

## MEDICAL BENEFITS - KAISER

	Low Option HMO	High Option HMO
<b>Medical Plan</b>		
Annual Deductible	None	None
Lifetime Maximum	None	None
Annual Co-Pay Maximum	\$1,500 individual, \$3,000 family	\$1,500 individual, \$3,000 family
<b>Hospital Care</b>		
Inpatient	\$500	\$100
Outpatient	\$20 copay	15 copay
Emergency Room (Copay waived if admitted)	\$100 copay No coverage for non-emergency	\$100 copay No coverage for non-emergency
Urgent Care	\$20 copay	\$15 copay
Skilled Nursing	No copay, 100 days/year	No copay, 100 days/year
<b>Physician Care</b>		
Office Visits	\$20 copay	\$15 copay
Specialist Visits	\$20 copay	\$15 copay
Periodic Health Evaluation	\$20 copay	\$15 copay
X-Ray & Lab Services	No charge	No charge
Outpatient Rehabilitation Therapy	\$20 copay	\$15 copay
Immunizations	No charge	No charge
Home Health Care Services	No copay, 100 visits / year	No copay, 100 visits / year
Chiropractic	Not Covered	Not Covered
Prosthetics/Orthotics	No charge, requires MD prescription	No charge, requires MD prescription
Durable Medical Equipment	No charge	No charge
Acupuncture	\$20 copay, as directed by primary MD	\$15 copay, as directed by primary MD
<b>Mental Health</b>		
Severe Disorders-Inpatient	\$500 copay, 30 day max. per calendar year for certain diagnoses	\$100 copay, 30 day max. per calendar year for certain diagnoses
Severe Disorders-Outpatient	\$20 copay individual, \$10 group visits, 20 visit limit per year for certain diagnoses	\$15 copay individual, \$7 group visits, 20 visit limit per year for certain diagnoses
Non-Severe Disorders-Inpatient	\$500 copay, 30 day max. per calendar year for certain diagnoses	\$100 copay, 30 day max. per calendar year for certain diagnoses
Non-Severe Disorders-Outpatient	\$20 copay individual, \$10 group visits, 20 visit limit per year for certain diagnoses	\$15 copay individual, \$7 group visits, 20 visit limit per year for certain diagnoses
Chem. Dependency Rehab-Outpatient	\$15 copay individual, \$5 group visits, no visit limit	\$20 copay individual, \$10 group visits, no visit limit
Detoxification-Inpatient (Detoxification only)	\$500 copay, Transitional Residential Recovery Service benefit available	\$100 copay, Transitional Residential Recovery Service benefit available
<b>Prescription Drugs</b>		
Retail: Generic/Brand	\$10 / \$35 copay	\$10 / \$30 copay
Mail Order: Generic/Brand	\$10 / \$35 copay, 100 day supply	\$10 / \$30 copay, 100 day supply
<b>Vision</b>		
Screening (Routine Preventive performed by PCP, excludes refractions)	\$20 copay	\$15 copay
Eyewear (Lens, Frame)	Not covered	Not covered