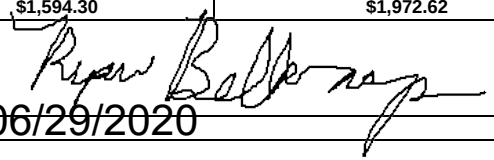
KAISER PERMANENTE®

Senior Lifestyle Corporation

	California	Colorado	Mid-Atlantic States
	Proposed 2020 MS6 DED $1,500	**Proposed 2020 MS6 DED $1,500**	**Proposed 2020 MS6 DED $1,500**
Annual Deductible: Individual / Family	$1,500 / $3,000	$1,500 / $3,000	$1,500 / $3,000
Maximum Out-Of-Pocket: Individual / Family	$3,000 / $6,000	$3,000 / $6,000	$3,000 / $6,000
Maximum Lifetime Benefit	Unlimited	Unlimited	Unlimited
Hospital Inpatient			
Services rendered while hospitalized	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient			
Primary Care	$30 per visit	$30 per visit	$30 per visit
Urgent Care	$30 per visit	$30 per visit	$30 per visit
Specialist	$50 per visit	$50 per visit	$50 per visit
Well-child preventive care visits (23 months & younger)	No charge	No charge	No charge
Scheduled prenatal care and first postpartum visit	No charge	20% coinsurance after deductible	No charge
Outpatient surgery	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
X-rays and Lab tests	20% coinsurance after deductible	20% coinsurance after deductible (X-rays) No charge (Lab tests)	20% coinsurance after deductible
Advanced Imaging (CT / MRI / PET)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Ambulance services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Emergency department visits	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient Prescription Drugs			
Pharmacy	$15 G / $40 B / 20% SPC (up to $150 max)	$20 G / $40 B / $60 NPB 20% SPC (up to $150 max)	$20 G / $40 B / $60 NPB / 50% SPC (up to $150 max)
Days Supply	Pharmacy: 30 days Mail Order: 100 days	Pharmacy: 30 days Mail Order: 90 days	Pharmacy: 30 days Mail Order: 90 days
Mental Health Services			
Inpatient psychiatric care	20% coinsurance after deductible	20% coinsurance*	20% coinsurance after deductible
Outpatient individual therapy visits	$30 per visit	$30 per visit	$30 per visit
Outpatient group therapy visits	$15 per visit	$15 per visit	$15 per visit
Chemical Dependency Services			
Inpatient detoxification	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient individual therapy visits	$30 per visit	$30 per visit	$30 per visit
Outpatient group therapy visits	$15 per visit	$15 per visit	$15 per visit
Transitional Residential Recovery Services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Infertility Services			
Covered services related to the diagnosis and treatment of infertility	50% coinsurance for covered services only	50% coinsurance for covered services only	50% coinsurance for covered services only
Additional Benefits			
Supplemental Durable Medical Equipment	No charge	No charge after deductible	No charge
Skilled Nursing Facility	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Home Health	No charge	20% coinsurance after deductible	20% coinsurance after deductible
Hospice Care	No charge	No charge	20% coinsurance after deductible
Optical eyewear	$250 allowance / every 24 months	$250 allowance / every 24 months	25% discount on frames at KP Optical / every 12 months
Hearing aids	$1,000 allowance / 1 device per ear / every 36 months	$1,000 allowance / 1 device per ear / every 36 months	$1,000 allowance / 1 device per ear / every 36 months
Chiropractic	$15 per visit / 40 visits (combined with acupuncture)	$15 per visit / 20 visits	$15 per visit / 20 visits
Dental	Not covered	Not covered	Not covered
Proposed Monthly Dues Effective 10/1/2020-9/30/2021			
Rate Tiers	**Rates**		**Rates**
Subscriber Only	**$535.00**	**$661.95**	**$642.39**
Subscriber and Spouse	**$1,118.15**	**$1,383.48**	**$1,342.60**
Subscriber and Child(ren)	**$1,011.15**	**$1,251.09**	**$1,214.12**
Family	**$1,594.30**	**$1,972.62**	**$1,914.33**

DISCLAIMER: This information is for illustrative purposes only. Please refer to your EOC documents for complete explanation of benefits.

Signature 

Date 06/29/2020

[1]Self only coverage (family of one)

[2]Each member in a family of 2 or more

[3]Entire Family of two or more Members