

KAISER PERMANENTE HSA-QUALIFIED DEDUCTIBLE HMO PLANS PLAN HIGHLIGHTS

EFFECTIVE 7/1/10-12/1/10

FEATURES	MOST POPULAR DEDUCTIBLE PLAN W/HSA		
	\$30/\$3,000 PLAN W/HSA MEMBER PAYS	\$0/\$2,700 PLAN W/HSA MEMBER PAYS	\$0/\$2,000 PLAN W/HSA MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE Individual/Family	\$3,000/\$6,000 ¹	\$2,700/\$5,450 ¹	\$2,000/\$4,000 ²
PHARMACY CALENDAR-YEAR DEDUCTIBLE	N/A	N/A	N/A
ANNUAL OUT-OF-POCKET MAXIMUM³ Individual/Family	\$5,950/\$11,900 ¹	\$4,500/\$9,000 ¹	\$3,500/\$7,000 ²
IN THE MEDICAL OFFICE Office visits Preventive exams ⁴ Maternity/Prenatal care ^{4,5} Well-child preventive care visits ^{4,6} Vaccines (immunizations) ⁴ Allergy injections Infertility services Occupational, physical, and speech therapy Most labs and imaging MRI/CT/PET Outpatient surgery	\$30 (after deductible) \$30 \$10 \$10 \$0 \$5 (after deductible) Not covered \$30 (after deductible) \$10 (after deductible) \$50 (after deductible) 30% (after deductible)	\$0 (after deductible) \$0 \$0 \$0 \$0 \$0 (after deductible) Not covered \$0 (after deductible) \$0 (after deductible) \$50 (after deductible) \$250 (after deductible)	\$0 (after deductible) \$0 \$0 \$0 \$0 \$0 (after deductible) Not covered \$0 (after deductible) \$0 (after deductible) \$50 (after deductible) \$150 (after deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital) Ambulance	30% (after deductible) \$100 (after deductible)	\$100 (after deductible) \$100 (after deductible)	\$100 (after deductible) \$100 (after deductible)
PRESCRIPTIONS⁷ Generic Brand-name	(up to a 30-day supply) \$10 (after deductible) \$30 (after deductible)	(up to a 30-day supply) \$10 (after deductible) \$30 (after deductible)	(up to a 30-day supply) \$10 (after deductible) \$30 (after deductible)
HOSPITAL CARE 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)	\$450 per day (after deductible) \$0 per admission (after deductible)	\$300 per day (after deductible) \$0 per admission (after deductible)
MENTAL HEALTH SERVICES In the medical office In the hospital	\$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) \$450 per day (after deductible)	\$0 (after deductible for individual therapy) \$0 (after deductible for group therapy) \$300 per day (after deductible)
CHEMICAL DEPENDENCY SERVICES 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) \$450 per day (after deductible)	\$0 (after deductible for individual therapy) \$300 per day (after deductible)
OTHER Certain durable medical equipment (DME) ⁸ Optical (eyewear) ⁹ Vision exam Home health care (up to 100 two-hour visits per calendar year) Hospice care	Not covered Not covered \$30 (after deductible) \$0 (after deductible) \$0 (after deductible)	Not covered Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)	Not covered Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)

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

¹This plan carries an embedded deductible. Each family member becomes eligible for copayments or coinsurance after meeting the individual deductible, or when the family deductible is satisfied. A family member can meet the individual annual out-of-pocket maximum before the family out-of-pocket maximum is satisfied.

²This plan has an aggregate deductible. For family enrollment, there is only one deductible for the whole family. Once it's met, either individually or collectively, the family pays only copayments and coinsurance for the remainder of the calendar year, or until the family out-of-pocket maximum is satisfied.

³The 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*).

⁴This service is not subject to a deductible.

⁵Scheduled prenatal visits

⁶Well-child visits through age 23 months

⁷Prescription 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.

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.