

PLAN FINDER FOR DEDUCTIBLE PLANS

Use this Plan Finder to help find a plan that best suits your lifestyle and financial needs.

I WANT **lower** monthly rates and a **fixed copayment** for preventive care services. I'm willing to have a deductible and pay for most services when I actually need them.

DEDUCTIBLE PLANS

Lower monthly rate
Higher out-of-pocket costs

Higher monthly rate
Moderate out-of-pocket costs

\$1,500 Deductible Plan

- Annual out-of-pocket maximum: \$3,500/individual or \$7,000/family
- Medical calendar-year deductible: \$1,500/individual or \$3,000/family
- Preventive care office visit:¹ \$30 per visit
- Nonpreventive office visit: \$30 per visit after deductible
- Most lab and X-rays: \$10 per encounter after deductible
- Hospital care: \$500 per day after deductible
- Emergency services: \$100 per visit after deductible
- Prescription drugs:
 - \$10 generic
 - \$35 brand after \$250 pharmacy deductible
- Chiropractic office visit: \$15 per visit (not subject to deductible)

\$500 Deductible Plan

- Annual out-of-pocket maximum: \$2,500/individual or \$5,000/family
- Medical calendar-year deductible: \$500/individual or \$1,000/family
- Preventive care office visit:¹ \$20 per visit
- Nonpreventive office visit: \$20 per visit after deductible
- Most lab and X-rays: \$10 per encounter after deductible
- Hospital care: \$100 per day after deductible
- Emergency services: \$100 per visit after deductible
- Prescription drugs:
 - \$10 generic
 - \$35 brand after \$250 pharmacy deductible

¹Preventive care office visits are not subject to the deductible. Preventive care services include well-child visits from 0 to 23 months, scheduled prenatal care, and vaccines (immunizations).

DEDUCTIBLE PLANS – FEATURES AT A GLANCE

This is a summary of the most frequently asked-about benefits and their copayments and coinsurance. Detailed information about your plan is included in the *Membership Agreement*, which will be mailed to you upon acceptance.

FEATURES	\$1,500 DEDUCTIBLE PLAN	\$500 DEDUCTIBLE PLAN
Medical calendar-year deductible		
Individual	\$1,500	\$500
Family	\$3,000	\$1,000
Pharmacy calendar-year deductible	\$250 for brand-name drugs	\$250 for brand-name drugs
Annual out-of-pocket maximum		
Individual	\$3,500	\$2,500
Family	\$7,000	\$5,000
Lifetime benefit maximum	None	None
PROFESSIONAL SERVICES (PLAN PROVIDER OFFICE VISITS)		
Primary and specialty care visits (includes routine and urgent care appointments)	\$30 per visit after deductible	\$20 per visit after deductible
Well-child visits from 0 to 23 months	\$30 per visit ¹	No charge ¹
Family planning visits	\$30 per visit ¹	\$20 per visit ¹
Scheduled prenatal care and first postpartum visit	\$30 per visit ¹	No charge ¹
Eye exams	\$30 per visit ¹	\$20 per visit ¹
Hearing tests	\$30 per visit ¹	\$20 per visit ¹
Chiropractic office visits	\$15 per visit (up to 20 visits per calendar year; not subject to deductible) ²	Not covered
Physical, occupational, and speech therapy visits	\$30 per visit after deductible	\$20 per visit after deductible
OUTPATIENT SERVICES		
Outpatient surgery	\$250 per procedure after deductible	\$50 per procedure after deductible
Allergy injection visits	\$5 per visit after deductible	\$5 per visit after deductible
Vaccines (immunizations)	No charge ¹	No charge ¹
Most X-rays and lab tests	\$10 per encounter after deductible	\$10 per encounter after deductible
Health education		
Individual visits	\$30 per visit ¹	\$20 per visit ¹
Group visits	No charge ¹	No charge ¹
HOSPITALIZATION SERVICES		
Room and board, surgery, anesthesia, X-rays, lab tests, and medications	\$500 per day after deductible	\$100 per day after deductible
EMERGENCY HEALTH COVERAGE		
Emergency Department visits	\$100 per visit after deductible (\$100 copayment is waived if admitted directly to the hospital)	\$100 per visit after deductible (\$100 copayment is waived if admitted directly to the hospital)
AMBULANCE SERVICES		
Emergency ambulance services	\$150 per trip after deductible	\$75 per trip after deductible

¹These services are not subject to the deductible.

²When prescribed by an American Specialty Health (ASH) Plans practicing chiropractor and authorized by ASH Plans

DEDUCTIBLE PLANS – FEATURES AT A GLANCE

FEATURES	\$1,500 DEDUCTIBLE PLAN	\$500 DEDUCTIBLE PLAN
PRESCRIPTION DRUG COVERAGE		
Covered items in accord with our drug formulary when obtained at Plan pharmacies	Brand-name items and compounded products are subject to a \$250 drug deductible; see the “Outpatient Prescription Drugs, Supplies, and Supplements” section of the <i>Membership Agreement</i> for details.	Brand-name items and compounded products are subject to a \$250 drug deductible; see the “Outpatient Prescription Drugs, Supplies, and Supplements” section of the <i>Membership Agreement</i> for details.
Generic drugs	\$10 up to a 100-day supply	\$10 up to a 100-day supply
Brand-name drugs	\$35 up to a 100-day supply after \$250 drug deductible	\$35 up to a 100-day supply after \$250 drug deductible
DURABLE MEDICAL EQUIPMENT (DME)		
DME used in the home in accord with our DME formulary	Not covered	20% coinsurance up to a \$2,000 calendar-year benefit limit ¹
MENTAL HEALTH SERVICES		
Inpatient psychiatric care	\$500 per day after deductible (up to 10 days per calendar year)	\$100 per day after deductible (up to 30 days per calendar year)
Outpatient visits		
Individual visits	\$30 per visit after deductible (up to a total of 10 individual/group visits per calendar year)	\$20 per visit after deductible (up to a total of 20 individual/group visits per calendar year)
Group therapy visits	\$15 per visit after deductible (up to a total of 10 individual/group visits per calendar year) Up to 30 additional group therapy visits that meet Medical Group criteria in the same calendar year	\$10 per visit after deductible (up to a total of 20 individual/group visits per calendar year) Up to 20 additional group therapy visits that meet Medical Group criteria in the same calendar year
Note: Visit and day limits do not apply to severe mental illness and serious emotional disturbances of children as described in the “Benefits, Deductibles, Copayments, and Coinsurance” section of the <i>Membership Agreement</i> .		
CHEMICAL DEPENDENCY SERVICES		
Inpatient detoxification	\$500 per day after deductible	\$100 per day after deductible
Outpatient individual therapy visits	\$30 per visit after deductible	\$20 per visit after deductible
Outpatient group therapy visits	\$5 per visit after deductible	\$5 per visit after deductible
Transitional residential recovery services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	\$100 per admission after deductible	\$100 per admission after deductible
HOME HEALTH SERVICES		
Home health care (up to 100 two-hour visits per calendar year)	No charge ¹	No charge ¹
OTHER		
Skilled nursing facility care	\$50 per day after deductible (up to 60 days per benefit period)	No charge after deductible (up to 100 days per benefit period)
Hospice care	No charge ¹	No charge ¹

¹These services are not subject to the deductible.

DEDUCTIBLE PLANS – MONTHLY RATES AT A GLANCE

Rate Area 1

The monthly rate you pay for your coverage depends on your age, which Kaiser Permanente rate area you live in based on your ZIP code, and how many family members are covered.¹ If you add dependents, drop dependents, or move to a new residence and change ZIP codes, your monthly rate may change.²

Please verify that you have received the booklet for the appropriate rate area by confirming that the subscriber's home ZIP code is listed under **Rate Area 1** of the ZIP code service area chart on the back cover of this booklet. If the subscriber's home ZIP code is not listed there, please contact our Member Service Call Center at **1-800-464-4000** for information on other rate areas.

Monthly rates for \$1,500 Deductible Plan

Use the age of the younger subscriber or spouse.¹

Category Age	Subscriber only	Subscriber + spouse	Subscriber + one child	Subscriber + two or more children	Subscriber, spouse + one or more children
19–24	\$96	\$197	\$187	\$268	\$321
25–29	\$109	\$214	\$195	\$268	\$321
30–34	\$137	\$278	\$231	\$328	\$414
35–39	\$154	\$300	\$249	\$328	\$414
40–44	\$200	\$398	\$306	\$427	\$582
45–49	\$230	\$468	\$347	\$427	\$582
50–54	\$311	\$609	\$430	\$527	\$727
55–59	\$311	\$609	\$430	\$568	\$747
60–64	\$373	\$730	\$523	\$623	\$810
65+ ⁴	\$959	\$1,918	\$1,343	\$1,817	\$2,222

Monthly child-only rates³

One child, up to age 18	\$89
Two children, up to age 18	\$178
Three or more children, up to age 18	\$255

Monthly rates for \$500 Deductible Plan

Use the age of the younger subscriber or spouse.¹

Category Age	Subscriber only	Subscriber + spouse	Subscriber + one child	Subscriber + two or more children	Subscriber, spouse + one or more children
19–24	\$186	\$405	\$371	\$554	\$638
25–29	\$210	\$431	\$371	\$583	\$732
30–34	\$234	\$475	\$431	\$615	\$829
35–39	\$251	\$525	\$431	\$651	\$829
40–44	\$282	\$575	\$442	\$681	\$842
45–49	\$310	\$603	\$474	\$689	\$842
50–54	\$357	\$720	\$529	\$712	\$931
55–59	\$409	\$797	\$577	\$749	\$931
60–64	\$454	\$908	\$614	\$860	\$1,052
65+ ⁴	\$959	\$1,918	\$1,343	\$1,817	\$2,222

Monthly child-only rates³

One child, up to age 18	\$160
Two children, up to age 18	\$320
Three or more children, up to age 18	\$515

Rates are effective through December 31, 2007. To be eligible for coverage, you must pass a medical review.

¹Rates are based on the age of the younger spouse. For example, if one person is 44 and the other is 39, your household's rate would be based on age 39.

²If your change results in a different premium amount, the new amount becomes effective the first month following your change.

³Rates are for child(ren) up to age 18 as of January 1 of each year.

⁴If you are eligible for Medicare, you may qualify for lower monthly rates under Kaiser Permanente Senior Advantage.

Please call **1-800-290-3829** for more information.