combined for services provided by Participating Providers and Non-Participating Providers.
- <sup>(4)</sup> Per admission inpatient deductibles do not contribute toward the Calendar Year Deductible or the Out-of-Pocket Maximum.
- <sup>(5)</sup> Exempt from deductibles.
- <sup>(6)</sup> 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.
- <sup>(7)</sup> 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.
- <sup>(8)</sup> 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.

<sup>(9)</sup> Benefits payable for treatment of alcohol and drug dependency are subject to a combined limit of \$10,000 per calendar year and \$25,000 lifetime for services provided by Participating Providers and Non-Participating Providers.

<sup>(10)</sup> Combined maximum deductibles of \$50 per calendar year.

## 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; routine adult physical exams; 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. Treatment of mental illness; substance abuse. 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. Extended well-child care for children ages 17–18. Services for which no charge is normally made in the absence of insurance.

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# POS PLANS

## BENEFITS SUMMARIES

## KAISER PERMANENTE CHOICE SOLUTION

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### 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 <sup>(1)</sup>	\$1,000 / \$3,000 <sup>(1)</sup>
<b>OFFICE VISITS</b>	\$20 copay	\$30 copay	40% <sup>(10)</sup> after deductible
<b>LAB AND X-RAY</b>	No Charge	20% after deductible	40% <sup>(10)</sup> after deductible
<b>HOSPITAL CARE</b>	\$250 copay per admission	20% after \$250 deductible per admission <sup>(4)</sup>	40% (Max per day \$1,000)
Emergency Room	\$100 copay <sup>(5)</sup> per visit (waived if admitted to hospital)	\$100 copay <sup>(11)</sup> per visit, regardless of facility / hospital accessed	\$100 copay <sup>(11)</sup> per visit, regardless of facility / hospital accessed
<b>Rx BENEFIT<sup>(8)</sup> (9)</b>			
Prescription – Generic	\$10 copay	\$20 copay (if obtained at participating pharmacies) <sup>(6)(7)</sup>	Not covered (if obtained at non-participating pharmacies)
Prescription – Brand	\$30 copay	\$40 copay after \$250 Brand deductible (if obtained at participating pharmacies) <sup>(6)(7)</sup>	Not covered (if obtained at non-participating pharmacies)
Prescription – Most Non-Formulary	\$40 copay	\$50 copay (if obtained at participating pharmacies) <sup>(6)(7)</sup>	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)
<b>ADDITIONAL BENEFITS</b>			
Maternity (Prenatal Care)	\$10 copay	20% after deductible	40% <sup>(10)</sup> after deductible
Annual Out-of-Pocket Maximum: Individual / Family	\$1,500 / \$3,000	\$3,000 / \$9,000 <sup>(2)</sup>	\$4,500 / \$13,500 <sup>(2)</sup>
Maximum Benefit while insured	Unlimited	\$2,000,000 <sup>(3)</sup>	\$2,000,000 <sup>(3)</sup>
Outpatient Surgery	\$100 copay per procedure	20% after deductible	40% <sup>(10)</sup> 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)	40% 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 <sup>(11)</sup> copay per trip	\$50 <sup>(11)</sup> copay per trip
<b>Mental Health Services</b>			
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)
<b>Chemical Dependency Services</b>			
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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# POS PLANS

## POS 30 / \$1,500

MEDICAL BENEFITS	HMO	PHCS Providers (PPO)	Non-Participating Providers (out-of-network)
	Member pays	Member pays	Member pays
Deductible: Individual / Family	No deductible	\$1,500 / \$4,500 <sup>(1)</sup>	\$1,500 / \$4,500
<b>OFFICE VISITS</b>	\$30 copay	\$40 copay	50% <sup>(10)</sup> after deductible
<b>LAB AND X-RAY</b>	No Charge	30% after deductible	50% <sup>(10)</sup> after deductible
<b>HOSPITAL CARE</b>	\$500 copay per admission	30% after \$250 deductible per admission <sup>(4)</sup>	50% (Max per day \$1,000)
Emergency Room	\$150 copay <sup>(6)</sup> per visit (waived if admitted to hospital)	\$150 copay <sup>(11)</sup> per visit, regardless of facility / hospital accessed	\$150 copay <sup>(11)</sup> per visit, regardless of facility / hospital accessed
<b>Rx BENEFIT<sup>(8)</sup> / <sup>(9)</sup></b>			
Prescription – Generic	\$10 copay	\$20 copay (if obtained at participating pharmacies) <sup>(6)/(7)</sup>	Not covered (if obtained at non-participating pharmacies)
Prescription – Brand	\$30 copay	\$40 copay after \$250 Brand deductible (if obtained at participating pharmacies) <sup>(6)/(7)</sup>	Not covered (if obtained at non-participating pharmacies)
Prescription – Most Non-Formulary	\$40 copay	\$50 copay (if obtained at participating pharmacies)	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)
<b>ADDITIONAL BENEFITS</b>			
Maternity (Prenatal Care)	\$15 copay	30% after deductible	50% <sup>(10)</sup> after deductible
Annual Out-of-Pocket Maximum: Individual / Family	\$2,000 / \$4,000	\$4,000 / \$12,000 <sup>(2)</sup>	\$6,000 / \$18,000 <sup>(2)</sup>
Maximum Benefit while insured	Unlimited	\$2,000,000 <sup>(3)</sup>	\$2,000,000 <sup>(3)</sup>
Outpatient Surgery	\$250 copay per procedure	30% after deductible	50% <sup>(10)</sup> 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 Care (up to 100 days per benefit period)	\$500 copay per admission	30% after \$250 deductible per admission (Combined maximum 60 visits per calendar year)	50% after \$500 deductible per admission (Combined maximum 60 visits per calendar year)
Ambulance Services	\$50 copay per trip	\$50 <sup>(11)</sup> copay per trip	\$50 <sup>(11)</sup> copay per trip
<b>Mental Health Services</b>			
In the Medical Office	\$30 copay (individual visit) \$15 copay (group visit)	\$40 copay	50% after deductible
In the Hospital	\$500 copay per admission	30% after \$250 deductible per admission	50% (Max per day \$1,000)
<b>Chemical Dependency Services</b>			
In the Medical Office	\$30 copay (individual visit) \$5 copay (group visit)	\$40 copay	50% after deductible
In the Hospital	\$500 copay per admission (detoxification only)	30% after \$250 deductible per admission	50% (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

- <sup>(1)</sup> Deductibles do not count toward satisfying the Out-of-Pocket Maximum.
- <sup>(2)</sup> 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.
- <sup>(3)</sup> Maximum benefit amount while insured is combined for services provided by Participating Providers and Non-Participating Providers.
- <sup>(4)</sup> Per admission deductibles do not contribute to the Calendar Year Deductible or the Out-of-Pocket Maximum.
- <sup>(5)</sup> 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.
- <sup>(6)</sup> Participating Pharmacies are Albertsons, Kmart, Longs, Raley's, Rite Aid, Safeway, Sav-on, Vons, and Walgreens.
- <sup>(7)</sup> 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.
- <sup>(8)</sup> Non-formulary prescriptions are underwritten by Kaiser Permanente Insurance Company.
- <sup>(9)</sup> 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.
- <sup>(10)</sup> 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.
- <sup>(11)</sup> 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.

## 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; routine adult physical exams; 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. Treatment of mental illness; substance abuse. 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. Extended well-child care for children ages 17–18. Services for which no charge is normally made in the absence of insurance.

# INDEMNITY PLAN

## BENEFITS SUMMARY

KAISER PERMANENTE CHOICE SOLUTION  
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<b>MEDICAL BENEFITS</b>	<b>Indemnity Plan</b>
	Member pays
Deductible: Individual / Family	\$500 / \$1,500 <sup>(1)</sup>
<b>OFFICE VISITS</b>	\$25 copay per visit <sup>(3)</sup>
<b>LAB AND X-RAY</b>	30% after deductible
<b>HOSPITAL CARE</b>	30% after \$500 deductible per admission <sup>(2)</sup>
Emergency Room	30% after deductible
<b>RX BENEFITS<sup>(5)</sup></b>	
Prescription – Generic	\$15 copay <sup>(6)</sup> (if obtained at participating pharmacies)
Prescription – Brand	\$40 copay (if obtained at participating pharmacies)
Prescription – Mail Order	2x the corresponding single copay per prescription up to 100 day supply
<b>ADDITIONAL BENEFITS</b>	
Maternity (Prenatal Care)	30% after deductible
Annual Out-of-Pocket Maximum: Individual / Family	\$1,500 / \$4,500
Maximum Benefit while insured	\$2,000,000
Outpatient Surgery	30% after deductible
Home Health Care <sup>(7)</sup> (up to 100 combined 2-hour visits per calendar year)	20% after deductible
Skilled Nursing Facility Care	30% after \$500 deductible per admission <sup>(2)</sup> (60 days per calendar year)
Ambulance Services	30% <sup>(4)</sup> after deductible
Mental Health Services	
In the Medical Office – Severe mental illness	\$25 copay per visit <sup>(3)</sup>
In the Hospital – Severe mental illness <sup>(6)</sup>	30% after \$500 deductible per admission <sup>(2)</sup>
In the Medical Office – All other covered mental illness	\$25 copay per visit
In the Hospital – All other covered mental illness	30% after \$500 deductible per admission <sup>(2)</sup>
Chemical Dependency Services	
In the Medical Office	\$25 copay per visit
In the Hospital <sup>(6)</sup>	30% after \$500 deductible per admission <sup>(2)</sup> (maximum of \$10,000 per calendar year)

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# INDEMNITY PLAN

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

## Footnotes

- <sup>(1)</sup> Deductibles do not count toward satisfying the Out-of-Pocket Maximum.
- <sup>(2)</sup> Inpatient deductibles neither contribute toward the Calendar Year Deductible nor do they contribute to the annual Out-of-Pocket Maximum.
- <sup>(3)</sup> Physician office visits, adult preventive screenings and exams, well-child preventive care visits, routine adult physical exams, pediatric visits, gynecological visits, and severe mental health visits and those treating the serious emotional disturbance of a child are subject to the per-visit copay noted in the chart. Copayments paid for such visits are neither subject to, nor do they contribute toward satisfaction of, the Calendar Year Deductible or the Out-of-Pocket Maximum. Remaining charges for such visits will be covered at 100 percent of the Maximum Allowable Charge (MAC). The insured will be responsible for any charges that exceed MAC.
- <sup>(4)</sup> Medically Necessary Non-emergency ambulance coverage is limited to a maximum of \$2,000 per calendar year for all services.
- <sup>(5)</sup> MedCare Pharmacy copayments are not subject to, nor do they contribute toward satisfaction of, the Calendar Year Deductible or the Out-of-Pocket Maximum. Prescriptions filled at a non-MedCare Pharmacy are not covered. Select prescription drugs are excluded from coverage.
- <sup>(6)</sup> 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.
- <sup>(7)</sup> Maximum deductible of \$50 per calendar year.

## Ⓢ Brand Name Prescription Drug and Generic Prescription Drug Rules

Member is responsible for paying the brand-name copay plus the difference in cost between the generic drug and the brand name drug when patient requests brand name drug and a generic version is available.

## Out-of-Area 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 not Medically Necessary; in excess of the Maximum Allowable Charge; not available in the United States; for personal comfort; or not completed in accordance with the Physician's orders. Charges for nonemergency care in an emergency care setting 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 Covered Person 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 Covered Person'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 that 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. Care, Services or treatment of or in connection with craniomandibular or temporomandibular joint disorders, unless for Medically Necessary surgical treatment of the disorder; 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. 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 Covered Person's: commission of or attempt to commit a felony; engagement in an illegal occupation; being intoxicated or 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 medicine for smoking cessation. Services for which no Charge is normally made in the absence of insurance.

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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 <sup>(1)</sup>	\$1,900 / \$3,800	\$2,700 / \$5,400
Annual Out-of-Pocket Maximum: Individual / Family <sup>(2)</sup>	\$3,400 / \$6,800	\$5,000 / \$10,000
<b>PREVENTIVE CARE</b>		
Routine Physical	\$0 no deductible	\$30 per visit no deductible
<b>OFFICE VISITS</b>	\$0 per visit after deductible	\$30 copay after deductible
<b>LAB AND X-RAY-OUTPATIENT</b>	\$0 after deductible	\$10 per encounter after deductible
<b>LAB AND X-RAY-MRI/CT/PET</b>	\$50 per procedure after deductible	\$50 per procedure after deductible
<b>HOSPITAL CARE</b>	\$300/per day after deductible	20% per admission after deductible
Emergency Room	\$100 per visit after deductible	20% per visit after deductible
<b>RX BENEFITS<sup>(3)</sup></b>		
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)
<b>ADDITIONAL BENEFITS</b>		
Maternity (Prenatal Care)	\$0 no deductible	\$10 copay per visit 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	\$0 per trip after deductible	20% per trip after deductible
<b>Mental Health Services</b>		
Doctor Fees <sup>(4)</sup>	\$0 per visit after deductible	\$30 copay per visit after deductible
Annual Maximum	Up to 20 visits per calendar year	Up to 20 visits per calendar year
Hospital Care	\$300 per day after deductible	20% per admission after deductible
Maximum Benefit while Insured	Up to 30 days per calendar year	Up to 30 days per calendar year
<b>Chemical Dependency Services</b>		
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

- <sup>(1)</sup> 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.
- <sup>(2)</sup> 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.
- <sup>(3)</sup> 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.
- <sup>(4)</sup> Visit or day limits do not apply to serious emotional disturbances of children and severe mental illness as described in the *Evidence of Coverage*.

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