

Carrier	Kaiser Permanente Insurance Company	Kaiser Permanente Insurance Company	Kaiser Permanente Insurance Company	Kaiser Permanente Insurance Company
Plan Name	HMO 20	HMO 30	DHMO 500	DHMO 1000
<b>General Plan Information</b>				
Annual Deductible/Individual	\$0	\$0	\$500	\$1,000
Annual Deductible/Family	\$0	\$0	\$1,000	\$2,000
Coinsurance	100%	100%	80%	70%
Office Visit/Exam	\$20 copay	\$30 copay	\$20 copay	\$30 copay
Outpatient Specialist Visit	\$20 copay	\$30 copay	\$20 copay	\$30 copay
Annual Out-of-Pocket Limit/Individual	\$1,500	\$1,500	\$3,000	\$3,000
Annual Out-of-Pocket Limit/Family	\$3,000	\$3,000	\$6,000	\$6,000
Deductible Included in Out-of-Pocket Limits	N/A	N/A	Yes	Yes
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Physician Election Required	No	No	No	No
<b>Outpatient Services</b>				
<b>Preventive Services</b>				
Well-Child Care	100% through age 23 months	100% through age 23 months	100% through age 23 months	100% through age 23 months
Immunizations	100%	100%	100%	100%
Well Woman Exams	100%	100%	100%	100%
Mammograms	100%	100%	100% for preventive	100% for preventive
Adult Periodic Exams with Preventive Tests	100%	100%	100%	100%
Diagnostic X-Ray and Lab Tests	100% \$20 copay for MRI/CT/PET	100% \$30 copay for MRI/CT/PET	\$10 copay per encounter after deductible; \$50 copay per procedure for MRI/CT/PET after deductible	\$10 copay per encounter after deductible; \$50 copay per procedure for MRI/CT/PET after deductible
<b>Maternity Care</b>				
Pregnancy and Maternity Care (Pre-Natal Care)	100%	100%	100%	100%
<b>Inpatient Hospital Services</b>				
Inpatient Hospitalization	100%	100%	80% after deductible	70% after deductible
Pre-Authorization of Services Required	Yes	Yes	Yes	Yes
Semi-Private Room & Board; Including Services and Supplies	100%	100%	80% after deductible	70% after deductible
<b>Surgical Services</b>				
Outpatient Facility Charge	\$20 copay per procedure	\$30 copay per procedure	80% after deductible	70% after deductible
<b>Emergency Services</b>				
Emergency Room	\$100 copay waived if admitted	\$100 copay waived if admitted	80% after deductible	70% after deductible
<b>Ambulance</b>				
Air	100%	100%	\$150 copay per trip; after deductible	\$150 copay per trip; after deductible
Ground	100%	100%	\$150 copay per trip; after deductible	\$150 copay per trip; after deductible
<b>Urgent Care</b>				
Urgent Care Facility	\$20 copay	\$30 copay	\$20 copay; deductible waived	\$30 copay; deductible waived
<b>Mental Health Benefits</b>				
Inpatient Care	100%	100%	80% after deductible	70% after deductible
Outpatient Care	\$20 copay	\$30 copay	\$20 copay; deductible waived	\$30 copay; deductible waived
<b>Substance Abuse</b>				
<b>Inpatient Care</b>				
Inpatient Hospitalization	100%	100%	80% after deductible	70% after deductible
Inpatient Detoxification Services	100%	100%	80% after deductible	70% after deductible
<b>Outpatient Care</b>				
Outpatient Services	\$20 copay	\$30 copay	\$20 copay; deductible waived	\$30 copay; deductible waived
<b>Prescription Drug Benefits</b>				
Prescription Drug Deductible	N/A	N/A	\$100 per member/calendar year	\$100 per member/calendar year
Generic	\$10 copay	\$15 copay	\$10 copay; deductible waived	\$10 copay; deductible waived
Brand (Formulary/Preferred)	\$20 copay	\$35 copay	\$30 copay; after \$100 prescription deductible	\$30 copay; after \$100 prescription deductible
Number of Days Supply	30 days	30 days	30 days	30 days
<b>Mail Order</b>				
Generic	\$20 copay	\$30 copay	\$20 copay; deductible waived	\$20 copay; deductible waived
Brand (Formulary/Preferred)	\$40 copay	\$70 copay	\$60 copay; after \$100 prescription deductible	\$60 copay; after \$100 prescription deductible
Number of Days Supply for Mail Order	100 days	100 days	100 days	100 days
<b>Other Services and Supplies</b>				
Durable Medical Equipment & Prosthetic Devices	100%	100%	80% deductible waived	80% deductible waived
Home Health Care	100% limited to 100 visits/calendar year	100% limited to 100 visits/calendar year	100% limited to 100 visits/calendar year; deductible waived	100% limited to 100 visits/calendar year; deductible waived
Skilled Nursing or Extended Care Facility	100% limited to 100 days/benefit period	100% limited to 100 days/benefit period	80% after deductible; limited to 100 days/benefit period	70% after deductible; limited to 100 days/benefit period
Hospice Care	100%	100%	100% deductible waived	100% deductible waived
Chiropractic Services	Not covered	Not covered	Not covered	Not covered
Acupuncture	Not covered	Not covered	Not covered	Not covered
<b>Vision</b>				
<b>Copay</b>				
Deductible Amount	N/A	N/A	N/A	N/A
Annual Allowance Amount	N/A	N/A	N/A	N/A
Examination	100%	100%	100%	100%
Materials	Not covered	Not covered	Not covered	Not covered
<b>Benefit Frequency</b>				
Examination	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Lenses	Not covered	Not covered	Not covered	Not covered
Frames	Not covered	Not covered	Not covered	Not covered
Contacts	Not covered	Not covered	Not covered	Not covered
<b>Hearing</b>				
Screening	100%	100%	100%	100%
Aid(s)	Not covered	Not covered	Not covered	Not covered
<b>Infertility</b>				
Diagnosis	See plan certificate	See plan certificate	See plan certificate	See plan certificate
Treatment	See plan certificate	See plan certificate	See plan certificate	See plan certificate
<b>Outpatient Rehabilitative Therapy Services</b>				
Physical	\$20 copay	\$30 copay	\$20 copay; after deductible	\$30 copay; after deductible
Occupational	\$20 copay	\$30 copay	\$20 copay; after deductible	\$30 copay; after deductible
Speech	\$20 copay	\$30 copay	\$20 copay; after deductible	\$30 copay; after deductible