

DEDUCTIBLE PLANS PLAN HIGHLIGHTS

EFFECTIVE 1/1/09–6/1/09

| FEATURES | \$30/\$1,500 PLAN MEMBER PAYS | \$30/\$1,000 PLAN MEMBER PAYS |
|---|---|---|
| MEDICAL CALENDAR-YEAR DEDUCTIBLE Individual/Family | \$1,500/\$3,000 ¹ | \$1,000/\$2,000 ¹ |
| PHARMACY CALENDAR-YEAR DEDUCTIBLE | \$250 for brand prescriptions | \$250 for brand prescriptions |
| ANNUAL OUT-OF-POCKET MAXIMUM² Individual/Family | \$3,500/\$7,000 | \$3,500/\$7,000 |
| IN THE MEDICAL OFFICE | | |
| Office visits | \$30 ³ | \$30 ³ |
| Preventive exams | \$30 ³ | \$30 ³ |
| Maternity/prenatal care ⁴ | \$0 ³ | \$0 ³ |
| Well-child preventive care visits ⁵ | \$0 ³ | \$0 ³ |
| Vaccines (immunizations) | \$0 ³ | \$0 ³ |
| Allergy injections | \$5 (after deductible) | \$5 (after deductible) |
| Infertility services | Not covered | Not covered |
| Occupational, physical, and speech therapy | \$30 (after deductible) | \$30 (after deductible) |
| Most labs and imaging | \$10 (after deductible) | \$10 (after deductible) |
| MRI/CT/PET | \$50 (after deductible) | \$50 (after deductible) |
| Outpatient surgery | \$250 (after deductible) | \$250 (after deductible) |
| EMERGENCY SERVICES | | |
| Emergency Department visits (waived if admitted directly to hospital) | \$100 (after deductible) | \$100 (after deductible) |
| Ambulance | \$75 (after deductible) | \$75 (after deductible) |
| PRESCRIPTIONS⁶ | | |
| Generic | (up to a 100-day supply) \$10 ³ | (up to a 100-day supply) \$10 ³ |
| Brand-name | \$35 (after \$250 pharmacy deductible) | \$35 (after \$250 pharmacy deductible) |
| HOSPITAL CARE | | |
| Physicians' services, room and board, tests, medications, supplies, therapies | \$500 per day (after deductible) | \$500 per day (after deductible) |
| Skilled nursing facility care | \$50 per day (after deductible) (up to 60 days per benefit period) | \$50 per day (after deductible) (up to 60 days per benefit period) |
| MENTAL HEALTH SERVICES⁷ | | |
| In the medical office (up to 20 visits per calendar year) | \$30 (for individual therapy) ³ \$15 (for group therapy) ³ | \$30 (for individual therapy) ³ \$15 (for group therapy) ³ |
| In the hospital (up to 30 days per calendar year) | \$500 per day (after deductible) | \$500 per day (after deductible) |
| CHEMICAL DEPENDENCY SERVICES | | |
| In the medical office | \$30 (for individual therapy) ³ | \$30 (for individual therapy) ³ |
| In the hospital (detoxification only) | \$500 per day (after deductible) | \$500 per day (after deductible) |
| OTHER | | |
| Certain durable medical equipment (DME) ⁸ | Not covered | Not covered |
| Optical (eyewear) | Not covered ⁹ | Not covered ⁹ |
| Vision exam | \$30 ³ | \$30 ³ |
| Home health care (up to 100 two-hour visits per calendar year) | \$0 ³ | \$0 ³ |
| Hospice care | \$0 ³ | \$0 ³ |

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

Note: The \$30/\$1,500 Deductible Plan is only available if offered with at least one copay plan. This option is available to groups with two or more subscribers. If the \$30/\$1,500 Deductible Plan is offered with two or more copay plans, regular multiple plan offering rules apply.

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

²The 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*).

³This service is not subject to a deductible.

⁴Scheduled prenatal visits and the first postpartum visit

⁵23 months or younger

⁶Prescription 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.

⁷Visit or day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage*.

⁸Please refer to the *Evidence of Coverage* for more information; most DME is not covered.

⁹Kaiser 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 for Kaiser Permanente optical locations.