FlourishPlan™

KAISER PERMANENTE®

HMO Benefits and Services

	High	Mid	Low
Coinsurance	100%	90%	90%
Deductible (single/family)	none	$300/$600	$400/$800
Out-of-Pocket Maximum (single/family)	$1000/ $2000	$1500/ $3000	$1500/ $3000
Lifetime Maximum	unlimited	unlimited	unlimited
Hospital Inpatient Care	$150 copay	90% after deductible	90% after deductible
Emergency Department Visits	$100 copay	90%	$110 copay
Ambulance Services[1]	$50 copay	90% after deductible	90% after deductible
Maternity Delivery	$150 copay	90% after deductible	90% after deductible
Office Visits PCP	$10 copay	$20 copay	$25 copay
Office Visits SCP	$10 copay	$20 copay	$25 copay
Preventive Lab and Radiology	no charge	90% after deductible	90% after deductible
Prenatal Office Visits[2]	no charge	no charge	no charge
Diagnostics Services Lab, Radiology	no charge	90% after deductible	90% after deductible
Urgent Care Services	$45 copay	$45 copay	$45 copay
Prescription Drugs[3] **– (generic/brand)**	$15/$25 copay	$15/$30 copay	$20/$40 copay
Durable Medical Equipment	80%	80%	80%
Vision Exam	$10 copay	$20 copay	$25 copay
Chiropractic Services (limited to 20 visits)	Not Covered	Not Covered	Not Covered
Extended Dependent Coverage	Up to age 23	Up to age 23	Up to age 23

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.

[1]Only when required by medical condition and transportation in any other vehicle would endanger health.

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

[3]Based on Kaiser Permanente drug formulary. Mail order 62-day supply included.

KAISER PERMANENTE®

Added Choice® POS Benefits and Services

	Option A1	Member may choose to seek care from Tier 1, 2, or 3 at any time.		Option A2	Member may choose to seek care from Tier 1, 2, or 3 at any time.		Option A3	Member may choose to seek care from Tier 1, 2, or 3 at any time.	
	TIER 1	**TIER 2**	**TIER 3**	**TIER 1**	**TIER 2**	**TIER 3**	**TIER 1**	**TIER 2**	**TIER 3**
Coinsurance	100%	80%	70%	90%	80%	70%	90%	80%	70%
Deductible (single/family)	none	$250/$500	$600/$1200	$300/$600	$500/$1000	$750/$1500	$400/$800	$750/$1500	$1000/$2000
Out-of-Pocket Maximum (single/family)	$1000/$2000	$2000/$4000	$4000/$8000	$1500/$3000	$2000/$4000	$3000/$6000	$1500/$3000	$2000/$4000	$3000/$6000
Lifetime Maximum	unlimited	$2,000,000		unlimited	$2,000,000		unlimited	$2,000,000	
Office Visits	$10 copay PCP $10 copay SCP	$10 copay PCP $30 copay SCP deductible waived	70% after deductible	$20 copay PCP $20 copay SCP	$20 copay PCP $35 copay SCP deductible waived	70% after deductible	$25 copay PCP $25 copay SCP	$25 copay PCP $45 copay SCP deductible waived	70% after deductible
Prenatal Office Visits[1]	no charge	no charge	70% after deductible	no charge	no charge	70% after deductible	no charge	no charge	70% after deductible
Preventive Lab and Radiology	no charge	no charge	50% after deductible	90% after deductible	80% after deductible	50% after deductible	90% after deductible	80% after deductible	50% after deductible
Diagnostic Services Lab, Radiology	no charge	80% after deductible	70% after deductible	90% after deductible	80% after deductible	70% after deductible	90% after deductible	80% after deductible	70% after deductible
Hospital Inpatient Care	$150 copay	80% after deductible	70% after deductible	90% after deductible	80% after deductible	70% after deductible	90% after deductible	80% after deductible	70% after deductible
Urgent Care	$45 copay	$50 copay	70% after deductible	$45 copay	$75 copay	70% after deductible	$45 copay	$75 copay	70% after deductible
Emergency Department Visits	$100 copay	covered under Tier 1	covered under Tier 1	90%	covered under Tier 1	covered under Tier 1	$110 copay	covered under Tier 1	covered under Tier 1
Ambulance Services[2]	$50 copay	80% after deductible	70% after deductible	90% after deductible	80% after deductible	70% after deductible	90% after deductible	80% after deductible	70% after deductible
Maternity Delivery	$150 copay	80% after deductible	70% after deductible	90% after deductible	80% after deductible	70% after deductible	90% after deductible	80% after deductible	70% after deductible
Chiropractic Services (limited to 20 visits)	Not Covered	80% after deductible	70% after deductible	Not Covered	80% after deductible	70% after deductible	Not Covered	80% after deductible	70% after deductible
Extended Dependent Coverage		Up to age 23			Up to age 23			Up to age 23	
Durable Medical Equipment	80%	80%	70%	80%	80%	70%	80%	80%	70%
Vision Exam	$10 copay	Covered Under Tier 1		$20 copay	Covered Under Tier 1		$25 copay	Covered Under Tier 1	
	Prescription drugs (generic/brand) – formulary[3] $15/$25 copay at Kaiser Permanente Pharmacy **Non-formulary (generic/brand)**[4] – $20/$30 copay (mail order: 90 day supply of maintenance drugs 2x copay)			**Prescription drugs (generic/brand)** – formulary[3] $15/$30 copay at Kaiser Permanente Pharmacy **Non-formulary (generic/brand)**[4] – $20/$40 copay (mail order: 90 day supply of maintenance drugs 2x copay)			**Prescription drugs (generic/brand)** – formulary[3] $20/$40 copay at Kaiser Permanente Pharmacy **Non-formulary (generic/brand)**[4] – $30/$40 copay (mail order: 90 day supply of maintenance drugs 2x copay)		

For Added Choice® POS exclusions see back cover

FlourishPlan™

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.

[1]Office visit copayment, then 100 percent, with deductible waived, for initial visit which establishes pregnancy. Follow-up (antepartum) visits not subject to copayment.

[2]Only when required by medical condition and transportation in any other vehicle would endanger health. Limited to a combined $1,000 maximum benefit per calendar year on Tier 2 and Tier 3.

[3]Kaiser Permanente and Affiliated Tier I pharmacies. Based on Kaiser Permanente drug formulary. Mail order 62-day supply included.

[4]MedImpact Network Pharmacies.

Coinsurance is based on Maximum Allowable Charge (MAC). MAC = the lesser of the Negotiated Rate, the Usual, Customary, and Reasonable Charge or the Actual Billed Charge. Member is responsible for any charges that exceed MAC for out-of-network services.

Important information
Written information on topics related to coverage offered to employer groups in the small group market is available and can be obtained by calling 1-877-284-7483.

Topics include:
1. Factors that affect rate setting and rate adjustments.
2. Provisions related to renewing coverage.
3. Plan designs and premium available to small groups.

Note: POS plans do not include a pre-existing condition clause.

KAISER PERMANENTE®

70614