Summary Of Medical Benefits

2014 Medical Plan Comparison

	Kaiser Senior Advantage	Companion Plan F	MedAdvantage + Rx Enhanced	MedAdvantage + Rx Classic
			In/Out of Network	In/Out of Network
Deductible	None	None	None	$50
Out-of-pocket maximum	$1,000	None	$2,500	$3,400
Doctor Office Visits				
Wellness Exam	No copay	No copay	No copay	No copay
Office visits	$10 / $20 copay	No copay	$20/$30 copay	$20/$40 copay
Urgent Care	$15 copay	No copay	$30/$30 copay	$30/$30 copay
X-Ray & Lab	No copay	No copay	No copay/you pay 10% coinsurance	No copay/you pay 20% coinsurance
Diagnostic tests	No copay	No copay	You pay 20%/20%	You pay 20%/20%
Hospital Services				
Ambulance	$75 copay	No copay	$100 copay	$100 copay
Hospital stay	$100 copay per day up to a maximum of $500 per Admit	No copay	$300/$400 copay per day up to a maximum of $1,800/$2400 per benefit period	$400/$500 copay per day up to a maximum of $1,600/$2,000 per benefit period
Skilled nursing facility	No copay for up to 100 days per year	No copay for up to 100 days per year	Days 1-100: $40/$60 copay per day	Days 1-100: $50/$70 copay per day
Emergency room	$50 copay; waived if admitted	No copay	$65 copay; waived if admitted	$65 copay; waived if admitted
Outpatient surgery (Ambulatory)	$50 copay	No copay	$175/$125 copay	$100/$150 copay
Rehabilitative services	$10 copay, limited to 20 per therapy per year for PT/OT/Speech	No copay	$30 copay	$40 copay

Services/Benefits Continued on Next Page

Other Services and Benefits				
	Kaiser Sr. Advantage	**Companion Plan F**	**MedAdvantage + RX Enhanced**	**MedAdvantage + RX Classic**
Eye examinations	$10 copay	Not Covered	$30 copay*/$30 copay with $45 allowed amount after copay. *Must use Vision Service Plan Provider (VSP)	$40 copay*/$40 copay with $45 allowed amount after copay. *Must use Vision Service Plan Provider (VSP)
Vision hardware	Up to $150 credit every 24 months	Not Covered	Up to $200 annual plan coverage limit	Up to $50 annual plan coverage limit
Dental services	Not Covered	Not Covered	You pay 50% with $500 allowed per year	You pay 50% with $500 allowed per year
Durable Medical Equipment	You pay 20%	No copay	You pay 10%/20%	You pay 20%/30%
Prescription Drugs				
Deductible/ Initial coverage	$0 deductible; your cost share is: 50% up to $25 limit per 30-day supply, up to $50 limit per prescription for 90-day supply Until you reach $4,550 in total out-of-pocket costs then you move on to the Catastrophic Coverage	Not Covered	$0 deductible; your cost share is (Tier 1-6): $5/$33/$45/$90/33%/Tier 6: No Longer in Use Until you reach $2,850 in total costs then you move on to the Coverage Gap Stage	$205 deductible; your cost share is (Tier 1-6): $7/$33/$45/$90/27%/ Tier 6: No longer in Use Until you reach $2,850 in total costs then you move on to the Coverage Gap Stage
Coverage Gap			You pay $5 copay per prescription for each 30-day supply or 79% of the costs whichever is lower; for brand name drugs you pay 47.5% of the price (plus the dispensing fee) until you reach $4,750 in total out-of-pocket costs then you move on to Catastrophic Coverage	You pay 79% of the costs for covered Part D generics; for brand name drugs you pay 47.5% of the price (plus the dispensing fee) until you reach $4,750 in total out-of-pocket costs then you move on to Catastrophic Coverage
Catastrophic	You pay the lesser of your copayment or $3 generic and $7 brand per prescription.		You pay the greater of 5% coinsurance or $2.65/$6.60 copay, for a 30/90 day supply.	You pay the greater of 5% coinsurance or $2.65/$6.60 copay, for a 30/90 day supply.

The benefit information provided herein is a brief summary, but not a comprehensive description of available benefits. Additional information about benefits is available to assist you in making a decision about your coverage. For more information, please contact the Human Resource Office at 503-768-6235 to request a summary of benefits book.