

# DEDUCTIBLE PLANS WITH HSA OPTION PLAN HIGHLIGHTS

EFFECTIVE 1/1/09–6/1/09

**MOST POPULAR  
DEDUCTIBLE PLAN**

FEATURES	\$30/\$2,700 PLAN W/HSA MEMBER PAYS	\$0/\$2,700 PLAN W/HSA MEMBER PAYS	\$0/\$2,200 PLAN W/HSA MEMBER PAYS	\$0/\$1,500 PLAN W/HSA MEMBER PAYS
<b>MEDICAL CALENDAR-YEAR DEDUCTIBLE</b> Individual/Family	\$2,700/\$5,450 <sup>1</sup>	\$2,700/\$5,450 <sup>1</sup>	\$2,200/\$4,400 <sup>2</sup>	\$1,500/\$3,000 <sup>2</sup>
<b>PHARMACY CALENDAR-YEAR DEDUCTIBLE</b>	N/A	N/A	N/A	N/A
<b>ANNUAL OUT-OF-POCKET MAXIMUM<sup>3</sup></b> Self-only enrollment/Family enrollment	\$5,250/\$10,500	\$2,700/\$5,450	\$2,200/\$4,400	\$1,500/\$3,000
<b>IN THE MEDICAL OFFICE</b> Office visits Preventive exams Maternity/Prenatal care <sup>5</sup> Well-child preventive care visits <sup>6</sup> Vaccines (immunizations) Allergy injections Infertility services Occupational, physical, and speech therapy Most labs and imaging MRI/CT/PET Outpatient surgery	\$30 (after deductible) \$30 <sup>4</sup> \$10 <sup>4</sup> \$10 <sup>4</sup> \$0 <sup>4</sup> \$5 (after deductible) Not covered \$30 (after deductible) \$10 (after deductible) \$50 (after deductible) 30% (after deductible)	\$0 (after deductible) \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 (after deductible) Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)	\$0 (after deductible) \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 (after deductible) Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)	\$0 (after deductible) \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 (after deductible) Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)
<b>EMERGENCY SERVICES</b> Emergency Department visits (waived if admitted directly to hospital) Ambulance	30% (after deductible) \$100 (after deductible)	\$0 (after deductible) \$0 (after deductible)	\$0 (after deductible) \$0 (after deductible)	\$0 (after deductible) \$0 (after deductible)
<b>PRESCRIPTIONS<sup>7</sup></b> Generic Brand-name	(up to a 100-day supply) \$10 (after deductible) \$30 (after deductible)	(up to a 100-day supply) \$0 (after deductible) \$0 (after deductible)	(up to a 100-day supply) \$0 (after deductible) \$0 (after deductible)	(up to a 100-day supply) \$0 (after deductible) \$0 (after deductible)
<b>HOSPITAL CARE</b> Physicians' services, room and board, tests, medications, supplies, therapies Skilled nursing facility care (up to 100 days per benefit period)	30% per admission (after deductible) 30% per admission (after deductible)	\$0 per admission (after deductible) \$0 per admission (after deductible)	\$0 per admission (after deductible) \$0 per admission (after deductible)	\$0 per admission (after deductible) \$0 per admission (after deductible)
<b>MENTAL HEALTH SERVICES<sup>8</sup></b> In the medical office (up to 20 visits per calendar year)  In the hospital (up to 30 days per calendar year)	\$30 (after deductible for individual therapy) \$15 (after deductible for group therapy) 30% per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 (after deductible for group therapy) \$0 per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 (after deductible for group therapy) \$0 per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 (after deductible for group therapy) \$0 per admission (after deductible)
<b>CHEMICAL DEPENDENCY SERVICES</b> In the medical office  In the hospital (detoxification only)	\$30 (after deductible for individual therapy) 30% per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 per admission (after deductible)
<b>OTHER</b> Certain durable medical equipment (DME) <sup>9</sup> Optical (eyewear) Vision exam Home health care (up to 100 two-hour visits per calendar year) Hospice care	Not covered Not covered <sup>10</sup> \$30 (after deductible) \$0 (after deductible) \$0 (after deductible)	Not covered Not covered <sup>10</sup> \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)	Not covered Not covered <sup>10</sup> \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)	Not covered Not covered <sup>10</sup> \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)

**Note:** Kaiser Permanente plans do not include a pre-existing condition clause.

<sup>1</sup>Each family member becomes eligible for copayments after meeting his or her individual deductible.

<sup>2</sup>The entire family deductible must be met before copayments apply for individual family members.

<sup>3</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*).

<sup>4</sup>This service is not subject to a deductible.

<sup>5</sup>Scheduled prenatal visits and the first postpartum visit

<sup>6</sup>23 months or younger

<sup>7</sup>Prescription drugs are covered in accord with our formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copayments; please refer to the *Evidence of Coverage* for detailed information about prescription drug copayments.

<sup>8</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>9</sup>Please refer to the *Evidence of Coverage* for most information; most DME is not covered.

<sup>10</sup>Kaiser Permanente members are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be coordinated with any other Health Plan vision benefit. The discounts will not apply to any sale, promotional, or packaged eyewear program, for any contact lens extended purchase agreement, or to low-vision aids or devices. Visit [kp.org/2020](http://kp.org/2020) for Kaiser Permanente optical locations.

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