KAISER PERMANENTE®

Important notice

Health plans are undergoing many changes due to the passage of the Patient Protection and Affordable Care Act. At Kaiser Permanente, we want to help you keep informed about how the federal health reform law affects your individual and family coverage.

We are currently working to implement the new federal health reform law in accordance with the schedule outlined by Congress. While many key aspects of the legislation will phase in over the next several years, some provisions will impact your benefits effective October 1, 2010. Among these provisions are: an expanded list of preventive care services, covered in network with no cost sharing; no lifetime maximums for designated essential health benefits; and the continuation of insurance coverage for dependent children up to age 26.

The information in this notice changes some of the information in the enclosed enrollment kit, which outlines our Kaiser Permanente for Individuals and Families coverage effective October 1, 2010, through December 31, 2011. There may be additional benefit and eligibility revisions based on further clarification from our federal regulators. If so, we will keep you informed of these changes.

If you have questions, please call **1-800-494-5314**, 8 a.m. to 8 p.m., Monday through Friday, and 9 a.m. to 5 p.m., Saturday, or call your broker.

Thank you for your interest in Kaiser Permanente.

Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, GA 30305

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PLANS & BENEFITS

Use this brochure to compare plans
and choose the one that's best for you.

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Atlanta, GA 30305

KAISER PERMANENTE®

Benefit highlights

	HMO				
	Premier	Plan 500	Plan 1000	Plan 2000	Plan 3000
Features					
Annual deductible (individual/family)	None	$500/$1,500	$1,000/$3,000	$2,000/$6,000	$3,000/$9,000
Annual out-of-pocket maximum (individual/family)	None	$2,000/$6,000			
Lifetime benefit maximum	Unlimited				
Benefits	Benefits with copays not subject to deductible/Benefits with coinsurance subject to deductible				
Preventive care (not subject to deductible—office visit copay may apply)					
Immunizations	No charge				
Well-child visit (to age 2)	No charge				
Certain preventive screenings	No charge				
Mammogram	No charge				
Outpatient services (per visit or procedure)					
Primary care office visit	$30 copay				
Specialist office visit	$50 copay				
Most X-rays and lab tests	No charge				
MRI, CT, and PET	$100 copay	30% coinsurance			
Outpatient surgery	$100 copay	30% coinsurance			
Inpatient hospital care					
Room and board, surgery, anesthesia, X-rays, lab tests, and medication	$500 per admission	30% coinsurance			
Maternity (other charges will apply for professional services)					
Obstetrician/Midwife	$1,000 copay				
Hospital delivery	$2,000 copay				
Emergency and urgent care					
Emergency Room visit (waived if admitted)	$150 copay				
Urgent care visit	$60 copay				
Ambulance service	$150 copay				
Prescription drugs					
Pharmacy deductible (individual/family)	$200/$600				
Generic drugs (Kaiser Permanente pharmacy/ network pharmacy)	$15 copay/$21 copay (after pharmacy deductible)				
Brand drugs (Kaiser Permanente pharmacy/ network pharmacy)	$30 copay/$36 copay (after pharmacy deductible)				
Other services					
Vision exam	$50 copay				

Have a question? We have answers. Call your broker today!

	BALANCE HMO (individual subscriber only)			
Plan 5000	Balance 2000	Balance 3000	Balance 5000	Balance 10000
$5,000/$15,000	$2,000	$3,000	$5,000	$10,000
	$5,000	$6,000	$10,000	
	$3 million			
	Benefits with copays not subject to deductible/Benefits with coinsurance subject to deductible			
	No charge			
	No charge			
	No charge			
	No charge			
	$40 copay			
	$50 copay			
	30% coinsurance			
	30% coinsurance			
	30% coinsurance			
	30% coinsurance			
	Not covered			
	Not covered			
	$150 copay			
	$60 copay			
	$150 copay			
$500/$1,500	$500 (brand drugs only)			
	$20 copay/$30 copay			
	$40 copay/$50 copay (after pharmacy deductible)			
	No coverage			

This plan summary is intended to only highlight some of the principal provisions of our plans. Please refer to your *Evidence of Coverage* for more details of your plan or for specific limitations and exclusions. Certain underwriting guidelines apply. Applicants are subject to medical review.

NOW PLUS				
Now 2000 Plus	Now 4000 Plus	Now 6000 Plus	Now 10000 Plus	Features
$2,000/$6,000	$4,000/$12,000	$6,000/$18,000	$10,000/$30,000	Annual deductible (individual/family)
$5,000/$9,000				Annual out-of-pocket maximum (individual/family)
$6 million				Lifetime benefit maximum
Benefits with copays not subject to deductible/Benefits with coinsurance subject to deductible				Benefits
				Preventive care (not subject to deductible—office visit copay may apply)
No charge				Immunizations
No charge				Well-child visit (to age 2)
No charge				Certain preventive screenings
No charge				Mammogram
Kaiser Permanente medical centers/non–Kaiser Permanente facilities				**Outpatient services (per visit or procedure)**
$40 copay				Primary care office visit
$60 copay				Specialist office visit
No charge/30% coinsurance				Most X-rays and lab tests
30% coinsurance				MRI, CT, and PET
30% coinsurance				Outpatient surgery
				Inpatient hospital care
30% coinsurance				Room and board, surgery, anesthesia, X-rays, lab tests, and medication
				Maternity (other charges will apply for professional services)
$1,500 copay				Obstetrician/Midwife
$3,000 copay				Hospital delivery
				Emergency and urgent care
$250 copay				Emergency Room visit (waived if admitted)
$70 copay				Urgent care visit
$250 copay				Ambulance service
				Prescription drugs
$300/$600 (brand drugs only)				Pharmacy deductible (individual/family)
$15 copay/$21 copay				Generic drugs (Kaiser Permanente pharmacy/ network pharmacy)
$40 copay/$46 copay (after pharmacy deductible)				Brand drugs (Kaiser Permanente pharmacy/ network pharmacy)
				Other services
$60 copay				Vision exam

Get a faster response when you apply online. Ask your broker how!

Benefit highlights

	NOW			
	Now 2000	Now 4000	Now 6000	Now 10000
Features				
Annual deductible (individual/family)	$2,000/$6,000	$4,000/$12,000	$6,000/$18,000	$10,000/$30,000
Annual out-of-pocket maximum (individual/family)	$5,000/$9,000			
Lifetime benefit maximum	$6 million			
Benefits	Benefits with copays not subject to deductible Benefits with coinsurance subject to deductible			
Preventive care (not subject to deductible—office visit copay may apply)				
Immunizations	No charge			
Well-child visit (to age 2)	No charge			
Certain preventive screenings	No charge			
Mammogram	No charge			
Outpatient services (per visit or procedure)	Kaiser Permanente medical centers/non–Kaiser Permanente facilities			
Primary care office visit	$40 copay			
Specialist office visit	$60 copay			
Most X-rays and lab tests	No charge/30% coinsurance			
MRI, CT, and PET	30% coinsurance			
Outpatient surgery	30% coinsurance			
Inpatient hospital care				
Room and board, surgery, anesthesia, X-rays, lab tests, and medication	30% coinsurance			
Maternity (other charges will apply for professional services)				
Obstetrician/Midwife	$1,500 copay			
Hospital delivery	$3,000 copay			
Emergency and urgent care				
Emergency Room visit (waived if admitted)	$250 copay			
Urgent care visit	$70 copay			
Ambulance service	$250 copay			
Prescription drugs				
Generic/Brand drugs	Not covered			
Other services				
Vision exam	$60 copay			

This plan summary is intended to only highlight some of the principal provisions of our plans. Please refer to your *Evidence of Coverage* for more details of your plan or for specific limitations and exclusions. Certain underwriting guidelines apply. Applicants are subject to medical review.

	HMO WITH HSA OPTION PLANS FOR INDIVIDUALS	
	HSA Option 3500/100% Self	HSA Option 5000/100% Self
Features		
Annual deductible	$3,500	$5,000
Annual out-of-pocket maximum	$3,500	$5,000
Lifetime benefit maximum	None	
Benefits	Benefits with copays not subject to deductible Benefits with coinsurance subject to deductible	
Preventive care (not subject to deductible)		
Preventive care visit	$15 office visit copay	
Preventive care services	No charge (office visit copay may apply)	
All other covered services		
Coinsurance	No charge (after deductible)	

	HMO WITH HSA OPTION PLANS FOR FAMILIES (2+)		
	HSA Option 3500/100% Family	HSA Option 5000/100% Family	HSA Option 5000/80% Family
Features			
Annual deductible	$3,500	$5,000	$5,000
Annual out-of-pocket maximum	$3,500	$5,000	$9,000
Lifetime benefit maximum	None		
Benefits	Benefits with copays not subject to deductible Benefits with coinsurance subject to deductible		
Preventive care (not subject to deductible)			
Preventive care visit	$15 office visit copay		
Preventive care services	No charge (office visit copay may apply)		
All other covered services			
Coinsurance	No charge (after deductible)		20% coinsurance (after deductible)

	BALANCE HSA
	Balance HSA 1200
Features	
Annual deductible	$1,200
Annual out-of-pocket maximum	$1,200
Lifetime benefit maximum	$3 million
Benefits	Benefits with copays not subject to deductible Benefits with coinsurance subject to deductible
Preventive care (not subject to deductible)	
Preventive care visit	$15 office visit copay
Preventive care services	No charge (office visit copay may apply)
All other covered services	
Coinsurance	No charge (after deductible)

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