

COPAYMENT PLANS – FEATURES AT A GLANCE

Here's an overview of our benefits and associated copayments and coinsurance for our copayment plan options, intended to help you compare coverage benefits. It is only a summary. Upon acceptance, you will receive an *Evidence of Coverage*, which includes detailed information on coverage, limits, exclusions, and out-of-pocket maximums.

FEATURES	PLAN 20/20	PLAN 25/100
Annual out-of-pocket maximum Individual/Family	\$2,000/\$6,000	\$2,000/\$6,000
Annual deductible Individual/Family	None	None
Lifetime maximum	None	None
OUTPATIENT CARE (including PREVENTIVE SERVICES)⁴		
Primary office visits including:⁵ Physical exams, well-child care, hearing tests, and minor surgery	\$20 per visit	\$25 per visit
Specialty office visits (including allergy testing)	\$45 per visit	\$45 per visit
Allergy treatment	No charge	No charge
Radiation therapy	\$20 per visit	\$25 per visit
Short-term physical, speech, and occupational therapy	\$20 per visit (up to 20 visits per therapy per calendar year)	\$25 per visit (up to 20 visits per therapy per calendar year)
Outpatient surgery	\$100 per visit	\$250 per visit
Laboratory and diagnostic tests, X-rays Most immunizations and respiratory therapy	No charge	No charge
Urgent care services at Kaiser Permanente facilities	\$45 per visit	\$45 per visit
VISION COVERAGE (See page 6 for more information.)		
Annual eye exams for eyeglasses Provided by Spectera®, Inc., at United Optical stores and affiliated community providers listed in our provider directory ⁶	\$45 per visit	\$45 per visit
Contact lens exams (at United Optical stores only)	\$50 per visit	\$50 per visit
Hardware allowance Member receives (toward the cost of eyeglass lenses, frames, and/or contact lenses when prescribed by a Plan physician or optometrist and dispensed at a United Optical location only)	\$100 allowance once every 24 months	\$100 allowance once every 24 months
HOSPITAL INPATIENT CARE		
No limits on covered days, including: Physician and surgeon services; room and board, anesthesia, operating and recovery rooms; laboratory and diagnostic tests, X-rays; drugs, dressings, casts; respiratory and radiation therapy	\$500 per admission	\$500 per admission
Maternity care⁷ Physician and hospital services, delivery, and normal nursery care (Separate charges will apply to the mother and the newborn.)	\$500 per admission	\$500 per admission

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FEATURES	PLAN 20/20	PLAN 25/100
PRESCRIPTION DRUGS⁸		
Covered formulary drugs and accessories Up to a 31-day supply at Kaiser Permanente and affiliated network pharmacies	\$20 generic or \$35 brand (when generic is not available) per prescription	\$100 deductible, then \$25 copay per prescription for generic or brand (when generic is not available). Costs apply to deductible only when a Kaiser Permanente or contracted network pharmacy is used. ⁹
	Up to a 62-day supply of maintenance drugs for the cost of one copay through the Kaiser Permanente Direct Mail Pharmacy	Up to a 62-day supply of maintenance drugs for the cost of one copay through the Kaiser Permanente Direct Mail Pharmacy (applies only after deductible is met)
Infertility drugs	Not covered	Not covered
MENTAL HEALTH SERVICES		
Outpatient care (up to 20 visits per calendar year)	\$45 per visit	Not covered
Inpatient care (up to 30 days of hospital care per calendar year)	\$500 per admission	Not covered
EMERGENCY SERVICES		
Emergency services at a Plan or non-Plan facility	\$75 per visit, copay waived if admitted	\$100 per visit, copay waived if admitted
Ambulance service (only when your condition requires the use of medical services and supplies that only a licensed ambulance can provide and the use of other means of transportation would endanger your health)	\$100 per trip	\$100 per trip
CHEMICAL DEPENDENCY SERVICES		
Outpatient detoxification, individual therapy	\$45 per visit	Not covered
Group therapy	\$5 per visit, maximum \$5 per day	Not covered
Inpatient care in a specialized facility Medical detoxification (one admission per member per calendar year)	\$500 per admission	Not covered
Inpatient care in a general hospital Medical detoxification (unlimited)	\$500 per admission	\$500 per admission
ALTERNATIVE CARE		
Extended care in a skilled nursing facility	No charge up to 100 days per calendar year	No charge; Kaiser Permanente pays up to \$5,000 maximum benefit per calendar year
Hospice/Respite care and home health services	No charge	No charge
ADDITIONAL BENEFITS		
Infertility services After diagnosis, all covered medical and hospital services including lab, X-rays, and artificial insemination associated with the treatment of involuntary infertility	30% of eligible charges	30% of eligible charges
Dependent coverage	To age 23, end of birth month	To age 23, end of birth month
DENTAL PLAN THROUGH DELTA DENTAL OF OHIO (See page 7 for more information.)		
Preventive dental plan services, including:¹⁰ Diagnostic and preventive services; emergency and palliative treatment; radiographs/X-rays	30% copayment (\$250 maximum benefit per member, per calendar year)	30% copayment (\$250 maximum benefit per member, per calendar year)

For footnotes, see page 5.

DEDUCTIBLE PLANS – FEATURES AT A GLANCE

Here's an overview of our benefits and associated copayments and coinsurance for our deductible plan options, intended to help you compare coverage benefits. It is only a summary. Upon acceptance, you will receive an *Evidence of Coverage*, which includes detailed information on coverage, limits, exclusions, out-of-pocket maximums, and deductibles.

FEATURES	PLAN 500/1000	PLAN 750/1500	PLAN 1000/2000
Annual out-of-pocket maximum Individual/Family	\$3,000/\$6,000	\$3,000/\$6,000	\$4,000/\$8,000
Annual deductible Individual/Family	\$500/\$1,000	\$750/\$1,500	\$1,000/\$2,000
Lifetime maximum	None	None	None
OUTPATIENT CARE (including PREVENTIVE SERVICES)			
Primary office visits including⁵ Physical exams, well-child care, hearing tests, and minor surgery	\$15 per visit	\$25 per visit	\$25 per visit
Specialty office visits (including allergy testing)	\$15 per visit	\$25 per visit	\$25 per visit
Allergy treatment	No charge	No charge	No charge
Radiation therapy	20% of eligible charges after deductible	20% of eligible charges after deductible	20% of eligible charges after deductible
Short-term physical, speech, and occupational therapy	20% of eligible charges after deductible (up to 10 visits per therapy per calendar year)	20% of eligible charges after deductible (up to 10 visits per therapy per calendar year)	20% of eligible charges after deductible (up to 10 visits per therapy per calendar year)
Outpatient surgery	20% of eligible charges after deductible	20% of eligible charges after deductible	20% of eligible charges after deductible
Laboratory and diagnostic tests, X-rays Most immunizations and respiratory therapy	20% of eligible charges after deductible	20% of eligible charges after deductible	20% of eligible charges after deductible
Urgent care services at Kaiser Permanente facilities	\$45 per visit	\$45 per visit	\$45 per visit
VISION COVERAGE (See page 6 for more information.)			
Annual eye exams for eyeglasses Provided by Spectera®, Inc., at United Optical stores and affiliated community providers listed in our provider directory ⁶	\$15 per visit	\$25 per visit	\$25 per visit
Contact lens exams At United Optical stores only	\$50 per visit	\$50 per visit	\$50 per visit
Hardware allowance Member receives (toward the cost of eyeglass lenses, frames, and/or contact lenses when prescribed by a	\$100 allowance once every 24 months	\$100 allowance once every 24 months	\$100 allowance once every 24 months
		Plan physician or optometrist and dispensed at a United Optical location only)	
HOSPITAL INPATIENT CARE			
No limits on covered days, including: Physician and surgeon services; room and board, anesthesia, operating and recovery rooms; laboratory and diagnostic tests, X-rays; drugs, dressings, casts; respiratory and radiation therapy	20% of eligible charges after deductible	20% of eligible charges after deductible	20% of eligible charges after deductible
Maternity care⁷ Physician and hospital services, delivery, and normal nursery care (Separate charges will apply to the mother and the newborn.)	20% of eligible charges after deductible	20% of eligible charges after deductible	20% of eligible charges after deductible

DEDUCTIBLE PLANS – FEATURES AT A GLANCE

FEATURES	PLAN 500/1000	PLAN 750/1500	PLAN 1000/2000
PRESCRIPTION DRUGS⁸			
Covered formulary drugs and accessories Up to a 31-day supply at Kaiser Permanente and affiliated network pharmacies	\$15 generic or \$30 brand (when generic is not available) per prescription \$2,000 maximum per member, per calendar year	\$15 generic or \$30 brand (when generic is not available) per prescription \$2,000 maximum per member, per calendar year	\$15 generic or \$30 brand (when generic is not available) per prescription \$1,500 maximum per member, per calendar year
	Up to a 62-day supply of maintenance drugs for the cost of one copay through the Kaiser Permanente Direct Mail Pharmacy	Up to a 62-day supply of maintenance drugs for the cost of one copay through the Kaiser Permanente Direct Mail Pharmacy	Up to a 62-day supply of maintenance drugs for the cost of one copay through the Kaiser Permanente Direct Mail Pharmacy
Infertility drugs	Not covered	Not covered	Not covered
MENTAL HEALTH SERVICES			
Outpatient care (up to 20 visits per calendar year)	Not covered	Not covered	Not covered
Inpatient care (up to 30 days of hospital care per calendar year)	Not covered	Not covered	Not covered
EMERGENCY SERVICES			
Emergency services at a Plan or non-Plan facility	\$110 per visit, copay waived if admitted	\$110 per visit, copay waived if admitted	\$110 per visit, copay waived if admitted
Ambulance service (only when your condition requires the use of medical services and supplies that only a licensed ambulance can provide and the use of other means of transportation would endanger your health)	\$100 per trip, after deductible	\$100 per trip, after deductible	\$100 per trip, after deductible
CHEMICAL DEPENDENCY SERVICES			
Outpatient detoxification, individual therapy	Not covered	Not covered	Not covered
Group therapy	Not covered	Not covered	Not covered
Inpatient care in a specialized facility Medical detoxification (one admission per member per calendar year)	Not covered	Not covered	Not covered
Inpatient care in a general hospital Medical detoxification (unlimited)	20% of eligible charges after deductible	20% of eligible charges after deductible	20% of eligible charges after deductible
ALTERNATIVE CARE			
Extended care in a skilled nursing facility	20% of eligible charges after deductible; Kaiser Permanente pays up to \$5,000 maximum benefit per calendar year	20% of eligible charges after deductible; Kaiser Permanente pays up to \$5,000 maximum benefit per calendar year	20% of eligible charges after deductible; Kaiser Permanente pays up to \$5,000 maximum benefit per calendar year
Hospice/Respite care and home health services	No charge	No charge	No charge
ADDITIONAL BENEFITS			
Infertility services After diagnosis, all covered medical and hospital services including lab, X-rays, and artificial insemination associated with the treatment of involuntary infertility	30% of eligible charges after deductible; 30% of outpatient charges (not subject to deductible)	30% of eligible charges after deductible; 30% of outpatient charges (not subject to deductible)	30% of eligible charges after deductible; 30% of outpatient charges (not subject to deductible)
Dependent coverage	To age 23, end of birth month	To age 23, end of birth month	To age 23, end of birth month
DENTAL PLAN THROUGH DELTA DENTAL OF OHIO (See page 7 for more information.)			
Preventive dental plan services, including:¹⁰ Diagnostic and preventive services; emergency and palliative treatment; radiographs/X-rays	30% copayment (\$250 maximum benefit per member, per calendar year)	30% copayment (\$250 maximum benefit per member, per calendar year)	30% copayment (\$250 maximum benefit per member, per calendar year)

For footnotes, see page 5.

Footnotes

⁴Member cost sharing is dependent on where the service is rendered and who performs the service (primary care or specialty care provider).

⁵Direct access for women's health services. Please note that a referral is not required for obstetrics/gynecology services. However, you must seek care from an Ob/Gyn specialist affiliated with your primary care physician. Contact Kaiser Permanente's Customer Relations department at **1-800-686-7100** to verify affiliation.

⁶Our contract with Spectera[®], Inc., is in effect as of the date of this publication. Vision coverage is a benefit in these plans. It is not optional.

⁷Up to 48 hours for routine delivery; up to 96 hours for cesarean delivery

⁸Kaiser Foundation Health Plan of Ohio uses a drug formulary. The medications included in the Kaiser Permanente drug formulary are chosen by a group of Kaiser Permanente physicians, pharmacists, and nurses known as the Pharmacy and Therapeutics Committee. This committee meets regularly to evaluate and choose those medications that are effective, safe, and useful in caring for our members. Nonformulary drugs may be approved for coverage if certain criteria are met.

Not all Kaiser Permanente health benefit plans include coverage for prescription drugs. Some drugs may be excluded from coverage. Some plans have limitations on the dollar amount of coverage. Some medications may have quantity restrictions limiting the amount of the drug you can receive per prescription or copayment. Coverage of certain formulary medications may also be subject to restrictions established by the Pharmacy and Therapeutics Committee.

For more information regarding our prescription drug benefit procedures or your benefit, please call Customer Relations at **216-621-7100** or **1-800-686-7100** or visit **members.kp.org** to view the Kaiser Permanente drug formulary.

⁹Prescription deductible applies to each member.

¹⁰Benefit levels and copayments are based on the Delta Dental PPO program underwritten and administered by Delta Dental of Ohio. Dental services do not count toward medical deductibles or out-of-pocket maximums. For complete plan details, refer to the *Certificate of Coverage*, which will be mailed to you from Delta Dental of Ohio upon enrollment in the plan. Participation in the dental plan is not optional for Plan members of Kaiser Permanente for Individuals and Families.

Note: These summaries of benefits contain highlights only. They are not contracts. Specific benefits, exclusions, and limitations are contained in the *Evidence of Coverage* you will receive. For specific questions about coverage, please call a Kaiser Permanente Customer Relations representative at **216-621-7100** or **1-800-686-7100**.

Benefits are effective January 1, 2007, through December 31, 2007. As of January 1, 2008, these benefits may change.

VISION COVERAGE

Your vision is an important part of your overall health. Whether or not your vision is 20/20, you should receive regular vision checkups. That's why we're pleased to offer you vision coverage as part of our commitment to your total well-being.¹

Our vision coverage provides affordable, quality vision care through the United Optical provider network. With this program, you will receive complete eye examinations for only the cost of your Kaiser Permanente for Individuals and Families plan copayment.

VISION BENEFIT

Vision coverage is a benefit of all our copayment and deductible plans. It is not optional.

VISION HARDWARE ALLOWANCE

As a Kaiser Permanente for Individuals and Families plan member with vision coverage, you are eligible for a retail hardware allowance of \$100 every 24 months along with your vision hardware discounts (ranging from 20 percent to 50 percent off retail prices). The allowance can be used toward eyeglass lenses, frames, or contact lenses when prescribed by a Plan physician or Plan optometrist at a United Optical location.

The 24-month period begins at the initial point of sale for each member. Any unused portion of the coverage allowance at the point of sale is not available to be used at a later time. If you use your allowance to purchase frames, we also cover mounting of eyeglass lenses in the frames, original fitting of the frames, and subsequent adjustment.

To use this allowance, you must obtain your vision hardware, including lenses, frames, or contact lenses, from a United Optical dispenser at any United Optical location. This does not apply to eye exams, which may be obtained at locations other than United Optical.

CONTACT LENSES

A contact lens examination is provided every 12 months upon payment of a \$50 charge by the member. Follow-up visits are provided at no additional charge. Your \$100 allowance can be used toward this examination charge and the purchase of contact lenses.

You also have the option to use \$78 of your retail hardware allowance to purchase the Contact Lens Package, which includes an evaluation, fitting, two follow-up visits, and up to two boxes of disposable contact lenses. The remaining balance of your allowance can be used to purchase additional contact lenses or other hardware accessories.

If you have a change in prescription of at least 0.50 diopter within 12 months of your initial exam, we will provide an allowance of

- \$60 toward the price of a single vision or contact lens, or
- \$90 toward the price of multifocal lenses for the affected eye(s) without requiring you to wait 24 months. The replacement lens must be for the same product type as your original order.

OUT-OF-NETWORK BENEFIT

Under this plan, there is no out-of-network benefit. In order to take advantage of your vision coverage, you must obtain services from a convenient United Optical location.

EXCLUSIONS

The following services and materials are excluded from coverage under the policy:

- Industrial and athletic safety frames
- Eyeglass lenses and contact lenses with no refractive value
- Replacement of lost, broken, or damaged lenses, frames, and contact lenses
- Lens adornment, such as engraving, faceting, or jewellery
- Low-vision devices
- Nonprescription products, such as eyeglass holders, eyeglass cases, and repair kits
- Nonprescription sunglasses
- Coverage for lenses, frames, and/or contact lenses if we have paid for these items in the previous 24 months of membership under your membership contract, unless the prescription changes as described above

¹Vision benefits are administered by Spectera®, Inc. Upon acceptance, you will receive an *Evidence of Coverage*, which includes complete coverage details.

DELTA DENTAL OF OHIO

In order to better suit your health care needs, we've arranged with Delta Dental of Ohio to provide you with a preventive dental plan.

COVERED SERVICES – CLASS I BENEFITS ¹	PLAN PAYS	YOU PAY
Diagnostic and preventive services ²	70%	30%
Emergency and palliative treatment ³	70%	30%
Radiographs – X-rays	70%	30%

The Delta Dental PPO is a preferred provider program that can reduce your out-of-pocket expenses if you receive care from one of the many PPO dentists.⁴ For covered services provided by a participating PPO dentist, you pay your applicable copayment. Delta Dental of Ohio will then pay the remaining amount subject to the limitations and exclusions as covered in the *Certificate of Coverage*, which will be mailed to you from Delta Dental of Ohio upon acceptance.

- Oral exams, prophylaxes (cleanings), and fluoride treatment (to age 19) are payable twice per calendar year.
- Bitewing X-rays are payable once per calendar year, and full-mouth X-rays are payable once in any five-year period.

In addition to these savings possibilities, this program gives you the following major advantages in selecting a dentist:

- It's flexible. You can choose any dentist from the Delta Dental of Ohio network of PPO dentists whenever you wish. Delta Dental of Ohio will even help you find a PPO dentist near you. All you need to do is contact Delta Dental of Ohio at **1-800-524-0149**, or go online at **deltadentaloh.com**.

You may send your claims to:
Delta Dental of Ohio
P.O. Box 9085
Farmington Hills, MI 48333-9085

- It offers you freedom. You and your eligible dependents are not required to use the same dentist. Each family member can have a different PPO dentist, if desired.
- It's easy to use. You are not required to stay with your PPO dentist for a certain length of time. You can change dentists whenever you like.

COVERAGE FOR NON-PPO DENTISTS

If you choose to see a dentist who is not a PPO member, you're still covered! You'll be responsible for paying the difference between the covered reimbursement of Delta Dental of Ohio (to your non-PPO dentist) and the dentist's total fee. You'll also be responsible for your copayment, coinsurance, and/or deductible for covered services.

¹The benefit year is January 1, 2007, through December 31, 2007. The maximum payment is \$250 per member total per benefit year on Class I benefits.

²Used to diagnose and/or prevent dental abnormalities or disease (includes exams, cleanings, and fluoride treatments)

³Used to temporarily relieve pain

⁴Benefit levels and copayments are based on the Delta Dental PPO program underwritten and administered by Delta Dental of Ohio. Dental services do not count toward medical deductibles or out-of-pocket maximums. For complete plan details, refer to the *Certificate of Coverage*, which will be mailed to you from Delta Dental of Ohio upon enrollment in the plan. Participation in the dental plan is not optional for Plan members of Kaiser Permanente for Individuals and Families.