2012 non–Medicare benefit summary

	Kaiser Permanente	ODS Health Plan, Inc.	
		IN-NETWORK	OUT-OF-NETWORK
Service area	Refer to page 27	Refer to page 27	
Eligible providers	Kaiser Permanente physicians and hospitals	Preferred physicians and providers	Any licensed physician or facility
Calendar year essential benefit plan maximum (medical & Rx)	None	$2,000,000	
Calendar year deductible	None	$200 per individual	
Calendar year medical out-of-pocket maximum	$1,000 per individual	$2,000+ deductible per individual	$6,000+ deductible per individual
	INSURED pays:	**INSURED** pays:	
PHYSICIAN SERVICES			
Office visits	$15 copay	$20 copay, no deductible	30% after deductible
Specialist visits	$15 copay	$20 copay, no deductible	30% after deductible
Preventive visits[2]	Covered in full	Covered in full	30% after deductible
LAB & X-RAY			
Routine lab test	$10 copay per visit	20% after deductible	30% after deductible
Routine X-ray procedures	$10 copay per visit	20% after deductible	30% after deductible
Diagnostic procedures	$10 copay per visit	20% after deductible	30% after deductible
INPATIENT HOSPITAL SERVICES			
Covered services	$200 copay per admit	20% after deductible	30% after deductible
MISCELLANEOUS SERVICES			
Alternative care	Discounts available	Costs vary by service	Costs vary by service
Ambulance	$75 copay	20% after deductible	30% after deductible
DME	20%	20% after deductible	30% after deductible
Emergency services	$100 copay[6]	$200 copay, then 20%[5]	$200 copay, then 20%[5]
Outpatient surgery	$15 copay	20% after deductible	30% after deductible
Skilled nursing	Covered in full[4]	20% after deductible	30% after deductible
Urgent care	$15 copay	$20 copay, no deductible	30% after deductible
VISION			
Routine eye exam	$15 copay	Discounts available; contact ODS	
Hardware	Not covered		
PRESCRIPTION DRUGS[9]	**Refer to pages 36–37**		
Generic and brand	40% of charge, up to a $150 maximum for each prescription, up to a 30-day		
Rx out-of-pocket maximum	$4,700 out-of-pocket maximum per member, per calendar year		

1 Must select a primary care physician (PCP). Six-month waiting period for pre-existing conditions apply.
2 Preventive services will be covered in accordance with PPACA guidelines. This applies to in-network services under ODS, PacificSource and Providence. 3 Pre-natal, delivery & postnatal physician services require a $200 copay; deductible does not apply. 4 Covered in full in a Medicare-certified facility for up to 100 days per calendar year. 5 ER copay waived if admitted. Coinsurance is still required. 6 ER copay waived if admitted.

This is a summary of benefits only, for general comparison. Any errors or omissions are purely unintentional. Should any discrepancies be found between this guide and the plan document, the information in the plan document shall prevail.

PacificSource Health Plans[1]		Providence Health Plans	
IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Refer to page 26		Refer to page 26	
Plan physicians and hospitals	Any licensed physician or facility	Plan physicians and hospitals	Any licensed physician or facility
None		None	
$200 per individual	$1,000 per individual	$200 per individual	
$2,000+ deductible per individual	$6,000+ deductible per individual	$2,000+ deductible per individual	$6,000+ deductible per individual
INSURED pays:		**INSURED** pays:	
■ $15 copay, no deductible[3] ■ $25 copay, no deductible ■ Covered in full	■ 30% after deductible ■ 30% after deductible ■ 30% after deductible	■ $20 copay, no deductible ■ $20 copay, no deductible ■ Covered in full	■ 30% after deductible ■ 30% after deductible ■ 30% after deductible
■ 20% after deductible ■ 20% after deductible ■ 20% after deductible	■ 30% after deductible ■ 30% after deductible ■ 30% after deductible	■ 20% after deductible ■ 20% after deductible ■ 20% after deductible	■ 30% after deductible ■ 30% after deductible ■ 30% after deductible
■ 20% after deductible	■ 30% after deductible	■ 20% after deductible	■ 30% after deductible
■ $25 copay, no deductible ■ 20%, no deductible ■ 20% after deductible ■ $200 copay, no deductible[6] ■ 20% after deductible ■ 20% after deductible ■ $25 copay, no deductible	■ 30% after deductible ■ 20%, no deductible ■ 30% after deductible ■ $200 copay, no deductible[6] ■ 30% after deductible ■ 30% after deductible ■ 30%, no deductible	■ $15 copay[7] ■ 20% after deductible ■ 20% after deductible ■ $200 copay, then 20%[6] ■ 20% after deductible ■ 20% after deductible ■ 20%, no deductible[8]	■ Not covered ■ 20% after deductible ■ 30% after deductible ■ $200 copay, then 20%[6] ■ 30% after deductible ■ 30% after deductible ■ 20%, no deductible[8]
■ Not covered ■ Not covered		■ Discounts available through Binyon's and TruVision	
supply			

7 $1,500 calendar year maximum; contact Providence customer service for a list of contracted providers.
8 Urgent/immediate care — ancillary charges billed separately will be subject to the applicable cost share. The deductible will apply to diagnostics (lab, X-rays, etc.) received during the visit. 9 Under ODS, at retail, brand drugs are covered up to a 31-day supply and generic drugs up to a 93-day supply.