

# ProsperPlan™ for Small Business

Effective January 1, 2009

**High Deductible HMO Health Plans**

**HMO Plans**

**Deductible HMO Plans**

**POS Plans**

**Deductible POS Plans**

# High Deductible HMO Health Plans

	Option 1 Member pays	Option 2 Member pays	Option 3 Member pays	Option 4 Member pays	
Services subject to deductible	<b>Coinsurance</b>	None	None	20%	20%
	<b>Deductible<sup>1</sup></b> (single/family)	\$2,500/\$5,000	\$5,000/\$10,000	\$2,500/\$5,000	\$3,000/\$6,000
	<b>Out-of-Pocket Maximum</b> (single/family)	\$2,500/\$5,000	\$5,000/\$10,000	\$5,000/\$10,000	\$5,000/\$10,000
	<b>Lifetime Maximum</b>	Unlimited			
	<b>Office Visits</b>	No charge	No charge	20%	\$20 copay
	<b>Prenatal Office Visits<sup>2</sup></b>	No charge			
	<b>Lab &amp; Radiology</b>	No charge	No charge	20%	20%
	<b>Urgent Care Services</b>	No charge	No charge	20%	\$45 copay
	<b>Ambulance Services<sup>3</sup></b>	No charge	No charge	20%	20%
	<b>Emergency Department Visits</b>	No charge	No charge	20%	20%
	<b>Hospital Inpatient Care</b>	No charge	No charge	20%	20%
	<b>Maternity Delivery</b>	No charge	No charge	20%	20%
	<b>Prescription Drugs<sup>4</sup></b>	No charge	No charge	20%	20%
	<b>Durable Medical Equipment</b>	No charge	No charge	20%	20%
	<b>Dental Plan<sup>5</sup></b>	Optional			
<b>Vision Exam</b>	Not covered				
<b>Hardware Allowance for Eyeglasses and Contacts<sup>6</sup></b>	Not covered				
Services NOT subject to deductible	<b>Preventive Exam</b>	No charge	No charge	\$15 copay	\$20 copay
	<b>Preventive Well-Child Care</b>	No charge	No charge	\$15 copay	\$20 copay
	<b>Preventive Screenings<sup>7</sup></b>	No charge	No charge	No charge	No charge
	<b>Immunizations</b>	No charge	No charge	No charge	No charge

This is a summary description and is not intended to replace the *Group Agreement and/or Evidence of Coverage*, which contain the complete provisions of this coverage. Some benefits may have specific limitations and/or exclusions. To obtain a Kaiser Permanente High Deductible Health Plan *Evidence of Coverage*, contact a marketing representative at 1-800-400-1907.

This Kaiser Permanente plan is a Health Savings Account (HSA) - compatible High Deductible Health Plan as defined by federal tax law. Enrollees may hold an HSA account with any financial institution of their choice.

<sup>1</sup>Deductible is embedded and applies to the plan Out-of-Pocket Maximum.

<sup>2</sup>Office visit copayment then 100 percent (deductible waived) for initial visit which establishes pregnancy. Follow-up (ante partum) visits not subject to copayment.

<sup>3</sup>Only when required by medical condition and transportation in any other vehicle would endanger health.

<sup>4</sup>Based on Kaiser Permanente drug formulary. Mail order 62-day supply included.

<sup>5</sup>Delta Dental PPO (Standard) is a preferred provider dental benefits program administered and underwritten by Delta Dental Plan of Ohio.

<sup>6</sup>Allowance toward the price of eyeglass lenses, frames, and/or contact lenses when prescribed by a Plan physician or optometrist and dispensed at a United Optical location every 24 months. Contact lens exam provided at an additional \$50 charge. OptumHealth Vision Care Allowance Program administered by Spectera, Inc.

<sup>7</sup>Includes preventive cervical, prostate, colorectal, and mammogram screenings.

# HMO Plans

	Option 1 Member pays	Option 7 Member pays	Option 11 Member pays	Option 12 Member pays	Option 13 Member pays
<b>Coinsurance</b>	None				
<b>Deductible</b> (single/family)	None				
<b>Out-of-Pocket Maximum</b> (single/family)	\$500/\$1,000	\$500/\$1,000	\$1,000/\$2,000	\$1,500/\$3,000	\$2,000/\$6,000
<b>Lifetime Maximum</b>	Unlimited				
<b>Office Visits<sup>1</sup></b> (Primary Care/Specialist)	\$15/\$25 copay	\$15/\$25 copay	\$10/\$20 copay	\$20/\$20 copay	\$25/\$35 copay
<b>Prenatal Office Visits<sup>2</sup></b>	No charge				
<b>Lab &amp; Radiology Services</b>	No charge				
<b>Urgent Care Services</b>	\$45 copay	\$45 copay	\$35 copay	\$35 copay	\$35 copay
<b>Ambulance Services<sup>3</sup></b>	No charge	No charge	\$50 copay	\$50 copay	\$50 copay
<b>Emergency Department Visits</b>	\$100 copay				
<b>Hospital Inpatient Care</b>	No charge	No charge	No charge	\$250 copay	\$500 copay
<b>Maternity Delivery</b>	No charge	No charge	No charge	\$250 copay	\$500 copay
<b>Prescription Drugs<sup>4</sup></b> (Generic/Brand)	\$10/\$35 copay*	\$10/\$35 copay*	\$10/\$35 copay*	\$15/\$40 copay*	\$20/\$45 copay*
<b>Durable Medical Equipment</b>	20%*				
<b>Chiropractic Services</b> (limited to 20 visits)	\$25 copay*	\$25 copay*	\$25 copay*	\$25 copay*	\$25 copay*
<b>Dental Plan<sup>5</sup></b> (preventive and palliative)	\$250 allowance per year*	Optional	Optional	Optional	Optional
<b>Vision Exam<sup>6</sup></b>	\$25 copay*	\$25 copay*	\$20 copay*	\$20 copay*	\$35 copay*
<b>Hardware Allowance for Eyeglasses and Contacts<sup>7</sup></b>	\$100 hardware allowance every 2 years*	Optional	Optional	Optional	Optional
<b>Extended Dependent Coverage</b>	Up to age 23, regardless of student status				

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\*Amount is not subject to nor does it apply to the Out-of-Pocket Maximum.

<sup>1</sup>Includes preventive adult physical exams and pediatric checkups.

<sup>2</sup>Office visit copayment then 100 percent (deductible waived) for initial visit which establishes pregnancy. Follow-up (ante partum) visits not subject to copayment.

<sup>3</sup>Only when required by medical condition and transportation in any other vehicle would endanger health.

<sup>4</sup>Based on Kaiser Permanente drug formulary. Mail order 62-day supply included.

<sup>5</sup>Delta Dental PPO (Standard) is a preferred provider dental benefits program administered and underwritten by Delta Dental Plan of Ohio.

<sup>6</sup>Vision exams provided by a Plan optometrist.

<sup>7</sup>Allowance toward the price of eyeglass lenses, frames, and/or contact lenses when prescribed by a Plan physician or optometrist and dispensed at a United Optical location every 24 months. Contact lens exam provided at an additional \$50 charge. OptumHealth

## Deductible HMO Plans

	Option 14 Member pays	Option 15 Member pays	Option 16 Member pays
<b>Coinsurance</b>		None	
<b>Deductible (single/family)</b>	\$2,000/\$6,000*	\$3,000/\$9,000*	\$1,100/\$2,200*
<b>Out-of-Pocket Maximum (single/family)</b>	\$500/\$1,000	\$1,000/\$2,000	\$750/\$1,500
<b>Lifetime Maximum</b>		Unlimited	
<b>Office Visits<sup>1</sup> (Primary Care/Specialist)</b>		\$25/\$40 copay	
<b>Preventive screenings<sup>1</sup></b>		No charge	
<b>Prenatal Office Visits<sup>2</sup></b>		No charge	
<b>Lab &amp; Radiology Services</b>		No charge after deductible is met	
<b>Urgent Care Services</b>		\$45 copay	
<b>Ambulance Services<sup>3</sup></b>		No charge after deductible is met	
<b>Emergency Department Visits</b>		\$150 copay	
<b>Hospital Inpatient Care</b>		\$250 copay after deductible is met	
<b>Maternity Delivery</b>		\$250 copay after deductible is met	
<b>Prescription Drugs<sup>4</sup> (Generic/Brand)</b>		\$15/\$40 copay*	
<b>Durable Medical Equipment</b>		20%*	
<b>Chiropractic Services (limited to 20 visits)</b>		\$25 copay*	
<b>Dental Plan<sup>5</sup> (preventive and palliative)</b>		Optional*	
<b>Vision Exam<sup>6</sup></b>		\$40 copay	
<b>Hardware Allowance for Eyeglasses and Contacts<sup>7</sup></b>		Optional*	
<b>Extended Dependent Coverage</b>		Up to age 23, regardless of student status	

This is a summary description and is not intended to replace the *Group Agreement* and/or *Evidence of Coverage*, which contain the complete provisions of this coverage. Some benefits may have specific limitations and/or exclusions. To obtain a Kaiser Permanente HMO Plan *Evidence of Coverage*, contact a marketing representative at 1-800-400-1907.

\*Amount is not subject to nor does it not apply to the Out-of-Pocket maximum.

<sup>1</sup>Includes preventive cervical, prostate, colorectal, and mammogram screenings.

<sup>2</sup>Office visit copayment then 100 percent (deductible waived) for initial visit which establishes pregnancy. Follow-up (ante partum) visits not subject to copayment.

<sup>3</sup>Only when required by medical condition and transportation in any other vehicle would endanger health.

<sup>4</sup>Based on Kaiser Permanente drug formulary. Mail order 62-day supply included.

<sup>5</sup>Delta Dental PPO (Standard) is a preferred provider dental benefits program administered and underwritten by Delta Dental Plan of Ohio.

<sup>6</sup>Vision exams provided by a Plan optometrist.

<sup>7</sup>Allowance toward the price of eyeglass lenses, frames, and/or contact lenses when prescribed by a Plan physician or optometrist and dispensed at a United Optical location every 24 months. Contact lens exam provided at an additional \$50 charge. OptumHealth Vision Care Allowance Program administered by Spectera, Inc.

Option 2 Member pays	Option 3 Member pays	Option 8 Member pays	Option 4 Member pays	Option 5 Member pays	Option 6 Member pays	Option 9 Member pays	Option 10 Member pays
	10%				20%		
None	None	\$250/\$500*	\$200/\$400*	\$200/\$400*	\$750/\$1,500*	\$500/\$1,000*	\$1,000/\$2,000*
	\$1,500/\$3,000		\$2,000/\$4,000	\$2,000/\$4,000	\$3,000/\$6,000	\$3,000/\$6,000	\$4,000/\$8,000
	Unlimited				Unlimited		
\$15/\$25 copay	\$20/\$30 copay	\$15/\$25 copay	\$15/\$25 copay	\$25/\$35 copay	\$30/\$40 copay	\$20/\$30 copay	\$25/\$35 copay
	No charge				No charge		
	No charge				No charge		
	10% after deductible is met				20% after deductible is met		
	\$45 copay				\$45 copay		
	10% after deductible is met				20% after deductible is met		
	10%				20%		
	10% after deductible is met				20% after deductible is met		
	10% after deductible is met				20% after deductible is met		
\$10/\$35 copay*	\$15/\$40 copay*	\$15/\$45 copay*	\$15/\$45 copay*	\$15/\$45 copay*	\$20/\$45 copay*	\$20/\$45 copay*	\$25/\$45 copay*
	20%*				20%*		
	\$25 copay*				\$25 copay*		
\$250 allowance per year*	Optional*	Optional*	\$250 allowance per year*	Optional*	Optional*	Optional*	Optional*
\$25 copay	\$30 copay	\$25 copay	\$25 copay	\$35 copay	\$40 copay	\$30 copay	\$35 copay
\$100 hardware allowance every 2 years*	Optional*	Optional*	\$100 hardware allowance every 2 years*	Optional*	Optional*	Optional*	Optional*
Up to age 23, regardless of student status			Up to age 23, regardless of student status				

# POS Plans

This is a summary description and is not intended to replace the Group Agreement and/or Evidence of Coverage (EOC), which contain the complete provisions of coverage. Some benefits may have specific limitations and/or exclusions. See the Kaiser Permanente HMO Plan and the Kaiser Permanente Insurance Company's (KPIC) Group Insurance Policy and Certificate of Insurance (COI) for complete details. To obtain a Kaiser Permanente HMO Plan EOC and the KPIC COI, contact a marketing representative at 1-800-400-1907.

The HMO Plan and the In-Network portion of the Point-of-Service (POS) Plans are underwritten by Kaiser Foundation Health Plan of Ohio. Kaiser Permanente Insurance Company (KPIC) underwrites Tiers 2 and 3 of the POS Plans. KPIC is a subsidiary of Kaiser Foundation Health Plans, Inc.

\*Amount is not subject to nor does it apply to the Out-of-Pocket Maximum.

<sup>1</sup>Office visit copayment, then 100 percent (deductible waived) for initial visit which establishes pregnancy. Follow-up (ante partum) visits not subject to copayments

<sup>2</sup>Office Visits limited to a combined maximum benefit of one routine visit per calendar year for Tiers 2 and 3.

<sup>3</sup>Well Child Visits limited to a \$500 combined Tier 2 and 3 benefit maximum per calendar year

<sup>4</sup>Includes preventive cervical, prostate, colorectal, and mammogram screenings.

<sup>5</sup>Only when required by medical condition and transportation in any other vehicle would endanger health. Limited to a \$1,000 maximum benefit per calendar year in Tiers 2 and 3.

<sup>6</sup>Limited to a combined \$2,000 maximum benefit per calendar year for Tiers 2 and 3.

	Option 1 Member may choose to seek care from Tier 1, 2, or 3 at any time.			Option 2 Member may choose to seek care from Tier 1, 2, or 3 at any time.		
	TIER 1 Member pays	TIER 2 Member pays	TIER 3 Member pays	TIER 1 Member pays	TIER 2 Member pays	TIER 3 Member pays
<b>Coinsurance</b>	None	20%	30%	None	30%	40%
<b>Deductible (single/family)</b>	None	\$200/\$400*	\$600/\$1,200*	None	\$300/\$600*	\$600/\$1,200*
<b>Out-of-Pocket Maximum (single/family)</b>	\$1,000/\$2,000	\$2,000/\$4,000	\$4,000/\$8,000	\$1,500/\$3,000	\$2,500/\$5,000	\$5,000/\$10,000
<b>Lifetime Maximum</b>	Unlimited	\$2,000,000		Unlimited	\$2,000,000	
<b>Office Visits (primary care/specialist)</b>	\$10/\$20 copay	\$10/\$30 copay <sup>†</sup>	30% after deductible	\$15/\$25 copay	\$15/\$35 copay <sup>†</sup>	40% after deductible
<b>Prenatal Office Visits<sup>1</sup></b>	No charge	No charge	30% after deductible	No charge	No charge	40% after deductible
<b>Preventive Office Visits<sup>2</sup></b>	\$10/\$20 copay	\$10/\$30 copay <sup>†</sup>	50% after deductible	\$15/\$25 copay	\$15/\$35 copay <sup>†</sup>	50% after deductible
<b>Well Child Visits<sup>3</sup></b>	\$10/\$20 copay	\$10/\$30 copay <sup>†</sup>	50% after deductible	\$15/\$25 copay	\$15/\$35 copay <sup>†</sup>	50% after deductible
<b>Preventive Screenings<sup>4</sup></b>	No charge	No charge	50% after deductible	No charge	No charge	50% after deductible
<b>Lab &amp; Radiology Services</b>	No charge	20% after deductible	30% after deductible	No charge	30% after deductible	40% after deductible
<b>Urgent Care</b>	\$35 copay	\$50 copay <sup>†</sup>	30% after deductible	\$35 copay	\$75 copay <sup>†</sup>	40% after deductible
<b>Ambulance Services<sup>5</sup></b>	\$50 copay	20% after deductible	30% after deductible	\$50 copay	30% after deductible	40% after deductible
<b>Emergency Services</b>	\$100 copay	Emergencies treated at providers in this tier are covered under the Tier 1 benefit level.		\$100 copay	Emergencies treated at providers in this tier are covered under the Tier 1 benefit level.	
<b>Non-emergent use of ER</b>	\$100 copay	20% after deductible	30% after deductible	\$100 copay	30% after deductible	40% after deductible
<b>Hospital Inpatient Care</b>	No charge	20% after deductible	30% after deductible	No charge	30% after deductible	40% after deductible
<b>Maternity Delivery</b>	No charge	20% after deductible	30% after deductible	No charge	30% after deductible	40% after deductible
<b>Durable Medical Equipment<sup>6</sup></b>	20%*	20% after deductible	30% after deductible	20%*	30% after deductible	40% after deductible
<b>Chiropractic Services (limited to 20 visits)</b>	\$25 copay*	20% after deductible	30% after deductible	\$25 copay*	30% after deductible	40% after deductible
<b>Prescription Drugs* (generic/brand)</b>	<b>Filled at KP and Affiliated Pharmacies:</b> <b>Formulary</b> \$10/\$35, mail order: 62-day supply \$10/\$35 <b>Non-formulary</b> \$15/\$40, mail order: 90-day supply \$30/\$80 <b>Filled at Participating MedImpact Pharmacies:</b> \$15/\$40			<b>Filled at KP and Affiliated Pharmacies:</b> <b>Formulary</b> \$10/\$35, mail order: 62-day supply \$10/\$35 <b>Non-formulary</b> \$20/\$40, mail order: 90-day supply \$40/\$80 <b>Filled at Participating MedImpact Pharmacies:</b> \$20/\$40		
<b>Extended Dependent Coverage</b>	Up to age 23, regardless of student status			Up to age 23, regardless of student status		

Option 3 Member may choose to seek care from Tier 1, 2, or 3 at any time.			Option 4 Member may choose to seek care from Tier 1, 2, or 3 at any time.			Option 5 Member may choose to seek care from Tier 1, 2, or 3 at any time.		
TIER 1 Member pays	TIER 2 Member pays	TIER 3 Member pays	TIER 1 Member pays	TIER 2 Member pays	TIER 3 Member pays	TIER 1 Member pays	TIER 2 Member pays	TIER 3 Member pays
None	20%	40%	None	30%	50%	None	20%	40%
None	\$400/\$800*	\$600/\$1,200*	None	\$500/\$1,000*	\$700/\$1,400*	None	\$500/\$1,000*	\$1,000/\$2,000*
\$1,500/\$3,000	\$2,000/\$4,000	\$4,000/\$8,000	\$2,000/\$6,000	\$3,000/\$6,000	\$5000/\$10,000	\$1,000/\$2,000	\$2,000/\$4,000	\$4,000/\$8,000
Unlimited	\$2,000,000		Unlimited	\$2,000,000		Unlimited	\$2,000,000	
\$20/\$20 copay	\$20/\$20 copay <sup>†</sup>	40% after deductible	\$20/\$25 copay	\$25/\$25 copay <sup>†</sup>	50% after deductible	\$20/\$25 copay	\$20/\$25 copay <sup>†</sup>	40% after deductible
No charge	No charge	40% after deductible	No charge	No charge	50% after deductible	No charge	No charge	40% after deductible
\$20/\$20 copay	\$20/\$20 copay <sup>†</sup>	50% after deductible	\$20/\$25 copay	\$25/\$25 copay <sup>†</sup>	50% after deductible	\$20/\$25 copay	\$20/\$25 copay <sup>†</sup>	50% after deductible
\$20/\$20 copay	\$20/\$20 copay <sup>†</sup>	50% after deductible	\$20/\$25 copay	\$25/\$25 copay <sup>†</sup>	50% after deductible	\$20/\$25 copay	\$20/\$25 copay <sup>†</sup>	50% after deductible
No charge	No charge	50% after deductible	No charge	No charge	50% after deductible	No charge	No charge	50% after deductible
No charge	20% after deductible	40% after deductible	No charge	30% after deductible	50% after deductible	No charge	20% after deductible	40% after deductible
\$35 copay	\$50 copay <sup>†</sup>	40% after deductible	\$35 copay	\$75 copay <sup>†</sup>	50% after deductible	\$35 copay	\$50 copay <sup>†</sup>	40% after deductible
\$50 copay	20% after deductible	40% after deductible	\$50 copay	30% after deductible	50% after deductible	\$50 copay	20% after deductible	40% after deductible
\$100 copay	Emergencies treated at providers in this tier are covered under the Tier 1 benefit level.		\$100 copay	Emergencies treated at providers in this tier are covered under the Tier 1 benefit level.		\$100 copay	Emergencies treated at providers in this tier are covered under the Tier 1 benefit level.	
\$100 copay	20% after deductible	40% after deductible	\$100 copay	30% after deductible	50% after deductible	\$100 copay	20% after deductible	40% after deductible
\$250 copay	20% after deductible	40% after deductible	\$250 copay	30% after deductible	50% after deductible	\$250 copay	20% after deductible	40% after deductible
\$250 copay	20% after deductible	40% after deductible	\$250 copay	30% after deductible	50% after deductible	\$250 copay	20% after deductible	40% after deductible
20%*	20% after deductible	40% after deductible	20%*	30% after deductible	50% after deductible	20%*	20% after deductible	40% after deductible
\$25 copay*	20% after deductible	40% after deductible	\$25 copay*	30% after deductible	50% after deductible	\$25 copay*	20% after deductible	40% after deductible
<b>Filled at KP and Affiliated Pharmacies:</b> <b>Formulary</b> \$15/\$40, mail order: 62-day supply \$15/\$40 <b>Non-formulary</b> \$30/\$50, mail order: 90-day supply \$60/\$100 <b>Filled at Participating MedImpact Pharmacies:</b> \$30/\$50			<b>Filled at KP and Affiliated Pharmacies:</b> <b>Formulary</b> \$15/\$40, mail order: 62-day supply \$15/\$40 <b>Non-formulary</b> \$30/\$50, mail order: 90-day supply \$60/\$100 <b>Filled at Participating MedImpact Pharmacies:</b> \$30/\$50			<b>Filled at KP and Affiliated Pharmacies:</b> <b>Formulary</b> \$15/\$40, mail order: 62-day supply \$15/\$40 <b>Non-formulary</b> \$30/\$50, mail order: 90-day supply \$30/\$100 <b>Filled at Participating MedImpact Pharmacies:</b> \$30/\$50		
Up to age 23, regardless of student status			Up to age 23, regardless of student status			Up to age 23, regardless of student status		

# POS Plans

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\*Amount is not subject to nor does it apply to the Out-of-Pocket Maximum.

<sup>1</sup>Office visit copayment, then 100 percent (deductible waived) for initial visit which establishes pregnancy. Follow-up (ante partum) visits not subject to copayments

<sup>2</sup>Office Visits limited to a combined maximum benefit of one routine visit per calendar year for Tiers 2 and 3.

<sup>3</sup>Well Child Visits limited to a \$500 combined Tier 2 and 3 benefit maximum per calendar year

<sup>4</sup>Includes preventive cervical, prostate, colorectal, and mammogram screenings.

<sup>5</sup>Only when required by medical condition and transportation in any other vehicle would endanger health. Limited to a \$1,000 maximum benefit per calendar year in Tiers 2 and 3.

<sup>6</sup>Limited to a combined \$2,000 maximum benefit per calendar year for Tiers 2 and 3.

	Option 6 Member may choose to seek care from Tier 1, 2, or 3 at any time.			Option 7 Member may choose to seek care from Tier 1, 2, or 3 at any time.		
	TIER 1 Member pays	TIER 2 Member pays	TIER 3 Member pays	TIER 1 Member pays	TIER 2 Member pays	TIER 3 Member pays
<b>Coinsurance</b>	None	30%	40%	None	10%	30%
<b>Deductible (single/family)</b>	None	\$1,000/\$2,000*	\$2,000/\$4,000*	None	\$200/\$400*	\$400/\$800*
<b>Out-of-Pocket Maximum (single/family)</b>	\$2,000/\$6,000	\$3,000/\$6,000	\$5,000/\$10,000	\$1,000/\$2,000	\$2,000/\$4,000	\$4,000/\$8,000
<b>Lifetime Maximum</b>	Unlimited	\$2,000,000		Unlimited	\$2,000,000	
<b>Office Visits (primary care/specialist)</b>	\$25/\$35 copay	\$25/\$35 copay	40% after deductible	\$10/\$20 copay	\$15/\$30 copay	30% after deductible
<b>Prenatal Office Visits<sup>1</sup></b>	No charge	No charge	40% after deductible	No charge	No charge	30% after deductible
<b>Preventive Office Visits<sup>2</sup></b>	\$25/\$35 copay	\$25/\$35 copay	50% after deductible	\$10/\$20 copay	\$15/\$30 copay	50% after deductible
<b>Well Child Visits<sup>3</sup></b>	\$25/\$35 copay	\$25/\$35 copay	50% after deductible	\$10/\$20 copay	\$15/\$30 copay	50% after deductible
<b>Preventive Screenings<sup>4</sup></b>	No charge	No charge	50% after deductible	No charge	No charge	50% after deductible
<b>Lab &amp; Radiology Services</b>	No charge	30% after deductible	40% after deductible	No charge	10% after deductible	30% after deductible
<b>Urgent Care</b>	\$35 copay	\$75 copay	40% after deductible	\$35 copay	\$50 copay	30% after deductible
<b>Ambulance Services<sup>5</sup></b>	\$50 copay	30% after deductible	40% after deductible	\$50 copay	10% after deductible	30% after deductible
<b>Emergency Services</b>	\$100 copay	Emergencies treated at providers in this tier are covered under the Tier 1 benefit level.		\$100 copay	Emergencies treated at providers in this tier are covered under the Tier 1 benefit level.	
<b>Non-emergent use of ER</b>	\$100 copay	30% after deductible	40% after deductible	\$100 copay	10% after deductible	30% after deductible
<b>Hospital Inpatient Care</b>	\$500 copay	30% after deductible	40% after deductible	No charge	10% after deductible	30% after deductible
<b>Maternity Delivery</b>	\$500 copay	30% after deductible	40% after deductible	No charge	10% after deductible	30% after deductible
<b>Durable Medical Equipment<sup>6</sup></b>	20%*	30% after deductible	40% after deductible	20%*	10% after deductible	30% after deductible
<b>Chiropractic Services (limited to 20 visits)</b>	\$25 copay*	30% after deductible	40% after deductible	\$25 copay*	10% after deductible	30% after deductible
<b>Prescription Drugs* (generic/brand)</b>	<b>Filled at KP and Affiliated Pharmacies:</b> <b>Formulary</b> \$20/\$45, mail order: 62-day supply \$20/\$45 <b>Non-formulary</b> \$30/\$50, mail order: 90-day supply \$60/\$100 <b>Filled at Participating MedImpact Pharmacies:</b> \$30/\$50			<b>Filled at KP and Affiliated Pharmacies:</b> <b>Formulary</b> \$10/\$35, mail order: 62-day supply \$10/\$35 <b>Non-formulary</b> \$15/\$40, mail order: 90-day supply \$30/\$80 <b>Filled at Participating MedImpact Pharmacies:</b> \$15/\$40		
<b>Extended Dependent Coverage</b>	Up to age 23, regardless of student status			Up to age 23, regardless of student status		

Option 11			Option 12			Option 13		
Member may choose to seek care from Tier 1, 2, or 3 at any time.			Member may choose to seek care from Tier 1, 2, or 3 at any time.			Member may choose to seek care from Tier 1, 2, or 3 at any time.		
TIER 1 Member pays	TIER 2 Member pays	TIER 3 Member pays	TIER 1 Member pays	TIER 2 Member pays	TIER 3 Member pays	TIER 1 Member pays	TIER 2 Member pays	TIER 3 Member pays
None	20%	50%	None	20%	50%	None	40%	50%
None	\$750/\$1,500*	\$1,500/\$3,000*	None	\$750/\$1,500*	\$1,500/\$3,000*	None	\$750/\$1,500*	\$1,500/\$3,000*
\$1,000/\$2,000	\$3,000/\$6,000	\$4,000/\$8,000	\$1,000/\$2,000	\$1,500/\$3,000	\$4,000/\$8,000	\$1,000/\$2,000	\$2,000/\$4,000	\$4,000/\$8,000
Unlimited	\$2,000,000		Unlimited	\$2,000,000		Unlimited	\$2,000,000	
\$20/\$40 copay	20% after deductible	50% after deductible	\$15/\$25 copay	20% after deductible	50% after deductible	\$15/\$25 copay	40% after deductible	50% after deductible
No charge	20% after deductible	50% after deductible	No charge	20% after deductible	50% after deductible	No charge	40% after deductible	50% after deductible
\$20/\$40 copay	20% after deductible	50% after deductible	\$15/\$25 copay	20% after deductible	50% after deductible	\$15/\$25 copay	40% after deductible	50% after deductible
\$20/\$40 copay	20% after deductible	50% after deductible	\$15/\$25 copay	20% after deductible	50% after deductible	\$15/\$25 copay	40% after deductible	50% after deductible
No charge	20% after deductible	50% after deductible	No charge	20% after deductible	50% after deductible	No charge	40% after deductible	50% after deductible
No charge	20% after deductible	50% after deductible	No charge	20% after deductible	50% after deductible	No charge	40% after deductible	50% after deductible
\$45 copay	20% after deductible	50% after deductible	\$45 copay	20% after deductible	50% after deductible	\$45 copay	40% after deductible	50% after deductible
\$50 copay	20% after deductible	50% after deductible	\$50 copay	20% after deductible	50% after deductible	\$50 copay	40% after deductible	50% after deductible
\$100 copay	Emergencies treated at providers in this tier are covered under the Tier 1 benefit level.		\$100 copay	Emergencies treated at providers in this tier are covered under the Tier 1 benefit level.		\$100 copay	Emergencies treated at providers in this tier are covered under the Tier 1 benefit level.	
\$100 copay	\$150, then 20% after deductible	\$150, then 50% after deductible	\$100 copay	\$150, then 20% after deductible	\$150, then 50% after deductible	\$100 copay	\$150, then 40% after deductible	\$150, then 50% after deductible
\$250 copay	20% after deductible	50% after deductible	\$500 copay	20% after deductible	50% after deductible	\$500 copay	40% after deductible	50% after deductible
\$250 copay	20% after deductible	50% after deductible	\$500 copay	20% after deductible	50% after deductible	\$500 copay	40% after deductible	50% after deductible
20%*	20% after deductible	50% after deductible	20%*	20% after deductible	50% after deductible	20%*	40% after deductible	50% after deductible
\$25 copay*	20% after deductible	50% after deductible	\$25 copay*	20% after deductible	50% after deductible	\$25 copay*	40% after deductible	50% after deductible
<b>Filled at KP and Affiliated Pharmacies:</b> <b>Formulary</b> \$15/\$40, mail order: 62-day supply \$15/\$40 <b>Non-formulary</b> \$30/\$50, mail order: 90-day supply \$60/\$100 <b>Filled at Participating MedImpact Pharmacies:</b> \$30/\$50			<b>Filled at KP and Affiliated Pharmacies:</b> <b>Formulary</b> \$15/\$40, mail order: 62-day supply \$15/\$40 <b>Non-formulary</b> \$30/\$50, mail order: 90-day supply \$60/\$100 <b>Filled at Participating MedImpact Pharmacies:</b> \$30/\$50			<b>Filled at KP and Affiliated Pharmacies:</b> <b>Formulary</b> \$15/\$40, mail order: 62-day supply \$15/\$40 <b>Non-formulary</b> \$30/\$50, mail order: 90-day supply \$60/\$100 <b>Filled at Participating MedImpact Pharmacies:</b> \$30/\$50		
Up to age 23, regardless of student status			Up to age 23, regardless of student status			Up to age 23, regardless of student status		

# Deductible POS Plans

	Option 8		
	Member may choose to seek care from Tier 1, 2, or 3 at any time.		
	TIER 1 Member pays	TIER 2 Member pays	TIER 3 Member pays
<b>Coinsurance</b>	10%	20%	30%
<b>Deductible (single/family)</b>	\$250/\$500*	\$500/\$1,000*	\$750/\$1,500*
<b>Out-of-Pocket Maximum (single/family)</b>	\$1,500/\$3,000	\$2,000/\$4,000	\$3,000/\$6,000
<b>Lifetime Maximum</b>	Unlimited	\$2,000,000	
<b>Office Visits (primary care/specialist)</b>	\$15/\$25 copay	\$15/\$30 copay <sup>†</sup>	30% after deductible
<b>Prenatal Office Visits<sup>1</sup></b>	No charge	No charge	30% after deductible
<b>Preventive Office Visits<sup>2</sup> (primary care/specialist)</b>	No charge	\$15/\$30 copay <sup>†</sup>	50% after deductible
<b>Well Child Visits<sup>3</sup> (primary care/specialist)</b>	No charge	\$15/\$30 copay <sup>†</sup>	50% after deductible
<b>Preventive Screenings<sup>4</sup></b>	No charge	20% after deductible	50% after deductible
<b>Lab &amp; Radiology Services</b>	10% after deductible	20% after deductible	30% after deductible
<b>Urgent Care</b>	\$45 copay	\$50 copay <sup>†</sup>	30% after deductible
<b>Ambulance Services<sup>5</sup></b>	10%	20% after deductible	30% after deductible
<b>Emergency Services</b>	10%	Emergencies treated at providers in this tier are covered under the Tier 1 benefit level.	
<b>Non-emergent use of ER</b>	10%	20% after deductible	30% after deductible
<b>Hospital Inpatient Care</b>	10% after deductible	20% after deductible	30% after deductible
<b>Maternity Delivery</b>	10% after deductible	20% after deductible	30% after deductible
<b>Durable Medical Equipment<sup>6</sup></b>	20%*	20% after deductible	30% after deductible
<b>Chiropractic Services (limited to 20 visits)</b>	\$25 copay*	20% after deductible	30% after deductible
<b>Prescription Drugs* (generic/brand)</b>	<b>Filled at KP and Affiliated Pharmacies:</b> <b>Formulary</b> \$15/\$45, mail order: 62-day supply \$15/\$45 <b>Non-formulary</b> \$30/\$50, mail order: 90-day supply \$60/\$100 <b>Filled at Participating MedImpact Pharmacies: \$30/\$50</b>		
<b>Extended Dependent Coverage</b>	Up to age 23, regardless of student status		

This is a summary description and is not intended to replace the Group Agreement and/or Evidence of Coverage (EOC), which contain the complete provisions of coverage. Some benefits may have specific limitations and/or exclusions. See the Kaiser Permanente HMO Plan and the Kaiser Permanente Insurance Company's (KPIC) Group Insurance Policy and Certificate of Insurance (COI) for complete details. To obtain a Kaiser Permanente HMO Plan EOC and the KPIC COI, contact a marketing representative at 1-800-400-1907.

The HMO Plan and the In-Network portion of the Point-of-Service (POS) Plans are underwritten by Kaiser Foundation Health Plan of Ohio. Kaiser Permanente Insurance Company (KPIC) underwrites Tiers 2 and 3 of the POS Plans. KPIC is a subsidiary of Kaiser Foundation Health Plans, Inc.

\*Amount is not subject to nor does it apply to the Out-of-Pocket Maximum.

†Copayments under Tier 2 are not subject to, nor do they contribute toward satisfaction of, the Calendar Year Deductible or Out-of-Pocket Maximum.

<sup>1</sup>Office visit copayment, then 100 percent (deductible waived) for initial visit which establishes pregnancy. Follow-up (ante partum) visits not subject to copayments

<sup>2</sup>Office Visits limited to a combined maximum benefit of one routine visit per calendar year for Tiers 2 and 3.

<sup>3</sup>Well Child Visits limited to a \$500 combined Tier 2 and 3 benefit maximum per calendar year

<sup>4</sup>Includes preventive cervical, prostate, colorectal, and mammogram screenings.

<sup>5</sup>Only when required by medical condition and transportation in any other vehicle would endanger health. Limited to a \$1,000 maximum benefit per calendar year in Tiers 2 and 3.

<sup>6</sup>Limited to a combined \$2,000 maximum benefit per calendar year for Tiers 2 and 3.

Option 9			Option 10			Option 14		
Member may choose to seek care from Tier 1, 2, or 3 at any time.			Member may choose to seek care from Tier 1, 2, or 3 at any time.			Member may choose to seek care from Tier 1, 2, or 3 at any time.		
TIER 1 Member pays	TIER 2 Member pays	TIER 3 Member pays	TIER 1 Member pays	TIER 2 Member pays	TIER 3 Member pays	TIER 1 Member pays	TIER 2 Member pays	TIER 3 Member pays
20%	30%	40%	20%	30%	50%	None	30%	50%
\$500/\$1,000*	\$750/\$1,500*	\$1,000/\$2,000*	\$750/\$1,500*	\$1,000/\$2,000*	\$1,500/\$3,000*	\$1,100/\$2,200*	\$1,500/\$3,000*	\$3,000/\$6,000*
\$3,000/\$6,000	\$3,000/\$6,000	\$4,000/\$8,000	\$3,000/\$6,000	\$4,000/\$8,000	\$5,000/\$10,000	\$750/\$1,500	\$1,000/\$2,000	\$5,000/\$10,000
Unlimited	\$2,000,000		Unlimited	\$2,000,000		Unlimited	\$2,000,000	
\$20/\$20 copay	\$20/\$20 copay <sup>†</sup>	40% after deductible	\$30/\$30 copay	\$30/\$30 copay <sup>†</sup>	50% after deductible	\$15/\$35 copay	\$20/\$50 copay <sup>†</sup>	50% after deductible
No charge	No charge	40% after deductible	No charge	No charge	50% after deductible	No charge	No charge	50% after deductible
No charge	\$20/\$20 copay <sup>†</sup>	50% after deductible	No charge	\$30/\$30 copay <sup>†</sup>	50% after deductible	No charge	\$20/\$50 copay <sup>†</sup>	50% after deductible
No charge	\$20/\$20 copay <sup>†</sup>	50% after deductible	No charge	\$30/\$30 copay <sup>†</sup>	50% after deductible	No charge	\$20/\$50 copay <sup>†</sup>	50% after deductible
No charge	30% after deductible	50% after deductible	No charge	30% after deductible	50% after deductible	No charge	30% after deductible	50% after deductible
20% after deductible	30% after deductible	40% after deductible	20% after deductible	30% after deductible	50% after deductible	No charge after deductible	30% after deductible	50% after deductible
\$45 copay	\$50 copay <sup>†</sup>	40% after deductible	\$45 copay	\$75 copay <sup>†</sup>	50% after deductible	\$45 copay	30% after deductible <sup>†</sup>	50% after deductible
20% after deductible	30% after deductible	40% after deductible	20% after deductible	30% after deductible	50% after deductible	No charge after deductible	30% after deductible	50% after deductible
20%	Emergencies treated at providers in this tier are covered under the Tier 1 benefit level.		20%	Emergencies treated at providers in this tier are covered under the Tier 1 benefit level.		\$150 copay	Emergencies treated at providers in this tier are covered under the Tier 1 benefit level.	
20%	30% after deductible	40% after deductible	20%	30% after deductible	50% after deductible	\$150 copay	\$150 copay, then 30% after deductible	\$150 copay, then 50% after deductible
20% after deductible	30% after deductible	40% after deductible	20% after deductible	30% after deductible	50% after deductible	\$250 copay, after deductible	30% after deductible	50% after deductible
20% after deductible	30% after deductible	40% after deductible	20% after deductible	30% after deductible	50% after deductible	\$250 copay, after deductible	30% after deductible	50% after deductible
20%*	30% after deductible	40% after deductible	20%*	30% after deductible	50% after deductible	20%*	30% after deductible	50% after deductible
\$25 copay*	30% after deductible	40% after deductible	\$25 copay*	30% after deductible	50% after deductible	\$25 copay*	30% after deductible	50% after deductible

**Filled at KP and Affiliated Pharmacies:**  
**Formulary** \$20/\$45, mail order: 62-day supply \$20/\$45  
**Non-formulary** \$30/\$60, mail order: 90-day supply \$60/\$120  
**Filled at Participating MedImpact Pharmacies:** \$30/\$60

**Filled at KP and Affiliated Pharmacies:**  
**Formulary** \$20/\$45, mail order: 62-day supply \$20/\$45  
**Non-formulary** \$30/\$60, mail order: 90-day supply \$60/\$120  
**Filled at Participating MedImpact Pharmacies:** \$30/\$60

**Filled at KP and Affiliated Pharmacies:**  
**Formulary** \$15/\$40, mail order: 62-day supply \$15/\$40  
**Non-formulary** \$30/\$50, mail order: 90-day supply \$60/\$100  
**Filled at Participating MedImpact Pharmacies:** \$30/\$50

Up to age 23, regardless of student status

Up to age 23, regardless of student status

Up to age 23, regardless of student status

