

# FlourishPlan™

Effective January 1, 2010

# HMO Benefits and Services

	"High" \$15/30 Option Member pays	"Mid" 90%/\$400 Option Member pays	"Low" 80%/\$700 Option Member pays
<b>Coinsurance</b>	none	10%	20%
<b>Deductible</b> (single/family)	none	\$400/\$800*	\$700/\$1,400*
<b>Out-of-Pocket Maximum</b> (single/family)	\$2,000/ \$4,000	\$1,500/ \$3,000	\$3,000/ \$6,000
<b>Lifetime Maximum</b>	unlimited	unlimited	unlimited
<b>Office Visits</b> (primary care/specialist)	\$15/\$30 copay	\$20/\$35 copay	\$25/\$40 copay
<b>Prenatal Office Visits<sup>1</sup></b>	no charge	no charge	no charge
<b>Preventive Office Visits</b> (adult and pediatric)	\$15	no charge	no charge
<b>Preventive Screenings<sup>2</sup></b>	no charge	no charge	no charge
<b>Lab &amp; Radiology Services</b>	no charge	10% after deductible	20% after deductible
<b>Urgent Care Visits</b>	\$50 copay	\$50 copay	\$50 copay
<b>Ambulance Services<sup>3</sup></b>	\$50 copay	10% after deductible	20% after deductible
<b>Emergency Department Visits</b>	\$150 copay	10%	20%
<b>Hospital Inpatient Care</b>	\$375 copay	10% after deductible	20% after deductible
<b>Maternity Delivery</b>	\$375 copay	10% after deductible	20% after deductible
<b>Durable Medical Equipment</b>	20%*	20%*	20%*
<b>Chiropractic Services</b> (limited to 20 visits)	\$25 copay*	\$25 copay*	\$25 copay*
<b>Prescription Drugs<sup>4</sup></b> (generic/brand)	\$20/\$45 copay*	\$20/\$45 copay*	\$20/\$45 copay*
<b>Dental Plan<sup>5</sup></b> (preventive and palliative)	optional*	optional*	optional*
<b>Vision Exam</b>	\$30 copay	\$35 copay	\$40 copay
<b>Hardware Allowance for Eyeglasses and Contacts<sup>6</sup></b>	optional*	optional*	optional*
<b>Extended Dependent Coverage</b>	Up to age 23 regardless of student status		

This is a summary description and is not intended to replace the *Group Agreement* and/or *Evidence of Coverage*, which contain the complete provisions of this coverage. Some benefits may have specific limitations and/or exclusions. To obtain a Kaiser Permanente HMO Plan *Evidence of Coverage*, contact a marketing representative at 1-800-400-1907.

\*Amount is not subject to nor does it apply to the Out-of-Pocket Maximum.

<sup>1</sup>Office visit copayment then 100 percent (deductible waived) for initial visit which establishes pregnancy. Follow-up (ante partum) visits not subject to copayment.

<sup>2</sup>Includes preventive cervical, prostate, colorectal, and mammogram screenings.

<sup>3</sup>Only when required by medical condition and transportation in any other vehicle would endanger health.

<sup>4</sup>Based on Kaiser Permanente drug formulary. Mail order 62-day supply included.

<sup>5</sup>Delta Dental PPO (Standard) is a preferred provider dental benefits program administered and underwritten by Delta Dental Plan of Ohio.

<sup>6</sup> Allowance toward the price of eyeglass lenses, frames, and/or contact lenses when prescribed by a Plan physician or optometrist and dispensed at a VSP® provider every 24 months. Contact lens exam provided at an additional \$50 charge. Vision allowance administered and underwritten by VSP Vision Care.

Note: HMO plans do not include a pre-existing condition clause.

# Added Choice® POS Benefits and Services

Member may choose to seek care from Tier 1, 2, or 3 at any time.

	"High" 80%/\$400 Option Member pays			"Mid" 80%/\$700 Option Member pays			"Low" 70%/\$1000 Option Member pays		
	TIER 1	TIER 2	TIER 3	TIER 1	TIER 2	TIER 3	TIER 1	TIER 2	TIER 3
<b>Coinsurance</b>	none	20%	30%	10%	20%	30%	20%	30%	40%
<b>Deductible</b> (single/family)	none	\$400/\$800*	\$700/\$1,400*	\$400/\$800*	\$700/\$1,400*	\$1,000/\$2,000*	\$700/\$1,400*	\$1000/\$2,000*	\$2,000/\$4,000*
<b>Out-of-Pocket Maximum</b> (single/family)	\$2000/\$4000	\$2500/\$5000	\$4000/\$8000	\$2,000/\$4,000	\$3,000/\$6,000	\$4,000/\$8,000	\$3,000/\$6,000	\$4,000/\$8,000	\$5,000/\$10,000
<b>Lifetime Maximum</b>	unlimited	\$2,000,000		unlimited	\$2,000,000		unlimited	\$2,000,000	
<b>Office Visits</b> (primary care/specialist)	\$15/\$30 copay	\$25/\$40 copay†	30% after deductible	\$20/\$35 copay	\$30/\$45 copay†	30% after deductible	\$25/\$40 copay	\$35/\$50 copay†	40% after deductible
<b>Prenatal Office Visits</b> <sup>1</sup>	no charge	no charge	30% after deductible	no charge	no charge	30% after deductible	no charge	no charge	40% after deductible
<b>Preventive Office Visits</b> <sup>2</sup> (primary care/specialist)	\$15/\$30 copay	\$25/\$40 copay†	50% after deductible	no charge	\$30/\$45 copay†	50% after deductible	no charge	\$35/\$50 copay†	50% after deductible
<b>Well Child Visits</b> <sup>3</sup> (primary care/specialist)	\$15/\$30 copay	\$25/\$40 copay†	50% after deductible	no charge	\$30/\$45 copay†	50% after deductible	no charge	\$35/\$50 copay†	50% after deductible
<b>Preventive Screenings</b> <sup>4</sup>	no charge	no charge	50% after deductible	no charge	20% after deductible	50% after deductible	no charge	30% after deductible	50% after deductible
<b>Lab &amp; Radiology Services</b>	no charge	20% after deductible	30% after deductible	10% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	40% after deductible
<b>Urgent Care Visits</b>	\$50 copay	\$75 copay†	30% after deductible	\$50 copay	\$75 copay†	30% after deductible	\$50 copay	\$75 copay†	40% after deductible
<b>Ambulance Services</b> <sup>5</sup>	\$50 copay	20% after deductible	30% after deductible	10% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	40% after deductible
<b>Emergency Services</b>	\$150 copay	Emergencies treated at providers in this tier are covered under the Tier 1 benefit level.		10%	Emergencies treated at providers in this tier are covered under the Tier 1 benefit level.		20%	Emergencies treated at providers in this tier are covered under the Tier 1 benefit level.	
<b>Non-emergent use of ER</b>	See Tier 2 and 3	20% after deductible	30% after deductible	See Tier 2 and 3	20% after deductible	30% after deductible	See Tier 2 and 3	30% after deductible	40% after deductible
<b>Hospital Inpatient Care</b>	\$375 copay	20% after deductible	30% after deductible	10% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	40% after deductible
<b>Maternity Delivery</b>	\$375 copay	20% after deductible	30% after deductible	10% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	40% after deductible
<b>Durable Medical Equipment</b> <sup>6</sup>	20%*	20% after deductible	30% after deductible	20%*	20% after deductible	30% after deductible	20%*	30% after deductible	40% after deductible
<b>Chiropractic Services</b> (limited to 20 visits)	\$25 copay*	20% after deductible	30% after deductible	\$25 copay*	20% after deductible	30% after deductible	\$25 copay*	30% after deductible	40% after deductible
<b>Prescription Drugs*</b> (generic/brand)									
<p><b>Filled at KP and Affiliated Pharmacies:</b>                      • <b>Formulary</b> \$20/\$45, mail order: 62-day supply \$20/\$45 • <b>Non-formulary</b> \$30/\$60, mail order: 90-day supply \$60/120  <b>Filled at Participating MedImpact Pharmacies:</b> \$30/\$60</p>									
<b>Extended Dependent Coverage</b>	Up to age 23 regardless of student status								

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This booklet is a summary only. The Kaiser Foundation Health Plan *Evidence of Coverage* and the Kaiser Permanente Insurance Company (KPIC) *Certificate of Insurance* contain a complete explanation of benefits, exclusions, and limitations. The information provided in this brochure is not intended for use as a benefit summary, nor is it designed to serve as the *Evidence of Coverage* or *Certificate of Insurance*.

The HMO Plan and the Tier 1 portion of the Point-of-Service (POS) Plans are underwritten by Kaiser Foundation Health Plan of Ohio. Kaiser Permanente Insurance Company (KPIC) underwrites Tiers 2 and 3 of the POS Plans. KPIC is a subsidiary of Kaiser Foundation Health Plans, Inc.

\*Amount is not subject to nor does it apply to the Out-of-Pocket Maximum.

<sup>1</sup> Copayments under Tier 2 are not subject to, nor do they contribute toward satisfaction of, the Calendar Year Deductible or Out-of-Pocket Maximum.

<sup>1</sup> Office Visit copayment, then 100 percent, with deductible waived, for initial visit which establishes pregnancy. Follow-up (antepartum) visits not subject to copayments.

<sup>2</sup> Office Visits limited to a combined maximum benefit of one routine visit per calendar year for Tiers 2 and 3.

<sup>3</sup> Well Child Visits limited to a \$500 combined Tier 2 and 3 benefit maximum per calendar year.

<sup>4</sup> Includes preventive cervical, prostate, colorectal, and mammogram screenings.

<sup>5</sup> Only when required by medical condition and transportation in any other vehicle would endanger health. Limited to a \$1,000 maximum benefit per calendar year in Tiers 2 and 3.

<sup>6</sup> Limited to a combined \$2000 maximum benefit per calendar year for Tier 2 and 3.

Coinsurance is based on Maximum Allowable Charge (MAC). MAC = the lesser of the Negotiated Rate, the Usual, Customary, and Reasonable Charge or the Actual Billed Charge. Member is responsible for any charges that exceed MAC for out-of-network services.

#### Important information

Written information on topics related to coverage offered to employer groups in the small group market is available and can be obtained by calling 1-877-284-7483. Topics include:

1. Factors that affect rate setting and rate adjustments.
2. Provisions related to renewing coverage.
3. Plan designs and premium available to small groups.

Note: POS plans do not include a pre-existing condition clause.

