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# Kaiser Plan Comparison

| Plan Name | HMO Traditional - "High Plan" | Deductible HMO - "Mid Plan" | Deductible HMO - "Low Plan" |
|---|---|---|---|
| **General Plan Information** | | | |
| Annual Deductible: Individual / Family | $0 / $0 | $1,000 / $2,000 | $3,000 / $6,000 |
| Coinsurance | 100% | 80% | 70% |
| Office Visit/Exam/Specialist | $20 copay | $20 copay (deductible doesn't apply) | $40 copay (deductible doesn't apply) |
| Annual Out-of-Pocket Limit: Individual / Family | $1,500 / $3,000 | $3,000 / $6,000 | $6,000 / $12,000 |
| **Outpatient Services** | | | |
| Adult Periodic Exams with Preventive Tests | 100% | 100% (deductible doesn't apply) | 100% (deductible doesn't apply) |
| Diagnostic X-Ray and Lab Tests | 100% | $10 copay (deductible doesn't apply) | $10 copay (deductible doesn't apply) |
| **Maternity Care** | | | |
| Pregnancy and Maternity Care (Pre-Natal Care) | 100% | 100% (deductible doesn't apply) | 100% (deductible doesn't apply) |
| **Inpatient Hospital Services** | | | |
| Inpatient Hospitalization | 100% | 80% after deductible | 70% after plan deductible |
| **Surgical Services** | | | |
| Outpatient Facility Charge | $20 copay | 80% after deductible | 70% after plan deductible |
| **Emergency Services** | | | |
| Emergency Room | $50 copay waived if admitted | 80% after deductible | 70% after plan deductible |
| Ambulance | $50 copay per trip | $150 per trip (deductible doesn't apply) | $150 per trip (deductible doesn't apply) |
| **Urgent Care** | | | |
| Urgent Care Facility | $20 copay | $20 copay (deductible doesn't apply) | $40 copay (deductible doesn't apply) |
| **Mental Health & Substance Abuse Benefits** | | | |
| Inpatient Care | 100% | 80% after deductible | 70% after plan deductible |
| Outpatient Care | $20 copay | $20 copay (deductible doesn't apply) | $40 copay (deductible doesn't apply) |
| **Prescription Drug Benefits** | | | |
| Generic | $10 copay | $10 copay | $10 copay |
| Brand | $10 copay | $30 copay | $30 copay |
| Number of Days Supply | 100 days | 30 days | 30 days |
| **Mail Order** | | | |
| Generic | $10 copay | $20 copay | $20 copay |
| Brand | $10 copay | $60 copay | $60 copay |
| Number of Days Supply for Mail Order | 100 days | 100 days | 100 days |
| **Other Services and Supplies** | | | |
| Durable Medical Equipment & Prosthetic Devices | 80% | 80% (deductible doesn't apply) | 80% (deductible doesn't apply) |
| Home Health Care | 100%<br>Up to 100 visits per accumulation period | 100% (deductible doesn't apply)<br>Up to 100 visits per accumulation period | 100% (deductible doesn't apply)<br>Up to 100 visits per accumulation period |
| Skilled Nursing or Extended Care Facility | 100%<br>Up to 100 days per benefit period | 80% (deductible doesn't apply)<br>Up to 100 days per benefit period | 70% (deductible doesn't apply)<br>Up to 100 days per benefit period |
| Hospice Care | 100% | 100% (deductible doesn't apply) | 100% (deductible doesn't apply) |
| **Outpatient Rehabilitative Therapy Services** | | | |
| Physical, Occupational, Speech | $20 copay | $20 copay (deductible doesn't apply) | $40 copay (deductible doesn't apply) |

The information described on this page is only intended to be a summary of your benefits. It does not include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description (SPD) for a complete summary of your beenfits. If the information on this page conflicts in any way with the SPD, the contract provisions of the appropriate policy or plan document (available through your employer) will prevail.