Medical – Kaiser Permanente

	KAISER TRAD PLAN	KAISER HDHP PLAN
	Kaiser In-Network	**Kaiser In-Network**
ANNUAL DEDUCTIBLE	$0 per individual $0 family limit	$3,200 per individual $6,400 family limit
ANNUAL OUT-OF-POCKET MAX	$600 per individual $1,200 family limit	$5,400 per individual $10,800 family limit
OFFICE VISIT	$10 copay then 100%	Plan pays 70% after deductible
PREVENTIVE SERVICES	Plan pays 100% (see contract for limitations)	Plan pays 100% (see contract for limitations)
CHIROPRACTIC CARE	$10 copay then 100% (up to 20 visits per year)	Not covered
LAB AND X-RAY	Plan pays 100%	Plan pays 70% after deductible
INPATIENT HOSPITALIZATION	Plan pays 100%	Plan pays 70% after deductible
OUTPATIENT SURGERY	$10 copay then 100%	Plan pays 70% after deductible
URGENT CARE	$30 copay then 100%	Plan pays 70% after deductible
EMERGENCY ROOM	$100 copay then 100% (copay waived if admitted)	Plan pays 70% after deductible
PRESCRIPTION DRUG DEDUCTIBLE	None	Prescriptions subject to medical plan deductible
PHARMACY (30 DAYS)		
GENERIC/PREFERRED/ NON-PREFERRED	$10/$20/$40	$20/$40/$60/($150 Specialty) copay after deductible
MAIL ORDER (90 DAYS)		
GENERIC/PREFERRED/ NON-PREFERRED	$20/$40/$80	$40/$80/$120 copay after deductible
VISION EXAMINATION		
UNDER AGE 19	$0 Copay (1 PCY)	Plan pays 70% after deductible (1 PCY)
AGE 19 & OVER	$10 Copay (1 PCY)	Plan pays 70% after deductible (1 PCY)
VISION HARDWARE		
UNDER AGE 19	Standard glasses or contact lenses; one pair PCY covered in full	Not Covered
AGE 19 & OVER	$150 Allowance every 2 calendar years	Not Covered

This is a brief summary of benefits and should be used for general comparison purposes only. Consult the Summary Plan Description (SPD) for complete and accurate information on the conditions, limitations, exclusions and coverage of benefits. In the event of a discrepancy, the SPD will prevail.