



**KAISER PERMANENTE®**

California Group Plans for 2009

**good health is no secret**

**WELCOME TO KAISER PERMANENTE**

## **Contents**

**Copayment Plans.....Page 1**

**Deductible Plans.....Page 2**

**HSA-Qualified Plans.....Page 3**

**KAISERQuotes**  
**.com**

1.877.752.4737

# COPAYMENT PLANS PLAN HIGHLIGHTS

	MOST POPULAR COPAYMENT PLAN				
FEATURES	\$50 PLAN MEMBER PAYS	\$30 PLAN MEMBER PAYS	\$20 PLAN MEMBER PAYS	\$15 PLAN MEMBER PAYS	\$5 PLAN MEMBER PAYS
<b>MEDICAL CALENDAR-YEAR DEDUCTIBLE</b>	\$0	\$0	\$0	\$0	\$0
<b>PHARMACY CALENDAR-YEAR DEDUCTIBLE</b>	\$250 for brand prescriptions	\$250 for brand prescriptions	\$0	\$0	\$0
<b>ANNUAL OUT-OF-POCKET MAXIMUM<sup>1</sup></b> Self-only enrollment/Family enrollment	\$3,500/\$7,000	\$3,500/\$7,000	\$3,000/\$6,000	\$3,000/\$6,000	\$1,500/\$3,000
<b>IN THE MEDICAL OFFICE</b>					
Office visits	\$50	\$30	\$20	\$15	\$5
Preventive exams	\$50	\$30	\$20	\$15	\$5
Maternity/Prenatal care <sup>2</sup>	\$15	\$0	\$0	\$0	\$0
Well-child preventive care visits <sup>3</sup>	\$15	\$0	\$0	\$0	\$0
Vaccines (immunizations)	\$0	\$0	\$0	\$0	\$0
Allergy injections	\$5	\$5	\$5	\$5	\$5
Infertility services	Not covered	Not covered	Not covered	50%	50%
Occupational, physical, and speech therapy	\$50	\$30	\$20	\$15	\$5
Most labs and imaging	\$10	\$10	\$10	\$10	\$10
MRI/CT/PET	\$50	\$50	\$50	\$50	\$50
Outpatient surgery	\$250 per procedure	\$200 per procedure	\$150 per procedure	\$100 per procedure	\$5 per procedure
<b>EMERGENCY SERVICES</b>					
Emergency Department visits (waived if admitted directly to hospital)	\$150	\$100	\$100	\$100	\$100
Ambulance	\$300	\$75	\$75	\$75	\$75
<b>PRESCRIPTIONS<sup>4</sup></b>					
Generic	(up to a 100-day supply) \$10 <sup>5</sup>	(up to a 100-day supply) \$10 <sup>5</sup>	(up to a 30-day supply) \$10 <sup>5</sup>	(up to a 30-day supply) \$10 <sup>5</sup>	(up to a 100-day supply) \$5 <sup>5</sup>
Brand-name	\$35 (after pharmacy deductible)	\$35 (after pharmacy deductible)	\$30 <sup>5</sup>	\$25 <sup>5</sup>	\$15 <sup>5</sup>
<b>HOSPITAL CARE</b>					
Physicians' services, room and board, tests, medications, supplies, therapies	\$500 per day	\$400 per day	\$300 per day	\$200 per day	\$0
Skilled nursing facility care (up to 100 days per benefit period)	\$0	\$0	\$0	\$0	\$0
<b>MENTAL HEALTH SERVICES<sup>6</sup></b>					
In the medical office (up to 20 visits per calendar year)	\$50 individual \$25 group	\$30 individual \$15 group	\$20 individual \$10 group	\$15 individual \$7 group	\$5 individual \$2 group
In the hospital (up to 30 days per calendar year)	\$500 per day	\$400 per day	\$300 per day	\$200 per day	\$0
<b>CHEMICAL DEPENDENCY SERVICES</b>					
In the medical office	\$50 individual	\$30 individual	\$20 individual	\$15 individual	\$5 individual
In the hospital (detoxification only)	\$500 per day	\$400 per day	\$300 per day	\$200 per day	\$0
<b>OTHER</b>					
Certain durable medical equipment (DME)	Not covered <sup>7</sup>	Not covered <sup>7</sup>	20% (\$2,000 maximum)	20% (\$2,000 maximum)	20% (\$2,000 maximum)
Optical (eyewear)	Not covered <sup>8</sup>	Not covered <sup>8</sup>	Not covered <sup>8</sup>	\$150 allowance <sup>9</sup>	\$150 allowance <sup>9</sup>
Vision exam	\$50	\$30	\$20	\$15	\$5
Home health care (up to 100 two-hour visits per calendar year)	\$0	\$0	\$0	\$0	\$0
Hospice care	\$0	\$0	\$0	\$0	\$0

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

<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*).

<sup>2</sup>Scheduled prenatal visits and the first postpartum visit

<sup>3</sup>23 months or younger

<sup>4</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>5</sup>This service is not subject to a deductible.

<sup>6</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>7</sup>Most DME for home use is not covered. Please refer to your *Evidence of Coverage* for a description of limited covered items.

<sup>8</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 do not apply to any sale, promotional, or packaged eyewear program, for any contact lenses extended purchase agreement, or to low-vision aids or devices. Visit [kp.org/2020](http://kp.org/2020) for Kaiser Permanente optical locations.

<sup>9</sup>Allowance toward the cost of eyeglass lenses, frames, and contact lenses fitting and dispensing every 24 months

# Benefits Comparison

Proposed Effective Date: 3/1/2010



\$30/\$1,000 (HMO)	\$30/\$1,500 (HMO)	\$40/\$2,000 Plan (HMO)
<b>Deductible</b>		
Individual: \$1,000 Family: \$2,000 Not Applicable	Individual: \$1,500 Family: \$3,000 Not Applicable	Individual: \$2,000 Family: \$4,000 Not Applicable
<b>Copay Limit</b>		
Individual: \$3,500 Family: \$7,000 Not Applicable	Individual: \$3,500 Family: \$7,000 Not Applicable	Individual: \$4,500 Family: \$9,000 Not Applicable
<b>Lifetime Benefit</b>		
Unlimited Not Applicable	Unlimited Not Applicable	Unlimited Not Applicable
<b>Office Visits</b>		
\$30 Not Applicable	\$30 Not Applicable	\$40 Not Applicable
<b>Lab &amp; X-Rays</b>		
\$10 after Deductible Not Applicable	\$10 after Deductible Not Applicable	\$10 after Deductible Not Applicable
<b>Physical Exams</b>		
\$30 Not Applicable	\$30 Not Applicable	\$40 Not Applicable
<b>Mental Services</b>		
\$30 individual \$15 group therapy (20 visits/calendar year) Not Applicable	\$30 individual \$15 group therapy (20 visits/calendar year) Not Applicable	\$40 individual \$20 group therapy (20 visits/calendar year) Not Applicable
<b>Prescription Drugs</b>		
\$10 Generic \$30 Brand Formulary Not Applicable	\$10 Generic \$30 Brand Formulary Not Applicable	\$10 Generic \$35 Brand Formulary Not Applicable
<b>Out-Patient Surgery</b>		
\$250 after Deductible Not Applicable	\$250 after Deductible Not Applicable	30% Not Applicable
<b>In-Patient Hospital &amp; Maternity</b>		
\$500/day after Deductible Not Applicable	\$500/day after Deductible Not Applicable	30%/admission Not Applicable
<b>In-Patient Chemical Dependency</b>		
\$500 after Deductible/day (detox only) Not Applicable	\$500 after Deductible/day (detox only) Not Applicable	30%/admission (detox only) Not Applicable
<b>In-Patient Mental Services</b>		
\$500/day after Deductible (30 days/calendar year) Not Applicable	\$500/day after Deductible (30 days/calendar year) Not Applicable	30%/admission (30 days/calendar year) Not Applicable
<b>Emergency Room</b>		
\$100 after Deductible (Waived if admitted) \$100 after Deductible (Waived if admitted)	\$100 after Deductible (Waived if admitted) \$100 after Deductible (Waived if admitted)	30% (Waived if admitted) 30% (Waived if admitted)

# Benefits Comparison

Proposed Effective Date: 3/1/2010



\$30/\$3,000 (HMO HSA) (HSA)	\$0/\$2,700 (HMO HSA) (HSA)	\$0/\$2,000 (HMO HSA) (HSA)
<b>Deductible</b>		
Individual: \$3,000 Family: \$6,000 Not Applicable	Individual: \$2,700 Family: \$5,450 Not Applicable	Individual: \$2,000 Family: \$4,000 Not Applicable
<b>Copay Limit</b>		
Individual: \$5,950 Family: \$11,900 Not Applicable	Individual: \$4,500 Family: \$9,000 Not Applicable	Individual: \$3,500 Family: \$7,000 Not Applicable
<b>Lifetime Benefit</b>		
Unlimited Not Applicable	Unlimited Not Applicable	Unlimited Not Applicable
<b>Office Visits</b>		
\$30 after Deductible Not Applicable	No Charge after Deductible Not Applicable	No Charge after Deductible Not Applicable
<b>Lab &amp; X-Rays</b>		
\$10 after Deductible Not Applicable	No Charge after Deductible Not Applicable	No Charge after Deductible Not Applicable
<b>Physical Exams</b>		
\$30 Not Applicable	No Charge Not Applicable	No Charge Not Applicable
<b>Mental Services</b>		
\$30 after Deductible individual \$15 after Deductible group therapy (20 visits/calendar year) Not Applicable	No Charge after Deductible (20 visits/calendar year) Not Applicable	No Charge after Deductible (20 visits/calendar year) Not Applicable
<b>Prescription Drugs</b>		
\$10 Generic \$30 Brand Formulary after Deductible Not Applicable	\$10 Generic \$30 Brand Formulary after Deductible Not Applicable	\$10 Generic \$30 Brand Formulary after Deductible Not Applicable
<b>Out-Patient Surgery</b>		
30% Not Applicable	\$250 after Deductible Not Applicable	\$150 after Deductible Not Applicable
<b>In-Patient Hospital &amp; Maternity</b>		
30%/admission Not Applicable	\$450/day after Deductible Not Applicable	\$300/day after Deductible Not Applicable
<b>In-Patient Chemical Dependency</b>		
30%/admission (detox only) Not Applicable	\$450 after Deductible/day (detox only) Not Applicable	\$300 after Deductible/day (detox only) Not Applicable
<b>In-Patient Mental Services</b>		
30%/admission (30 days/calendar year) Not Applicable	\$450/day after Deductible (30 days/calendar year) Not Applicable	\$300/day after Deductible (30 days/calendar year) Not Applicable
<b>Emergency Room</b>		
30% (Waived if admitted) 30% (Waived if admitted)	\$100 after Deductible (Waived if admitted) \$100 after Deductible (Waived if admitted)	\$100 after Deductible (Waived if admitted) \$100 after Deductible (Waived if admitted)