

OPEN ENROLLMENT PLANS (non-FEI)
 HIPAA PLANS (FEI)
 2012 BENEFITS AND SERVICES



BENEFIT DESCRIPTION		Basic Plan You Pay	Standard Plan You Pay
Deductible		\$1,000 Single \$2,000 Family	\$ 750 Single \$1,500 Family
Member Copayment (% of Covered Services)		40%	30%
Annual Out-of Pocket Maximum		\$ 5,000 Single \$10,000 Family	\$ 5,000 Single \$10,000 Family
Lifetime Limits		None	None
Outpatient Care*	Primary Care visits	\$25 per visit	\$25 per visit
	Specialty Care visits, including Pre and Postnatal Care	\$40 per visit	\$40 per visit
	Respiratory Therapy, Radiation Therapy, Chemotherapy, Physician House Calls (Standard Plan Only), and Surgical procedures performed in an outpatient hospital or ambulatory surgical center	40% of eligible charges after deductible	30% of eligible charges after deductible
Hospital Inpatient Care*		40% of eligible charges after deductible, No limit on covered days	30% of eligible charges after deductible; No limit on covered days
Ambulance*		\$110 per trip	\$110 per trip
Chemical Dependency Services	Outpatient Detoxification, Outpatient Individual Therapy, Outpatient Group Therapy	Not Covered	30% of eligible charges after deductible; 10 visits per member per calendar year
	Inpatient Detoxification in a general hospital	Not Covered	30% of eligible charges after deductible; No limit on covered days
	Inpatient Detoxification in a specialized facility	Not Covered	30% of eligible charges after deductible; Limit 5 days per member per contract year
Dialysis*		40% of eligible charges after deductible	30% of eligible charges after deductible
Durable Medical Equipment (Equipment for temporary use not to exceed a 6-month period of time)		40% of eligible charges after deductible	30% of eligible charges after deductible
Emergency Services*	Emergency Services at a Plan or Non-Plan Facility	\$110 per visit (waived if admitted)	\$110 per visit (waived if admitted)
Family Planning*		\$40 per visit	\$40 per visit
Home Health, Hospice		Not Covered	30% of eligible charges after deductible
Infertility Services*	Inpatient	40% of eligible charges after deductible	30% of eligible charges after deductible
	Outpatient	\$40 per visit	\$40 per visit
Laboratory, X-Ray and Other Diagnostic Services*		40% of eligible charges after deductible	30% of eligible charges after deductible
Biologically Based Mental Illnesses*	Inpatient	40% of eligible charges after deductible, no limit on covered days	30% of eligible charges after deductible, no limit on covered days
	Outpatient Individual Therapy	\$40 per visit	\$40 per visit
	Outpatient Group Therapy	\$20 Per visit	\$20 per visit
Other Mental Illnesses	Inpatient	Not Covered	30% of eligible charges after deductible; limit 5 days per member per contract year
	Outpatient Individual Therapy, Outpatient Group Therapy	Not Covered	30% of eligible charges after deductible; 10 visits per member per calendar year
Outpatient Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation	Physical Therapy, Occupational Therapy, Speech Therapy, Multidisciplinary Rehabilitation	Not Covered	Not Covered
Reconstructive Surgery*	Inpatient	40% of eligible charges after deductible	30% of eligible charges after deductible
	Outpatient	\$40 per visit	\$40 per visit
Skilled Nursing Facility		Not Covered	30% of eligible charges after deductible; Unlimited number of days
Transplants*-One year wait period on Open Enrollment Plans	Inpatient	40% of eligible charges after deductible	30% of eligible charges after deductible
	Outpatient	\$40 per visit	\$40 per visit

Urgent Care Services*		\$45 per visit	\$45 per visit
Vision		Not Covered	Not Covered
Dependent Age Limit		Age 28 end of birth month	Age 28 end of birth month
Student Dependent Age Limit		Age 28 end of birth month	Age 28 end of birth month
Prescription Drugs	At Plan affiliated pharmacies only	Not Covered	\$15 per prescription
Preventive Services		No Charge	No Charge
*Basic Health Services. Copayments will not exceed 40% of the average cost to the Health Plan for the service.			
THIS SUMMARY OF BENEFITS CONTAINS HIGHLIGHTS ONLY. Specific benefits, exclusions, and limitations are contained in the <i>Evidence of Coverage</i> you will receive when you become a member. For specific questions about coverage, please call an Individual Service Representative at 1-800-524-7371, ext. 5613.			

Health Plan Drug Formulary

Kaiser Permanente of Ohio uses a closed drug formulary. The medications included in the Kaiser Permanente Formulary are chosen by a group of Kaiser Permanente physicians, pharmacists, and nurses known as the Pharmacy and Therapeutics Committee. This Committee meets regularly to evaluate and choose those medications that are effective, safe, and useful in caring for our members. Non-formulary drugs may be approved for coverage if certain criteria are met.

Not all Kaiser Permanente health benefit plans include coverage for prescription drugs. Some drugs may be excluded from coverage. Some plans have limitations on the dollar amount of coverage. Some medications may have quantity restrictions limiting the amount of the drug you can receive per prescription or copayment. Coverage of certain formulary medications may also be subject to restrictions established by the Pharmacy and Therapeutics Committee.

For more information regarding our prescription drug benefit procedures or your benefit, please call our Customer Relations Department at 216-621-7100 or 1-800-686-7100 or visit kp.org to view the Member Drug Formulary.

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