PPO PLANS

BENEFITS SUMMARY

KAISER PERMANENTE CHOICE SOLUTION
A *CHOICE* Administrators® Program

	PPO HSA 2200*	
MEDICAL BENEFITS	**Participating Network Providers**	**Non-Participating Network Providers**
	Member pays	Member pays
Deductible: Individual / Family	$2,200 / $4,400[1]	$3,200 / $6,400[1]
OFFICE VISITS	$40 after deductible	50% after deductible
LAB AND X-RAY – OUTPATIENT	30% after deductible	50% after deductible
HOSPITAL CARE	30% after deductible	50% ($600 Max per day) after deductible
Emergency Room	30% ($100 copay per visit) after deductible	30% ($100 copay per visit) after deductible
RX BENEFITS		
Prescription – Generic	$15 copay[7] after deductible (if obtained at participating pharmacies)	Not covered (if obtained at non-participating pharmacies)
Prescription – Brand	$35 copay[7] after deductible (if obtained at participating pharmacies)	Not covered (if obtained at non-participating pharmacies)
Prescription – Mail Order – Generic	2x the corresponding single copay per prescription, up to 100 day supply	Not covered (if obtained at non-participating pharmacies)
Prescription – Mail Order – Brand	2x the corresponding single copay per prescription, up to 100 day supply	Not covered (if obtained at non-participating pharmacies)
ADDITIONAL BENEFITS		
Maternity (Prenatal Care)	20% after deductible	50% after deductible
Annual Out-of-Pocket Maximum: Individual / Family	$4,000 / $8,000[2]	$8,000 / $16,000[2]
Maximum Benefit while insured	$5,000,000[3]	$5,000,000[3]
Outpatient Surgery	30% after deductible	50% ($400 Max. per procedure) after deductible
Home Health Care (up to 100 combined 2-hour visits per calendar year)	20% after deductible	20% after deductible
Skilled Nursing Facility Care (Up to 100 days per benefit period)	30% (combined Max. 60 visits per calendar year) after deductible	50% (combined Max. 60 visits per calendar year) after deductible
Ambulance Services	50%[6] after deductible	50%[6] after deductible
Mental Health Services		
In the Medical Office – Severe mental illness[8]	30% after deductible	50% after deductible
In the Hospital – Severe mental illness[8]	30% after deductible	50% ($600 Max per day) after deductible
In the Medical Office – All other covered mental illness (combined 20 days per calendar year)	30% after deductible	50% after deductible
In the Hospital – All other covered mental illness (combined 20 days per calendar year)	30% after deductible	50% ($175 max per day) after deductible
Chemical Dependency Services[11]		
In the Medical Office (combined 20 days per calendar year)	30% after deductible	50% after deductible
In the Hospital (combined 20 days per calendar year)	30% after deductible	50% after deductible

*HSA - Qualified High Deductible Health Plan

800.416.4395
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KAISER PERMANENTE®

KP5234B.4.08

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This chart only describes a summary of benefits. For a complete understanding of benefits, please read this summary in conjunction with the Kaiser Permanente Insurance Company Certificate of Insurance, which contains a complete explanation of benefits, exclusions, and limitations. The information provided in this chart is not intended for use as a Summary Plan Description, nor is it designed to serve as the Certificate of Insurance.

The PPO Insurance Plan is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, Inc.

Footnotes

(1) Calendar Year Deductible amounts are combined for services provided by Participating Providers and Non-Participating Providers. Deductibles do not count toward satisfying the Out-of-Pocket Maximum.

(2) Covered Charges incurred toward satisfaction of the Out-of-Pocket Maximum at the Non-Participating Providers tier will accumulate toward satisfaction of the Out-of-Pocket Maximum at the Participating Providers tier. Covered Charges incurred toward satisfaction of the Out-of-Pocket Maximum at the Participating Providers tier will not accumulate toward satisfaction of the Out-of-Pocket Maximum at the Non-Participating Providers tier.

(3) Maximum benefit amount while insured is combined for services provided by Participating Providers and Non-Participating Providers.

(4) Per admission inpatient deductibles do not contribute toward the Calendar Year Deductible or the Out-of-Pocket Maximum.

(5) Exempt from deductibles.

(6) The Participating Provider Network does not contract for ambulance coverage. Therefore, medically necessary non-emergency ambulance service is payable at the Non-Participating Providers level. Non-emergency ambulance coverage is limited to a maximum of $2,000 per calendar year for all KPIC-covered services.

(7) MedCare Pharmacy copays are not subject to, nor do they contribute toward satisfaction of, the Calendar Year Deductible or the Out-of-Pocket Maximum. Select prescription drugs are excluded from this coverage.

(8) Severe Mental Illness is limited to the following: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

(9) Benefits for treatment of other covered mental illnesses and alcohol and drug dependency are limited to 20 inpatient days per calendar year combined for both Participating Providers and Non-Participating Providers.

(10) Benefits for treatment of other covered mental illnesses and alcohol and drug dependency are limited to 20 outpatient days per calendar year combined for both Participating Providers and Non-Participating Providers.

(11) In addition to the specified day and visit limit noted above, benefits payable for treatment of alcohol and drug dependency are subject to a combined limit of $10,000 per calendar year and $25,000 lifetime for services provided by Participating Providers and Non-Participating Providers.

(12) Combined maximum deductibles of $50 per calendar year.

Participating Providers and Non-Participating Providers exclusions and limitations

Unless specifically covered under the Group Policy, expenses incurred in connection with the following services are excluded: Charges, services, or care that are provided or reimbursed by Kaiser Foundation Health Plan, Inc. (KFHP); not medically necessary; in excess of the Maximum Allowable Charge; not available in the United States; for personal comfort; not completed in accordance with the Physician's orders. Emergency Department facility fees or charges for nonemergency weekend (Friday through Sunday) hospital admissions. Charges arising from work or that can be covered under workers' compensation or any similar law, or for which the Group Policyholder or Member is required by law to maintain alternative insurance or coverage. Charges for military service related conditions or where care is provided at government expense. Services or care provided in a Member's home, by a family member, or by a resident of the household. Dental care and dental X-rays, appliances, or orthodontia, including surgery on the jawbone, unless due to injury to natural teeth. Cosmetic services; plastic surgery; sex transformation; sexual dysfunction; surrogacy arrangements; biotechnology drugs or diagnostics; nonprescription drugs or medicines; treatment, procedures, or drugs Kaiser Permanente Insurance Company (KPIC) determines to be experimental or investigational. Education, counseling, therapy, or care for learning deficiencies or behavioral problems. Services, care, or treatment of or in connection with obesity or weight management. Services, care, or treatment of or in connection with craniomandibular or temporomandibular joint disorders, unless for medically necessary surgical treatment of the disorder. Services, care, or treatment of or in connection with musculoskeletal therapy; health education; biofeedback; hypnotherapy; routine adult physical exams; immunizations; medical social services; hearing exams, aids, or therapy; radial keratotomy or similar procedures; reversal of sterilization; or routine foot care. Services or care required by a court of law or for insurance, travel, employment, school, camp, government licensing, or similar purposes. Transplants, including donor costs. Custodial care; care in an intermediate care facility; maintenance therapy for rehabilitation; or living or transportation expenses. Treatment of mental illness; substance abuse. Services or supplies necessary to treat an injury to which a contributing cause was a Member's: commission of or attempt to commit a felony; engagement in an illegal occupation; intoxication or being under the influence of a narcotic, unless administered by a Physician. Services of a private-duty nurse. Vision care, including routine exams, eye refractions, orthoptics, glasses, contact lenses, or fittings. Drugs and medicines for the purpose of smoking cessation. Extended well-child care for children ages 17–18. Services for which no charge is normally made in the absence of insurance.