

# Small Group Plan Guide

**New Plan Designs:**  
a streamlined product  
portfolio offering flexible  
plan pairings to meet the  
needs of small business

EFFECTIVE AS OF  
APRIL 1, 2012



## different is good

Unlike your other health insurance options, Kaiser Permanente provides both the health plan and the health care. The result is a tangible difference for our customers: State-of-the-art medical care, greater convenience, lower costs, and outstanding levels of satisfaction. **Yes, it's different. And clearly, our difference is good.**

## a different model

High quality care doesn't need to be expensive. With our unique model, Kaiser Permanente makes it convenient for members to get state-of-the-art medical care. This helps our customers maintain a healthy, productive workforce and helps drive down health care costs through:

- Carefully selected doctors
- Truly coordinated care
- Focus on prevention and early diagnosis

## our difference makes a difference

- In member and employer satisfaction
- In the quality of care
- In employee health and productivity
- In controlling health care costs

## Small Group Plan Portfolio Options

With Kaiser Permanente, you have the flexibility to select plans and pairings that meet the needs of your group. You can choose to offer any one of our 11 KP in-network HMO plans as a stand alone plan, or you can offer a pairing between a KP in-network plan and one of our eight Multi-Choice options.

**If you would like to offer a Multi-Choice option, you will need to pair it with a KP plan.**

Please use the provided grid to help make your selection. Pairings in green offer exceptional value and choice. Pairings in yellow provide you with additional options, but these plan pairings will be priced higher. Pairings that fall in the orange coded section are restricted and should not be paired with a Multi-Choice plan.

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	POS/0/15/S1	POS/500/20/S1	POS/1000/20/S1	POS/1500/20/S1	POS/2000/20/S1	POS/2500/20/S1	POS/3000/40/S1	POS/5000/40/S1
KP/0/15/S1	Green	Green	Green	Green	Green	Green	Green	Green
KP/0/25/S1	Orange	Green	Green	Green	Green	Green	Green	Green
KP/500/20/S1	Orange	Green	Green	Green	Green	Green	Green	Green
KP/1000/20/S1	Orange	Orange	Green	Green	Green	Green	Green	Green
KP/1500/20/S1	Orange	Yellow	Orange	Green	Green	Green	Green	Green
KP/2000/20/S1	Orange	Orange	Yellow	Orange	Green	Green	Green	Green
KP/2500/20/S1	Orange	Orange	Orange	Orange	Orange	Green	Green	Green
KP/3000/40/S1	Orange	Orange	Orange	Orange	Orange	Orange	Green	Green
KP/4000/40/S1	Orange	Orange	Orange	Orange	Orange	Orange	Orange	Green
KP/5000/40/S1	Orange	Orange	Orange	Orange	Orange	Orange	Yellow	Green
KP/7500/40/S1	Orange	Orange	Orange	Orange	Orange	Orange	Orange	Orange

### KEY

- Recommended pairing
- Pairing will be priced higher
- Pairing restricted

# HMO Plans

KP/0/15/S1

KP/0/25/S1

KP/500/20/S1

KP/1000/20/S1

KP/1500/20/S1

KP/2000/20/S1

	KP/0/15/S1	KP/0/25/S1	KP/500/20/S1	KP/1000/20/S1	KP/1500/20/S1	KP/2000/20/S1
<b>Deductible (Individual/Family)</b>	\$0	\$0	\$500/\$1,000	\$1,000/\$2,000	\$1,500/\$3,000	\$2,000/\$4,000
<b>Coinsurance Maximum (Individual/Family)</b>	\$0	\$0	\$0	\$0	\$0	\$0
<b>Maximum Benefit While Covered</b>	Unlimited <sup>1</sup>	Unlimited <sup>1</sup>	Unlimited <sup>1</sup>	Unlimited <sup>1</sup>	Unlimited <sup>1</sup>	Unlimited <sup>1</sup>
<b>Coinsurance (after deductible)</b>	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
<b>Office Services</b>						
Primary Care (including lab and radiology)	\$15 copay	\$25 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay
Specialty Care (including lab and radiology)	\$25 copay	\$35 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay
High Tech Radiology Services (MRI, CT, PET, others)	\$25 copay	\$35 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay
Preventive Services <sup>2</sup>	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Maternity (obstetrician/midwife) <sup>2</sup>	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
<b>Emergency Services</b>						
Emergency Room Visit—per visit; copay waived if admitted	\$200 copay	\$200 copay	\$200 copay	\$200 copay	\$200 copay	\$200 copay
Ambulance—per trip	\$150 copay	\$150 copay	\$150 copay	\$150 copay	\$150 copay	\$150 copay
After-Hours Urgent Care—per visit	\$30 copay	\$50 copay	\$40 copay	\$40 copay	\$40 copay	\$40 copay
<b>Outpatient Services</b>						
High Tech Radiology Services (MRI, CT, PET, others)	\$50 copay	\$50 copay	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Physical and Occupational Therapy (20 visits per calendar year)	\$25 copay	\$35 copay	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Outpatient Hospital or Surgical Facility (including lab and radiology)	\$50 copay	\$50 copay	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Physician and Other Professional Charges	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
<b>Inpatient Services</b>						
Hospital (facility charge)—per admission	\$200 copay	\$200 copay	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Physician and Other Professional Charges	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
<b>Mental Health<sup>3</sup></b>						
Outpatient Mental Health (Up to 20 visits per calendar year)	\$25 copay	\$35 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay
Inpatient Mental Health Facility (30 days per calendar year)	\$200 copay	\$200 copay	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Inpatient Mental Health Professional	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
<b>Other Services</b>						
DME/Prosthetics and Orthotics	Plan pays 50%	Plan pays 50%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Vision Exam	\$25 copay	\$35 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay
<b>Pharmacy Services</b>						
Preferred Generic Drugs—Kaiser Permanente Pharmacy/ Designated Community Pharmacy <sup>4</sup>	\$15 copay/\$25 copay	\$15 copay/\$25 copay	\$15 copay/\$25 copay	\$15 copay/\$25 copay	\$15 copay/\$25 copay	\$15 copay/\$25 copay
Preferred Brand Drugs—Kaiser Permanente Pharmacy/ Designated Community Pharmacy <sup>4</sup>	\$30 copay/\$40 copay	\$30 copay/\$40 copay	\$30 copay/\$40 copay	\$30 copay/\$40 copay	\$30 copay/\$40 copay	\$30 copay/\$40 copay
Home Delivery—90-day supply—Kaiser Permanente Pharmacy (Generic Preferred/Brand Preferred)	\$30 copay/\$60 copay	\$30 copay/\$60 copay	\$30 copay/\$60 copay	\$30 copay/\$60 copay	\$30 copay/\$60 copay	\$30 copay/\$60 copay

<sup>1</sup>Some benefits may have limitations.

<sup>2</sup>Deductible does not apply.

<sup>3</sup>Chemical Dependency covered for detoxification only under the Medical Plan.

<sup>4</sup>Refills must be obtained at a Kaiser Permanente Pharmacy or through Home Delivery.

This is a summary description and is not intended to replace the *Group Agreement*, *Group Policy*, and/or *Evidence of Coverage*, which contain the complete provisions of this coverage. Some benefits may have specific limitations and/or exclusions.

# HMO Plans

KP/2500/20/S1

KP/3000/40/S1

KP/4000/40/S1

KP/5000/40/S1

KP/7500/40/S1

<b>Deductible (Individual/Family)</b>	\$2,500/\$5,000	\$3,000/\$6,000		\$4,000/\$8,000	\$5,000/\$10,000	\$7,500/\$15,000
<b>Coinsurance Maximum (Individual/Family)</b>	\$0	\$0		\$0	\$0	\$0
<b>Maximum Benefit While Covered</b>	Unlimited <sup>1</sup>	Unlimited <sup>1</sup>		Unlimited <sup>1</sup>	Unlimited <sup>1</sup>	Unlimited <sup>1</sup>
<b>Coinsurance (after deductible)</b>	Plan pays 100%	Plan pays 100%		Plan pays 100%	Plan pays 100%	Plan pays 100%
<b>Office Services</b>						
Primary Care (including lab and radiology)	\$20 copay	\$40 copay		\$40 copay	\$40 copay	\$40 copay
Specialty Care (including lab and radiology)	\$30 copay	\$50 copay		\$50 copay	\$50 copay	\$50 copay
High Tech Radiology Services (MRI, CT, PET, others)	\$30 copay	\$50 copay		\$50 copay	\$50 copay	\$50 copay
Preventive Services <sup>2</sup>	Plan pays 100%	Plan pays 100%		Plan pays 100%	Plan pays 100%	Plan pays 100%
Maternity (obstetrician/midwife) <sup>2</sup>	Plan pays 100%	Plan pays 100%		Plan pays 100%	Plan pays 100%	Plan pays 100%
<b>Emergency Services</b>						
Emergency Room Visit—per visit; copay waived if admitted	\$200 copay	\$250 copay		\$250 copay	\$250 copay	\$250 copay
Ambulance—per trip	\$150 copay	\$150 copay		\$150 copay	\$150 copay	\$150 copay
After-Hours Urgent Care—per visit	\$40 copay	\$80 copay		\$80 copay	\$80 copay	\$80 copay
<b>Outpatient Services</b>						
High Tech Radiology Services (MRI, CT, PET, others)	Plan pays 100%	Plan pays 100%		Plan pays 100%	Plan pays 100%	Plan pays 100%
Physical and Occupational Therapy (20 visits per calendar year)	Plan pays 100%	Plan pays 100%		Plan pays 100%	Plan pays 100%	Plan pays 100%
Outpatient Hospital or Surgical Facility (including lab and radiology)	Plan pays 100%	Plan pays 100%		Plan pays 100%	Plan pays 100%	Plan pays 100%
Physician and Other Professional Charges	Plan pays 100%	Plan pays 100%		Plan pays 100%	Plan pays 100%	Plan pays 100%
<b>Inpatient Services</b>						
Hospital (facility charge)—per admission	Plan pays 100%	Plan pays 100%		Plan pays 100%	Plan pays 100%	Plan pays 100%
Physician and Other Professional Charges	Plan pays 100%	Plan pays 100%		Plan pays 100%	Plan pays 100%	Plan pays 100%
<b>Mental Health<sup>3</sup></b>						
Outpatient Mental Health (Up to 20 visits per calendar year)	\$30 copay	\$50 copay		\$50 copay	\$50 copay	\$50 copay
Inpatient Mental Health Facility (30 days per calendar year)	Plan pays 100%	Plan pays 100%		Plan pays 100%	Plan pays 100%	Plan pays 100%
Inpatient Mental Health Professional	Plan pays 100%	Plan pays 100%		Plan pays 100%	Plan pays 100%	Plan pays 100%
<b>Other Services</b>						
DME/Prosthetics and Orthotics	Plan pays 100%	Plan pays 100%		Plan pays 100%	Plan pays 100%	Plan pays 100%
Vision Exam	\$30 copay	\$50 copay		\$50 copay	\$50 copay	\$50 copay
<b>Pharmacy Services</b>						
Preferred Generic Drugs—Kaiser Permanente Pharmacy/ Designated Community Pharmacy <sup>4</sup>	\$15 copay/\$25 copay	\$15 copay/\$25 copay		\$15 copay/\$25 copay	\$15 copay/\$25 copay	\$15 copay/\$25 copay
Preferred Brand Drugs—Kaiser Permanente Pharmacy/ Designated Community Pharmacy <sup>4</sup>	\$30 copay/\$40 copay	\$30 copay/\$40 copay		\$30 copay/\$40 copay	\$30 copay/\$40 copay	\$30 copay/\$40 copay
Home Delivery—90-day supply—Kaiser Permanente Pharmacy (Generic Preferred/Brand Preferred)	\$30 copay/\$60 copay	\$30 copay/\$60 copay		\$30 copay/\$60 copay	\$30 copay/\$60 copay	\$30 copay/\$60 copay

<sup>1</sup>Some benefits may have limitations.

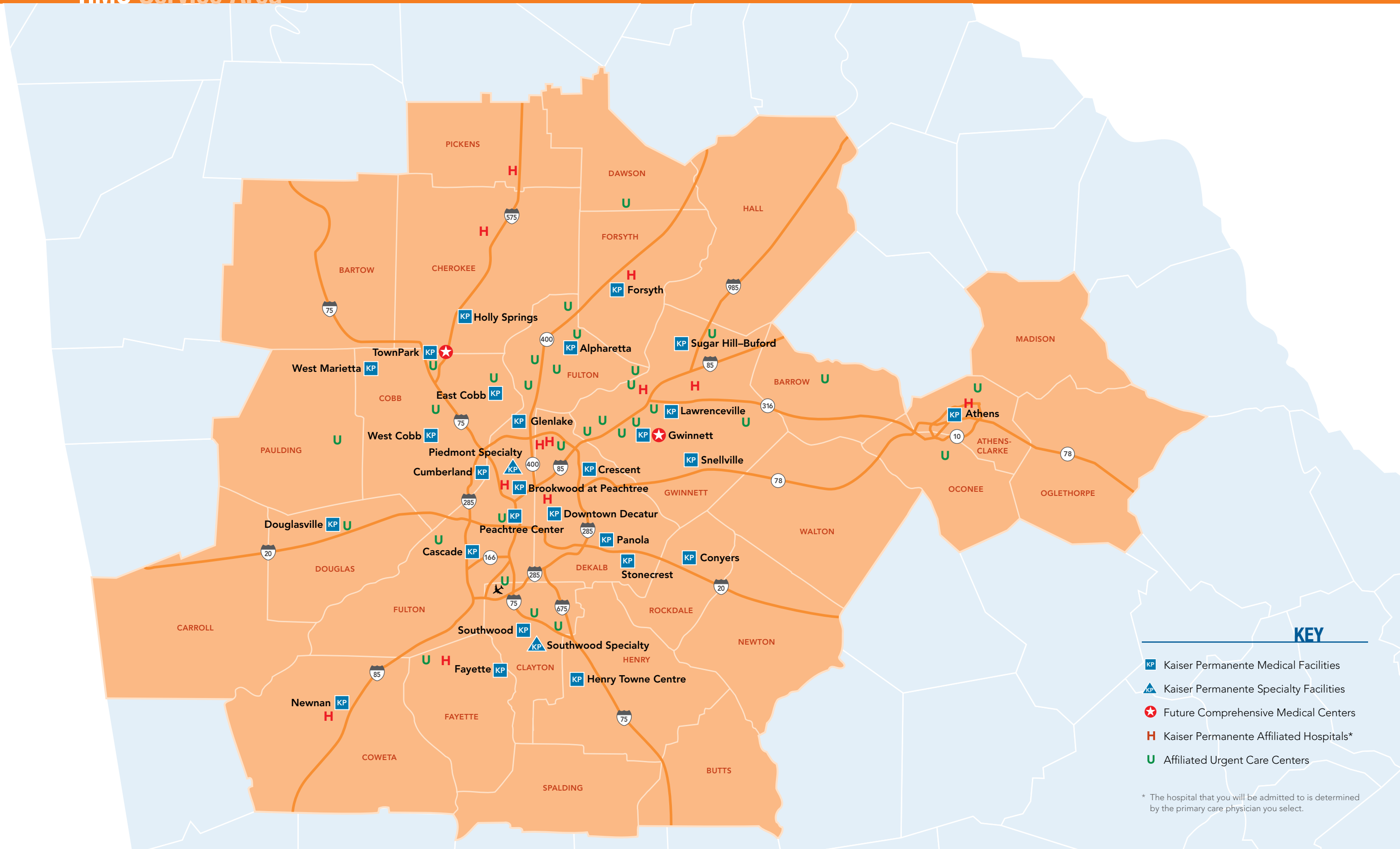
<sup>2</sup>Deductible does not apply.

<sup>3</sup>Chemical Dependency covered for detoxification only under the Medical Plan.

<sup>4</sup>Refills must be obtained at a Kaiser Permanente Pharmacy or through Home Delivery.

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# HMO Service Area



## KEY

- Kaiser Permanente Medical Facilities
- Kaiser Permanente Specialty Facilities
- Future Comprehensive Medical Centers
- Kaiser Permanente Affiliated Hospitals\*
- Affiliated Urgent Care Centers

\* The hospital that you will be admitted to is determined by the primary care physician you select.

# Multi-Choice Plans

POS/0/15/S1

Multi-Choice Plans must be paired with a Kaiser Permanente HMO Plan. Please refer to the plan pairing grid on page 4 for options.

POS/500/20/S1

	Select Providers	PPO Providers (PHCS Network)	Non-participating Providers
<b>Deductible</b> (Individual/Family)	\$0	\$1,000/\$2,000	\$2,000/\$6,000
<b>Coinsurance Maximum</b> (Individual/Family)	\$0	\$2,000/\$4,000	\$4,000/\$12,000
<b>Maximum Benefit While Covered</b>	Unlimited <sup>1</sup>	\$2,000,000 combined	
<b>Coinsurance</b> (after deductible)	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Office Services</b>			
Primary Care (including lab and radiology)	\$15 copay	\$30 copay	Plan pays 60%
Specialty Care (including lab and radiology)	\$25 copay	\$40 copay	Plan pays 60%
High Tech Radiology Services (MRI, CT, PET, others)	\$25 copay	Plan pays 80%	Plan pays 60%
Preventive Services—Primary Care/Specialty Care	Plan pays 100% <sup>2</sup>	Plan pays 80%	Plan pays 60%
Maternity (obstetrician/midwife)	Plan pays 100% <sup>2</sup>	Plan pays 80%	Plan pays 60%
<b>Emergency Services</b>			
Emergency Room Visit—per visit; copay waived if admitted	\$200 copay	\$200 copay	\$200 copay
Ambulance—per trip	\$150 copay	\$150 copay	\$150 copay
After-Hours Urgent Care—per visit	\$30 copay	Plan pays 80%	Plan pays 60%
<b>Outpatient Services</b>			
High Tech Radiology Services (MRI, CT, PET, others)	\$50 copay	Plan pays 80%	Plan pays 60%
Physical and Occupational Therapy (20 visits per calendar year)	\$25 copay	Plan pays 80%	Plan pays 60%
Outpatient Hospital or Surgical Facility (including lab and radiology)	\$50 copay	Plan pays 80%	Plan pays 60%
Physician and Other Professional Charges	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Inpatient Services</b>			
Hospital (facility charge)—per admission	\$200 copay	Plan pays 80%	Plan pays 60%
Physician and Other Professional Charges	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Mental Health<sup>3</sup></b>			
Outpatient Mental Health (up to 20 visits per calendar year)	\$25 copay	\$40 copay	Plan pays 60%
Inpatient Mental Health Facility (30 days per calendar year)	\$200 copay	Plan pays 80%	Plan pays 60%
Inpatient Mental Health Professional	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Other Services</b>			
DME/Prosthetics and Orthotics	Plan pays 50%	Plan pays 80%	Plan pays 60%
Vision Exam	\$25 copay	\$40 copay	Plan pays 60%
<b>Pharmacy Services</b>			
Preferred Generic Drugs	\$15 copay	\$20 copay (all generics)	
Preferred Brand Drugs	\$30 copay	\$50 copay	
All Non-Preferred Drugs	\$45 copay	\$75 copay (non-preferred brand)	
		\$5,000 combined annual benefit maximum	
Home Delivery—90-day supply—Kaiser Permanente Pharmacy (Generic Preferred/Brand Preferred/Non-Preferred)	\$30/\$60/\$90	\$60/\$150/\$225	Not applicable

	Select Providers	PPO Providers (PHCS Network)	Non-participating Providers
<b>Deductible</b> (Individual/Family)	\$500/\$1000	\$1,500/\$3,000	\$3,000/\$9,000
<b>Coinsurance Maximum</b> (Individual/Family)	\$0	\$2,000/\$4,000	\$4,500/\$13,500
<b>Maximum Benefit While Covered</b>	Unlimited <sup>1</sup>	\$2,000,000 combined	
<b>Coinsurance</b> (after deductible)	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Office Services</b>			
Primary Care (including lab and radiology)	\$20 copay	\$35 copay	Plan pays 60%
Specialty Care (including lab and radiology)	\$30 copay	\$45 copay	Plan pays 60%
High Tech Radiology Services (MRI, CT, PET, others)	\$50 copay	Plan pays 80%	Plan pays 60%
Preventive Services—Primary Care/Specialty Care	Plan pays 100% <sup>2</sup>	Plan pays 80%	Plan pays 60%
Maternity (obstetrician/midwife)	Plan pays 100% <sup>2</sup>	Plan pays 80%	Plan pays 60%
<b>Emergency Services</b>			
Emergency Room Visit—per visit; copay waived if admitted	\$200 copay	\$200 copay	\$200 copay
Ambulance—per trip	\$150 copay	\$150 copay	\$150 copay
After-Hours Urgent Care—per visit	\$40 copay	Plan pays 80%	Plan pays 60%
<b>Outpatient Services</b>			
High Tech Radiology Services (MRI, CT, PET, others)	Plan pays 100%	Plan pays 80%	Plan pays 60%
Physical and Occupational Therapy (20 visits per calendar year)	Plan pays 100%	Plan pays 80%	Plan pays 60%
Outpatient Hospital or Surgical Facility (including lab and radiology)	Plan pays 100%	Plan pays 80%	Plan pays 60%
Physician and Other Professional Charges	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Inpatient Services</b>			
Hospital (facility charge)—per admission	Plan pays 100%	Plan pays 80%	Plan pays 60%
Physician and Other Professional Charges	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Mental Health<sup>3</sup></b>			
Outpatient Mental Health (up to 20 visits per calendar year)	\$30 copay	\$45 copay	Plan pays 60%
Inpatient Mental Health Facility (30 days per calendar year)	Plan pays 100%	Plan pays 80%	Plan pays 60%
Inpatient Mental Health Professional	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Other Services</b>			
DME/Prosthetics and Orthotics	Plan pays 100%	Plan pays 80%	Plan pays 60%
Vision Exam	\$30 copay	\$45 copay	Plan pays 60%
<b>Pharmacy Services</b>			
Preferred Generic Drugs	\$15 copay	\$20 copay (all generics)	
Preferred Brand Drugs	\$30 copay	\$50 copay	
All Non-Preferred Drugs	\$45 copay	\$75 copay (non-preferred brand)	
		\$5,000 combined annual benefit maximum	
Home Delivery—90-day supply—Kaiser Permanente Pharmacy (Generic Preferred/Brand Preferred/Non-Preferred)	\$30/\$60/\$90	\$60/\$150/\$225	Not applicable

<sup>1</sup>Some benefits may have limitations.

<sup>2</sup>Deductible does not apply.

<sup>3</sup>Chemical Dependency covered for detoxification only under the Medical Plan.

This is a summary description and is not intended to replace the *Group Agreement*, *Group Policy*, and/or *Evidence of Coverage*, which contain the complete provisions of this coverage. Some benefits may have specific limitations and/or exclusions.

Select Providers and Kaiser Permanente HMO coverage is provided by Kaiser Foundation Health Plan of Georgia, Inc. PPO and Non-participating Provider coverages are underwritten by Kaiser Permanente Insurance Company (KPIC). Provider options and benefit levels are described in the Kaiser Permanente Multi-Choice brochure and the *Evidence of Coverage*.

# Multi-Choice Plans

POS/1000/20/S1

Multi-Choice Plans must be paired with a Kaiser Permanente HMO Plan. Please refer to the plan pairing grid on page 4 for options.

POS/1500/20/S1

	Select Providers	PPO Providers (PHCS Network)	Non-participating Providers
<b>Deductible</b> (Individual/Family)	\$1,000/\$2,000	\$2,000/\$4,000	\$4,000/\$12,000
<b>Coinsurance Maximum</b> (Individual/Family)	\$0	\$2,000/\$4,000	\$5,000/\$15,000
<b>Maximum Benefit While Covered</b>	Unlimited <sup>1</sup>	\$2,000,000 combined	
<b>Coinsurance</b> (after deductible)	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Office Services</b>			
Primary Care (including lab and radiology)	\$20 copay	\$40 copay	Plan pays 60%
Specialty Care (including lab and radiology)	\$30 copay	\$60 copay	Plan pays 60%
High Tech Radiology Services (MRI, CT, PET, others)	\$50 copay	Plan pays 80%	Plan pays 60%
Preventive Services—Primary Care/Specialty Care	Plan pays 100% <sup>2</sup>	Plan pays 80%	Plan pays 60%
Maternity (obstetrician/midwife)	Plan pays 100% <sup>2</sup>	Plan pays 80%	Plan pays 60%
<b>Emergency Services</b>			
Emergency Room Visit—per visit; copay waived if admitted	\$200 copay	\$200 copay	\$200 copay
Ambulance—per trip	\$150 copay	\$150 copay	\$150 copay
After-Hours Urgent Care—per visit	\$40 copay	Plan pays 80%	Plan pays 60%
<b>Outpatient Services</b>			
High Tech Radiology Services (MRI, CT, PET, others)	Plan pays 100%	Plan pays 80%	Plan pays 60%
Physical and Occupational Therapy (20 visits per calendar year)	Plan pays 100%	Plan pays 80%	Plan pays 60%
Outpatient Hospital or Surgical Facility (including lab and radiology)	Plan pays 100%	Plan pays 80%	Plan pays 60%
Physician and Other Professional Charges	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Inpatient Services</b>			
Hospital (facility charge)—per admission	Plan pays 100%	Plan pays 80%	Plan pays 60%
Physician and Other Professional Charges	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Mental Health<sup>3</sup></b>			
Outpatient Mental Health (up to 20 visits per calendar year)	\$30 copay	\$60 copay	Plan pays 60%
Inpatient Mental Health Facility (30 days per calendar year)	Plan pays 100%	Plan pays 80%	Plan pays 60%
Inpatient Mental Health Professional	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Other Services</b>			
DME/Prosthetics and Orthotics	Plan pays 100%	Plan pays 80%	Plan pays 60%
Vision Exam	\$30 copay	\$60 copay	Plan pays 60%
<b>Pharmacy Services</b>			
Preferred Generic Drugs	\$15 copay	\$20 copay (all generics)	
Preferred Brand Drugs	\$30 copay	\$50 copay	
All Non-Preferred Drugs	\$45 copay	\$75 copay (non-preferred brand)	
		\$5,000 combined annual benefit maximum	
Home Delivery—90-day supply—Kaiser Permanente Pharmacy (Generic Preferred/Brand Preferred/Non-Preferred)	\$30/\$60/\$90	\$60/\$150/\$225	Not applicable

	Select Providers	PPO Providers (PHCS Network)	Non-participating Providers
<b>Deductible</b> (Individual/Family)	\$1,500/\$3,000	\$2,500/\$5,000	\$5,000/\$15,000
<b>Coinsurance Maximum</b> (Individual/Family)	\$0	\$2,500/\$5,000	\$5,000/\$15,000
<b>Maximum Benefit While Covered</b>	Unlimited <sup>1</sup>	\$2,000,000 combined	
<b>Coinsurance</b> (after deductible)	Plan pays 100%	Plan pays 80%	Plan pays 60%
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Maternity (obstetrician/midwife)	Plan pays 100% <sup>2</sup>	Plan pays 80%	Plan pays 60%
<b>Emergency Services</b>			
Emergency Room Visit—per visit; copay waived if admitted	\$200 copay	\$200 copay	\$200 copay
Ambulance—per trip	\$150 copay	\$150 copay	\$150 copay
After-Hours Urgent Care—per visit	\$40 copay	Plan pays 80%	Plan pays 60%
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High Tech Radiology Services (MRI, CT, PET, others)	Plan pays 100%	Plan pays 80%	Plan pays 60%
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Preferred Generic Drugs	\$15 copay	\$20 copay (all generics)	
Preferred Brand Drugs	\$30 copay	\$50 copay	
All Non-Preferred Drugs	\$45 copay	\$75 copay (non-preferred brand)	
		\$5,000 combined annual benefit maximum	
Home Delivery—90-day supply—Kaiser Permanente Pharmacy (Generic Preferred/Brand Preferred/Non-Preferred)	\$30/\$60/\$90	\$60/\$150/\$225	Not applicable

<sup>1</sup>Some benefits may have limitations.

<sup>2</sup>Deductible does not apply.

<sup>3</sup>Chemical Dependency covered for detoxification only under the Medical Plan.

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Select Providers and Kaiser Permanente HMO coverage is provided by Kaiser Foundation Health Plan of Georgia, Inc. PPO and Non-participating Provider coverages are underwritten by Kaiser Permanente Insurance Company (KPIC). Provider options and benefit levels are described in the Kaiser Permanente Multi-Choice brochure and the *Evidence of Coverage*.



# Multi-Choice Plans

POS/2000/20/S1

Multi-Choice Plans must be paired with a Kaiser Permanente HMO Plan. Please refer to the plan pairing grid on page 4 for options.

POS/2500/20/S1

	Select Providers	PPO Providers (PHCS Network)	Non-participating Providers
<b>Deductible</b> (Individual/Family)	\$2,000/\$4,000	\$3,000/\$6,000	\$6,000/\$18,000
<b>Coinsurance Maximum</b> (Individual/Family)	\$0	\$3,000/\$6,000	\$6,000/\$18,000
<b>Maximum Benefit While Covered</b>	Unlimited <sup>1</sup>	\$2,000,000 combined	
<b>Coinsurance</b> (after deductible)	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Office Services</b>			
Primary Care (including lab and radiology)	\$20 copay	\$40 copay	Plan pays 60%
Specialty Care (including lab and radiology)	\$30 copay	\$60 copay	Plan pays 60%
High Tech Radiology Services (MRI, CT, PET, others)	\$50 copay	Plan pays 80%	Plan pays 60%
Preventive Services—Primary Care/Specialty Care	Plan pays 100% <sup>2</sup>	Plan pays 80%	Plan pays 60%
Maternity (obstetrician/midwife)	Plan pays 100% <sup>2</sup>	Plan pays 80%	Plan pays 60%
<b>Emergency Services</b>			
Emergency Room Visit—per visit; copay waived if admitted	\$200 copay	\$200 copay	\$200 copay
Ambulance—per trip	\$150 copay	\$150 copay	\$150 copay
After-Hours Urgent Care—per visit	\$40 copay	Plan pays 80%	Plan pays 60%
<b>Outpatient Services</b>			
High Tech Radiology Services (MRI, CT, PET, others)	Plan pays 100%	Plan pays 80%	Plan pays 60%
Physical and Occupational Therapy (20 visits per calendar year)	Plan pays 100%	Plan pays 80%	Plan pays 60%
Outpatient Hospital or Surgical Facility (including lab and radiology)	Plan pays 100%	Plan pays 80%	Plan pays 60%
Physician and Other Professional Charges	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Inpatient Services</b>			
Hospital (facility charge)—per admission	Plan pays 100%	Plan pays 80%	Plan pays 60%
Physician and Other Professional Charges	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Mental Health<sup>3</sup></b>			
Outpatient Mental Health (up to 20 visits per calendar year)	\$30 copay	\$60 copay	Plan pays 60%
Inpatient Mental Health Facility (30 days per calendar year)	Plan pays 100%	Plan pays 80%	Plan pays 60%
Inpatient Mental Health Professional	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Other Services</b>			
DME/Prosthetics and Orthotics	Plan pays 100%	Plan pays 80%	Plan pays 60%
Vision Exam	\$30 copay	\$60 copay	Plan pays 60%
<b>Pharmacy Services</b>			
Preferred Generic Drugs	\$15 copay	\$20 copay (all generics)	
Preferred Brand Drugs	\$30 copay	\$50 copay	
All Non-Preferred Drugs	\$45 copay	\$75 copay (non-preferred brand)	
		\$5,000 combined annual benefit maximum	
Home Delivery—90-day supply—Kaiser Permanente Pharmacy (Generic Preferred/Brand Preferred/Non-Preferred)	\$30/\$60/\$90	\$60/\$150/\$225	Not applicable

	Select Providers	PPO Providers (PHCS Network)	Non-participating Providers
<b>Deductible</b> (Individual/Family)	\$2,500/\$5,000	\$4,000/\$8,000	\$7,000/\$21,000
<b>Coinsurance Maximum</b> (Individual/Family)	\$0	\$4,000/\$8,000	\$7,000/\$21,000
<b>Maximum Benefit While Covered</b>	Unlimited <sup>1</sup>	\$2,000,000 combined	
<b>Coinsurance</b> (after deductible)	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Office Services</b>			
Primary Care (including lab and radiology)	\$20 copay	\$45 copay	Plan pays 60%
Specialty Care (including lab and radiology)	\$30 copay	\$65 copay	Plan pays 60%
High Tech Radiology Services (MRI, CT, PET, others)	\$50 copay	Plan pays 80%	Plan pays 60%
Preventive Services—Primary Care/Specialty Care	Plan pays 100% <sup>2</sup>	Plan pays 80%	Plan pays 60%
Maternity (obstetrician/midwife)	Plan pays 100% <sup>2</sup>	Plan pays 80%	Plan pays 60%
<b>Emergency Services</b>			
Emergency Room Visit—per visit; copay waived if admitted	\$200 copay	\$200 copay	\$200 copay
Ambulance—per trip	\$150 copay	\$150 copay	\$150 copay
After-Hours Urgent Care—per visit	\$40 copay	Plan pays 80%	Plan pays 60%
<b>Outpatient Services</b>			
High Tech Radiology Services (MRI, CT, PET, others)	Plan pays 100%	Plan pays 80%	Plan pays 60%
Physical and Occupational Therapy (20 visits per calendar year)	Plan pays 100%	Plan pays 80%	Plan pays 60%
Outpatient Hospital or Surgical Facility (including lab and radiology)	Plan pays 100%	Plan pays 80%	Plan pays 60%
Physician and Other Professional Charges	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Inpatient Services</b>			
Hospital (facility charge)—per admission	Plan pays 100%	Plan pays 80%	Plan pays 60%
Physician and Other Professional Charges	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Mental Health<sup>3</sup></b>			
Outpatient Mental Health (up to 20 visits per calendar year)	\$30 copay	\$65 copay	Plan pays 60%
Inpatient Mental Health Facility (30 days per calendar year)	Plan pays 100%	Plan pays 80%	Plan pays 60%
Inpatient Mental Health Professional	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Other Services</b>			
DME/Prosthetics and Orthotics	Plan pays 100%	Plan pays 80%	Plan pays 60%
Vision Exam	\$30 copay	\$65 copay	Plan pays 60%
<b>Pharmacy Services</b>			
Preferred Generic Drugs	\$15 copay	\$20 copay (all generics)	
Preferred Brand Drugs	\$30 copay	\$50 copay	
All Non-Preferred Drugs	\$45 copay	\$75 copay (non-preferred brand)	
		\$5,000 combined annual benefit maximum	
Home Delivery—90-day supply—Kaiser Permanente Pharmacy (Generic Preferred/Brand Preferred/Non-Preferred)	\$30/\$60/\$90	\$60/\$150/\$225	Not applicable

<sup>1</sup>Some benefits may have limitations.

<sup>2</sup>Deductible does not apply.

<sup>3</sup>Chemical Dependency covered for detoxification only under the Medical Plan.

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Select Providers and Kaiser Permanente HMO coverage is provided by Kaiser Foundation Health Plan of Georgia, Inc. PPO and Non-participating Provider coverages are underwritten by Kaiser Permanente Insurance Company (KPIC). Provider options and benefit levels are described in the Kaiser Permanente Multi-Choice brochure and the *Evidence of Coverage*.

# Multi-Choice Plans

## POS/3000/40/S1

Multi-Choice Plans must be paired with a Kaiser Permanente HMO Plan. Please refer to the plan pairing grid on page 4 for options.

## POS/5000/40/S1

	Select Providers	PPO Providers (PHCS Network)	Non-participating Providers
<b>Deductible</b> (Individual/Family)	\$3,000/\$6,000	\$5,000/\$10,000	\$8,000/\$24,000
<b>Coinsurance Maximum</b> (Individual/Family)	\$0	\$5,000/\$10,000	\$8,000/\$24,000
<b>Maximum Benefit While Covered</b>	Unlimited <sup>1</sup>	\$2,000,000 combined	
<b>Coinsurance</b> (after deductible)	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Office Services</b>			
Primary Care (including lab and radiology)	\$40 copay	\$45 copay	Plan pays 60%
Specialty Care (including lab and radiology)	\$50 copay	\$65 copay	Plan pays 60%
High Tech Radiology Services (MRI, CT, PET, others)	\$50 copay	Plan pays 80%	Plan pays 60%
Preventive Services—Primary Care/Specialty Care	Plan pays 100% <sup>2</sup>	Plan pays 80%	Plan pays 60%
Maternity (obstetrician/midwife)	Plan pays 100% <sup>2</sup>	Plan pays 80%	Plan pays 60%
<b>Emergency Services</b>			
Emergency Room Visit—per visit; copay waived if admitted	\$250 copay	\$250 copay	\$250 copay
Ambulance—per trip	\$150 copay	\$150 copay	\$150 copay
After-Hours Urgent Care—per visit	\$80 copay	Plan pays 80%	Plan pays 60%
<b>Outpatient Services</b>			
High Tech Radiology Services (MRI, CT, PET, others)	Plan pays 100%	Plan pays 80%	Plan pays 60%
Physical and Occupational Therapy (20 visits per calendar year)	Plan pays 100%	Plan pays 80%	Plan pays 60%
Outpatient Hospital or Surgical Facility (including lab and radiology)	Plan pays 100%	Plan pays 80%	Plan pays 60%
Physician and Other Professional Charges	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Inpatient Services</b>			
Hospital (facility charge)—per admission	Plan pays 100%	Plan pays 80%	Plan pays 60%
Physician and Other Professional Charges	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Mental Health<sup>3</sup></b>			
Outpatient Mental Health (up to 20 visits per calendar year)	\$50 copay	\$65 copay	Plan pays 60%
Inpatient Mental Health Facility (30 days per calendar year)	Plan pays 100%	Plan pays 80%	Plan pays 60%
Inpatient Mental Health Professional	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Other Services</b>			
DME/Prosthetics and Orthotics	Plan pays 100%	Plan pays 80%	Plan pays 60%
Vision Exam	\$50 copay	\$65 copay	Plan pays 60%
<b>Pharmacy Services</b>			
Preferred Generic Drugs	\$15 copay	\$20 copay (all generics)	
Preferred Brand Drugs	\$30 copay	\$50 copay	
All Non-Preferred Drugs	\$45 copay	\$75 copay (non-preferred brand)	
		\$5,000 combined annual benefit maximum	
Home Delivery—90-day supply—Kaiser Permanente Pharmacy (Generic Preferred/Brand Preferred/Non-Preferred)	\$30/\$60/\$90	\$60/\$150/\$225	Not applicable

	Select Providers	PPO Providers (PHCS Network)	Non-participating Providers
<b>Deductible</b> (Individual/Family)	\$5,000/\$10,000	\$7,500/\$15,000	\$10,000/\$30,000
<b>Coinsurance Maximum</b> (Individual/Family)	\$0	\$7,500/\$15,000	\$10,000/\$30,000
<b>Maximum Benefit While Covered</b>	Unlimited <sup>1</sup>	\$2,000,000 combined	
<b>Coinsurance</b> (after deductible)	Plan pays 100%	Plan pays 80%	Plan pays 60%
<b>Office Services</b>			
Primary Care (including lab and radiology)	\$40 copay	\$45 copay	Plan pays 60%
Specialty Care (including lab and radiology)	\$50 copay	\$65 copay	Plan pays 60%
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<b>Emergency Services</b>			
Emergency Room Visit—per visit; copay waived if admitted	\$250 copay	\$250 copay	\$250 copay
Ambulance—per trip	\$150 copay	\$150 copay	\$150 copay
After-Hours Urgent Care—per visit	\$80 copay	Plan pays 80%	Plan pays 60%
<b>Outpatient Services</b>			
High Tech Radiology Services (MRI, CT, PET, others)	Plan pays 100%	Plan pays 80%	Plan pays 60%
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Home Delivery—90-day supply—Kaiser Permanente Pharmacy (Generic Preferred/Brand Preferred/Non-Preferred)	\$30/\$60/\$90	\$60/\$150/\$225	Not applicable

<sup>1</sup>Some benefits may have limitations.

<sup>2</sup>Deductible does not apply.

<sup>3</sup>Chemical Dependency covered for detoxification only under the Medical Plan.

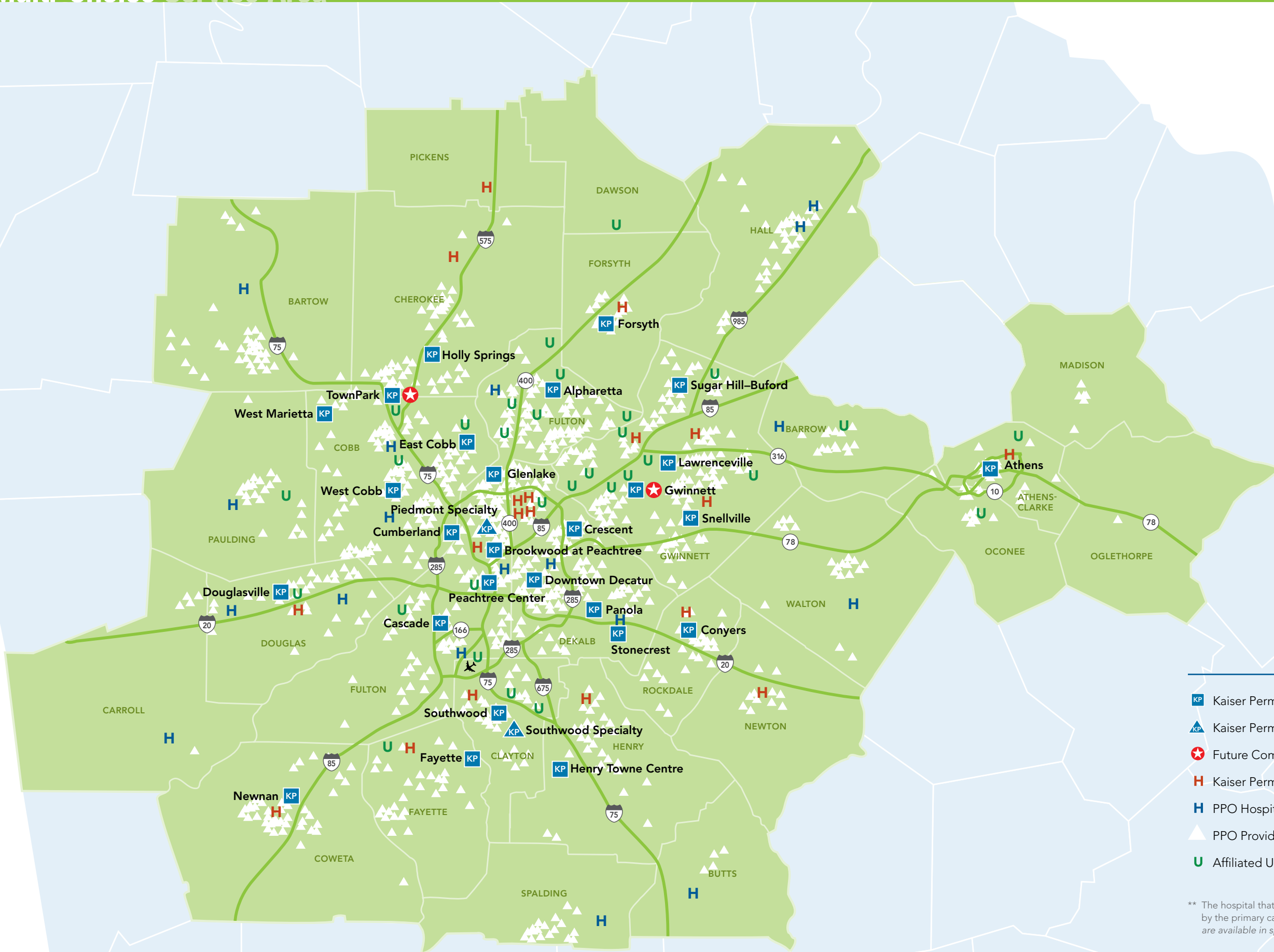
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# Multi-Choice Service Area

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## KEY

- Kaiser Permanente Medical Facilities
- Kaiser Permanente Specialty Facilities
- Future Comprehensive Medical Centers
- Kaiser Permanente Affiliated Hospitals\*
- PPO Hospitals (Tier2)
- PPO Providers (Tier2)
- Affiliated Urgent Care Centers

\*\* The hospital that you will be admitted to is determined by the primary care physician you select. Some locations are available in specific cases.

## When it's time to decide on your plan options, choosing a fixed dollar contribution can benefit your company's bottom line.

### What is a fixed dollar contribution?

Having a fixed dollar contribution means choosing a Kaiser Permanente HMO as your standard plan (or benchmark). This way, you maintain a fixed dollar contribution level relative to the HMO plan, while offering the Multi-Choice plan as an option your employees can buy up on a dollar-for-dollar basis to obtain.

### How does a fixed dollar contribution provide value to your company's bottom line?

When you choose a Kaiser Permanente HMO as your standard plan offering, you have the potential to save on your contribution levels over time. It will keep your costs lower, while providing your employees with a choice of plans and the high quality, award-winning care they deserve. Additionally, you'll know exactly what your annual contribution will be up front, regardless of which plans your employees choose—which means no surprises to hit your budget later in the year.

### Here's an example....

Let's say you've decided to offer both an HMO plan and a Multi-Choice plan to your employees this year—with the company contributing at a rate of 50%. The HMO plan costs \$260 and the Multi-Choice plan costs \$380, so typically you'd have an employee and employer cost of \$130 and \$190 respectively. But if you choose a fixed dollar contribution, you'll keep your costs lower by contributing only \$130 toward the Multi-Choice plan. At the same time, you'll provide your employees with a choice of plans and the high quality, award-winning care they deserve.

	Fixed Dollar Contribution			
	HMO	Multi-Choice	HMO	Multi-Choice
Plan Cost	\$260	\$380	\$260	\$380
Employer Contribution	\$130 (\$260x50%)	\$190 (\$380x50%)	\$130 (\$260x50%)	\$130 (benchmarked)
Employee Contribution	\$130	\$190	\$130	\$250 (buy-up)

Your Potential Savings = \$60 per employee premium.

## Kaiser Permanente HSA-Qualified Deductible HMO Plans

Our HSA-Qualified Deductible HMO plans are designed to lower premiums, while still providing the coverage and health resources needed to keep members healthy.

As a core benefit, we offer a wide range of preventive care services that are not subject to the deductible. For most other services, a deductible and coinsurance will apply.

After the deductible is met, members will either be fully covered, or traditional health care coverage with coinsurance will apply, depending on the plan they select.

The coinsurance aren't lost dollars; they apply to the out-of-pocket maximum. The out-of-pocket maximum is the most a member will ever have to pay for covered health services in a given year. Once the out-of-pocket maximum has been reached, Kaiser Permanente will be responsible for 100 percent of the allowable charges for these services for the remainder of the calendar year.

As with all of our HMO plans, members enrolled in our HSA-Qualified Deductible HMO plans will have access to doctors at our medical facilities in metro-Atlanta and Athens.

## HSA Administrator — Wells Fargo Bank

Kaiser Permanente selected Wells Fargo Bank as its preferred Health Savings Account (HSA) trustee and administrator for the HSA accounts. Affordable and easy to use, the HSA accounts help people take charge of their health care dollars and their future.

Kaiser Permanente provides and administers the health plan, while Wells Fargo Bank administers the HSA accounts. Those who choose Wells Fargo Bank can enjoy the convenience of the HSA Visa® debit card to pay for qualified medical expenses.

In addition, Wells Fargo Bank is pleased to furnish a coordinated HSA program that enables you to offer your clients increased flexibility and choice. With these HSA accounts, your clients can avoid the inconvenience of having to search for an HSA provider. We've done the legwork. If they prefer to use another HSA trustee, that's okay too. Our HSA-qualified plans are designed to work with all HSA providers.

Visit [wellsfargo.com/hsa](https://wellsfargo.com/hsa) for more information.

## Self-Only and Family (2+) Plan Combinations

	PLAN A		PLAN B		PLAN C		PLAN D		PLAN E	
	Self-Only*	Family	Self-Only*	Family	Self-Only*	Family	Self-Only*	Family	Self-Only*	Family
Deductible (Individual/Family)	\$1,200*	\$2,400	\$2,850*	\$5,700	\$1,200*	\$2,400	\$2,850*	\$5,700	\$5,000*	\$10,000
Out-of-Pocket Max (Individual/Family)	\$1,200*	\$2,400	\$2,850*	\$5,700	\$3,600*	\$7,200	\$4,850*	\$9,700	\$5,000*	\$10,000
Maximum Benefit While Covered	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Coinsurance	Plan pays 100% (after annual deductible)		Plan pays 100% (after annual deductible)		Plan pays 80% (after annual deductible)		Plan pays 80% (after annual deductible)		Plan pays 100% (after annual deductible)	
Preventive visits	Plan pays 100%									
All other covered services	Subject to Annual Deductible and Coinsurance									

\* These plans have a non-embedded deductible and require any one or any combination of family members to meet the deductible before the co-insurance takes effect. This is a summary description and is not intended to replace the Group Agreement, Group Policy, and/or Evidence of Coverage, which contain the complete provisions of this coverage. Some benefits may have specific limitations and/or exclusions. Benefits subject to Department of Insurance approval.