

# Kaiser Health Plan Comparison 2010-2011

<b>SEIU</b>		<b>Kaiser Permanente</b>			
		<b>High Plan Package 1 (Traditional SCOE High Plan)</b>	<b>High Plan Package 2 (Not previously offered)</b>	<b>MID Plan (Deductible HMO)</b>	<b>High Deductible Plan with Health Savings Acct</b>
<b>Calendar Year Deductible</b>	(Ind / Fam)	None	None	\$500 / \$1,000	\$1,250 / \$2,500
<b>Annual Out of Pocket Max</b>	(Ind / Fam)	\$1,500 / \$3,000	\$1,500 / \$3,000	\$3,000 / \$6,000	\$3,000 / \$6,000
<b>Lifetime Maximum</b>		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>Acupuncture</b>		Not covered	Not covered	Not covered	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>	\$506.54	\$488.84	\$408.16	\$317.51
	<b>Employee + 1 Dependent</b>	\$1,089.06	\$1,051.02	\$877.55	\$682.65
	<b>Family</b>	\$1,494.29	\$1,442.10	\$1,204.08	\$936.66

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.