

Benefit	Kaiser Permanente Added Choice-Triple Option Plan 220/T007			
	Kaiser Permanente HMO Plan 220	Kaiser Permanente HMO In Plan	PHCS In-Network	Indemnity Out of Network
Annual Deductible <i>Individual</i> <i>Family</i>	No Deductible No Deductible	No Deductible No Deductible	\$500 \$1,500 No Cross Accumulation	\$600 \$1,800 No Cross Accumulation
Out of Pocket Max <i>Individual</i> <i>Family</i>	\$2,000 \$4,500	\$2,000 \$4,500	\$4,000 \$12,000 No Cross Accumulation	\$7,000 \$21,000 No Cross Accumulation
Life Time Max	Unlimited	Unlimited	\$1,000,000	
Covered Providers	CPMG	CPMG	PHCS	All Licensed Providers
Routine OVC	\$25 copayment	\$25 copayment	\$30 copayment	50% coinsurance
Specialty OVC	\$35 copayment	\$35 copayment	\$40 copayment	
Preventive Care	\$25 copayment	\$25 copayment	\$30 copayment	50% coinsurance
Maternity <i>Prenatal Care</i> <i>Inpatient Hospital</i>	\$25 copayment \$500 copayment per admit	\$25 copayment \$500 copayment per admit	\$30 copayment 30% coinsurance	50% coinsurance 50% coinsurance
Prescription Drugs Mail-Order	\$15 generic/\$30 brand for 30-day supply \$30 generic/\$60 brand for 90-day supply	\$15 generic/\$30 brand for 30-day supply \$30 generic/\$60 brand for 90-day supply	\$25 generic/\$35 brand for 30-day supply \$50 generic/\$70 brand for 90-day supply MedImpact	\$25 generic/\$35 brand for 30-day supply \$50 generic/\$70 brand for 90-day supply Non-MedImpact
Inpatient Hospital	\$500 copayment per admit	\$500 copayment per admit	30% coinsurance	50% coinsurance
Outpatient / Ambulatory Surgery	\$350 copayment	\$350 copayment	30% coinsurance	50% coinsurance
Laboratory & X-ray	100% covered	100% covered	30% coinsurance	50% coinsurance
Therapeutic X-ray	\$35 copayment per visit	\$35 copayment per visit	30% coinsurance	50% coinsurance
MRI/CAT/PET	\$100 per procedure	\$100 per procedure	30% coinsurance	50% coinsurance
Emergency Care	\$150 copayment	\$150 copayment	Covered as In-Network Benefit	Covered as In-Network Benefit
Ambulance	20% to max of \$500/trip	20% to max of \$500/trip	Covered as In-Network Benefit	Covered as In-Network Benefit
Urgent/Non routine/After Hours Care	\$50 copayment	\$50 copayment	30% coinsurance	50% coinsurance
Mental Health <i>Inpatient Hospital</i> <i>Outpatient Care</i>	\$500 copayment per admit \$25 copayment per visit	\$500 copayment per admit \$25 copayment per visit	30% coinsurance \$30 copayment	50% coinsurance 50% coinsurance
Alcohol & Substance Abuse <i>Inpatient Hospital</i> <i>Outpatient Care</i>	\$500 copayment per admit \$25 copayment per visit	\$500 copayment per admit \$25 copayment per visit	30% coinsurance \$30 copayment	Covered under Network Tiers Covered under Network Tiers
Physical, Occupational & Speech Therapy	\$500 copayment per admit Outpatient: \$25 copayment / 20 visits	\$500 copayment per admit Outpatient: \$25 copayment / 20 visits	30% coinsurance	50% coinsurance
Supplemental DME	KP pays 80% up to \$2,000	KP pays 80% up to \$2,000	Covered under HMO Plan Only	Covered under HMO Plan Only
Basic DME	KP pays 80% - no annual maximum	KP pays 80% - no annual maximum	KP pays 80% - no annual maximum	KP pays 80% - no annual maximum
Oxygen	20% coinsurance	20% coinsurance	Covered under HMO Plan Only	Covered under HMO Plan Only
Organ Transplant	\$500 copayment per admit	\$500 copayment per admit	Covered under HMO Plan Only	Covered under HMO Plan Only
Home Health Care	100% covered	100% covered	30% coinsurance	50% coinsurance
Hospice Care	100% covered	100% covered	60 visits per year combined	
Skilled Nursing Facility	100% covered / 100 Days	100% covered / 100 Days	30% coinsurance	50% coinsurance
Vision Care	\$25 copayment/exam only Hardware not covered	\$25 copayment/exam only Hardware not covered	Covered under Network Tiers	Covered under Network Tiers
Chiropractic Care	Not covered	Not covered	Covered under HMO Plan Only	Covered under HMO Plan Only
Referral Required	No	No	\$40 copay/20 visits year Yes	Not covered Yes

