

# Kaiser Health Plan Comparison 2011- 2012

MGMT/CONF SEIU ROP	Kaiser Permanente			
	High Plan Package 1 (Traditional SCOE High Plan)	High Plan Package 2	MID Plan (Deductible HMO)	High Deductible Plan with Health Savings Acct
Calendar Year Deductible (Ind / Fam)	None	None	\$500 / \$1,000	\$1,250 / \$2,500
Annual Out of Pocket Max (Ind / Fam)	\$1,500 / \$3,000	\$1,500 / \$3,000	\$3,000 / \$6,000	\$3,000 / \$6,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
<b>Hospital Services</b>				
All Inpatient Services	\$250 per admit	\$500 per admit	20% coinsurance after Deductible	\$250 per admission after Deductible
Out Patient Services	\$10 per Surgery	\$20 per Surgery	20% coinsurance after Deductible	\$150 per surgery after Deductible
<b>Physician Services</b>				
Physician Office Visit	\$10 per visit	\$20 per visit	\$20 copay NOT subject to Deductible	\$20 copay after Deductible
Specialist Visit	\$10 per visit	\$20 per visit	\$20 copay NOT subject to Deductible	\$20 copay after Deductible
Preventive Care	\$10 per visit	\$20 per visit	\$20 copay NOT subject to Deductible	\$20 copay NOT subject to Deductible
Allergy Testing & Treatment	\$10 per visit	\$20 per visit	\$20 copay NOT subject to Deductible	\$20 copay after Deductible
Diagnostic X-Ray and Lab	No charge	No charge	\$10 copay after Deductible	\$10 copay after Deductible
<b>Ambulance Service</b>	\$50 per trip	\$50 per trip	\$150 per trip after Deductible	\$100 per trip after Deductible
<b>Emergency</b> (waived if admitted)	\$50 per visit, waived if admitted	\$50 per visit, waived if admitted	20% coinsurance after Deductible	\$100 per visit after Deductible
<b>Chiropractic</b> (thru American Specialty Health)	\$15 per visit / 20 visits per calendar yr	\$15 per visit / 20 visits per calendar yr	\$15 per visit / 20 visits per calendar yr	Not covered
<b>Durable Medical Equipment</b>	No charge	No charge	20% coinsurance NOT subject to Deductible	20% coinsurance after Deductible
<b>Hospice</b>	No Charge	No Charge	No Charge NOT subject to Deductible	No Charge after Deductible
<b>Physical Therapy</b>	\$10 per visit	\$20 per visit	\$20 per visit after Deductible	\$20 per visit after Deductible
<b>Skilled Nursing Facility Care</b>	No Charge (100 days/cal. year)	No Charge (100 days/cal. year)	20% coinsurance (100 days/cal year)	\$250 per admit after Deductible (100 days/cal. year)
<b>Prescription Drugs</b>	\$10 generic/ \$20 brand for up to 100-day supply	\$10 generic/ \$25 brand for up to 100-day supply	\$10 generic/ \$30 brand for a 100 day supply	<b>Subject to Plan Deductible then copay below:</b> \$10 / \$30 (30 day supply) \$20 / \$60 (60 day supply) \$30 / \$90 (100 day supply)
<b>MONTHLY RATE</b>				
<b>Refer to the Monthly Rate Sheet for the Employee Share of cost</b>				
<b>Single</b>	\$589.53	\$568.93	\$474.99	\$369.64
<b>Employee + 1 Dependent</b>	\$1,267.47	\$1,223.18	\$1,021.23	\$794.74
<b>Family</b>	\$1,739.09	\$1,678.33	\$1,401.23	\$1,090.45

No significant changes in covered benefits for plan year.

This is a brief plan comparison. Refer to plan materials for specific coverage benefits. Plan materials will prevail over any discrepancies in this brief comparison.