

HSA-QUALIFIED PLANS—MONTHLY RATES AT A GLANCE

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Plan 2500/5000

Category Age ¹	Single		Family of 2		Family of 3+	
	Male	Female	Male	Female	Male	Female
18	\$61.93	\$92.71	\$211.55	\$211.55	\$317.32	\$317.32
19-24	\$77.44	\$130.87	\$259.41	\$259.41	\$362.31	\$362.31
25-29	\$84.72	\$128.60	\$258.14	\$258.14	\$356.26	\$356.26
30-34	\$92.13	\$138.76	\$245.94	\$245.94	\$348.10	\$348.10
35-39	\$108.32	\$167.18	\$273.82	\$273.82	\$398.58	\$398.58
40-44	\$131.95	\$200.36	\$328.20	\$328.20	\$481.13	\$481.13
45-49	\$159.46	\$201.24	\$345.98	\$391.47	\$502.86	\$596.26
50-54	\$190.27	\$215.09	\$376.52	\$387.28	\$573.65	\$575.21
55-59	\$230.46	\$222.70	\$454.06	\$420.85	\$696.48	\$630.86
60-64	\$301.29	\$267.80	\$595.38	\$517.41	\$887.96	\$764.04
65+ ²	\$385.04	\$331.51	\$764.61	\$659.42	\$1,149.84	\$989.21

Plan 5000/10000

Category Age ¹	Single		Family of 2		Family of 3+	
	Male	Female	Male	Female	Male	Female
18	\$46.93	\$70.26	\$160.32	\$160.32	\$240.47	\$240.47
19-24	\$58.68	\$99.18	\$196.59	\$196.59	\$274.57	\$274.57
25-29	\$64.20	\$97.46	\$195.62	\$195.62	\$269.98	\$269.98
30-34	\$69.82	\$105.16	\$186.38	\$186.38	\$263.80	\$263.80
35-39	\$82.09	\$126.69	\$207.51	\$207.51	\$302.06	\$302.06
40-44	\$100.00	\$151.84	\$248.71	\$248.71	\$364.61	\$364.61
45-49	\$120.84	\$152.50	\$262.19	\$296.67	\$381.08	\$451.86
50-54	\$144.19	\$163.00	\$285.34	\$293.49	\$434.72	\$435.91
55-59	\$174.65	\$168.77	\$344.10	\$318.93	\$527.81	\$478.08
60-64	\$228.32	\$202.95	\$451.19	\$392.11	\$672.91	\$579.01
65+ ²	\$291.79	\$251.23	\$579.44	\$499.73	\$871.38	\$749.65



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HSA EXPLANATION AND BROCHURE

For footnotes, see page 30.

HSA-QUALIFIED PLANS – FEATURES AT A GLANCE

Here's an overview of our benefits and associated copayments and coinsurance for our HSA-qualified 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 2500/5000	PLAN 5000/10000
Annual out-of-pocket maximum Individual/Family	\$2,500/\$5,000	\$5,000/\$10,000
Annual deductible Individual/Family	\$2,500/\$5,000	\$5,000/\$10,000
Lifetime maximum	None	None
OUTPATIENT CARE		
Primary office visits including: ⁵ Physical exams, well-child care, hearing tests, and minor surgery	No charge after deductible	No charge after deductible
Specialty office visits (including allergy testing)	No charge after deductible	No charge after deductible
Allergy treatment	No charge after deductible	No charge after deductible
Radiation therapy	No charge after deductible	No charge after deductible
Prenatal care	No charge after deductible	No charge after deductible
Short-term physical, speech, and occupational therapy	No charge after deductible	Not covered
Outpatient surgery	No charge after deductible	No charge after deductible
Laboratory and diagnostic tests, X-rays Immunizations for travel and respiratory therapy	No charge after deductible	No charge after deductible
Urgent care services at Kaiser Permanente facilities	No charge after deductible	No charge after deductible
PREVENTIVE CARE		
Preventive exams	\$15 per visit, not subject to deductible	\$15 per visit, not subject to deductible
Preventive well-child exams	\$15 per visit, not subject to deductible	\$15 per visit, not subject to deductible
Preventive lab and X-rays	No charge, not subject to deductible	No charge, not subject to deductible
General immunizations	No charge, not subject to deductible	No charge, not subject to deductible
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	No charge after deductible	No charge after deductible
Maternity care ⁷ Physician and hospital services, delivery, and normal nursery care (Separate charges will apply to the mother and the newborn.)	No charge after deductible	No charge after deductible

HSA-QUALIFIED PLANS – FEATURES AT A GLANCE

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FEATURES	PLAN 2500/5000	PLAN 5000/10000
PRESCRIPTION DRUGS⁹		
Covered formulary drugs and accessories Up to a 31-day supply at Kaiser Permanente and affiliated network pharmacies	No charge after deductible \$2,000 maximum per member per calendar year	No charge after deductible \$1,500 maximum per member per calendar year
Infertility drugs	Up to a 62-day supply of maintenance drugs through the Kaiser Permanente Direct Mail Pharmacy Not covered	Up to a 62-day supply of maintenance drugs through the Kaiser Permanente Direct Mail Pharmacy Not covered
MENTAL HEALTH SERVICES		
Outpatient care	Not covered	Not covered
Inpatient care	Not covered	Not covered
EMERGENCY SERVICES		
Emergency services at a Plan or non-Plan facility	No charge after deductible	No charge after deductible
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)	No charge after deductible	No charge after deductible
CHEMICAL DEPENDENCY SERVICES		
Outpatient detoxification, individual therapy	Not covered	Not covered
Group therapy	Not covered	Not covered
Inpatient care in a specialized facility Medical detoxification (one admission per member per calendar year)	No charge after deductible	No charge after deductible
Inpatient care in a general hospital Medical detoxification (unlimited)	No charge after deductible	No charge after deductible
ALTERNATIVE CARE		
Extended care in a skilled nursing facility	No charge after deductible Kaiser Permanente pays up to \$5,000 maximum benefit per calendar year	Not covered
Hospice/Respite care and home health services	No charge after deductible	No charge after deductible
ADDITIONAL BENEFITS		
Infertility services, inpatient and outpatient After diagnosis, all covered medical and hospital services including lab, X-rays, and artificial insemination associated with the treatment of involuntary infertility	No charge after deductible	No charge after deductible
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 35 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)