

		<b>In-Network Coverage</b>		
<b>Plan facts</b>	Member services Member services hours Web address Product name	(800) 464-4000 Annual enrollment information: (800) 464-4000 Mon-Fri: 7:00 AM-7:00 PM; Sat-Sun: 7:00 AM-3:00 PM PT http://my.kp.org/citigroup Kaiser Permanente		
<b>Your medical expenses</b>	Annual deductible Out-of-pocket maximum (includes deductible) Office visits Maternity care prenatal office visits Inpatient hospitalization Outpatient surgical care Outpatient lab and X-ray Emergency room care Urgent care facility	\$500 (individual) / \$1,000 (family max) \$3,000 (individual) / \$6,000 (family max) per calendar year Covered at 90% after deductible Covered at 90%, no deductible Covered at 90% after deductible Covered at 90% after deductible Covered at 90% after deductible Covered at 90% after deductible \$100 copay/visit (waived if admitted) Covered at 90% after deductible		
<b>Your prescription drug expenses</b>	Retail	\$10 copay (generic), \$20 copay (preferred brand) per prescription up to 30-day supply		
	Mail order	\$20 copay (generic), \$40 copay (brand name) per prescription up to 100-day supply		
<b>Preventive care</b>	Routine physical and GYN exam Routine vision exam Well-child care and immunizations Routine mammography	Covered at 100%, no deductible. Limit 1 visit per year Covered at 100%, no deductible. Services provided by optometrist covered at 90% after deductible Covered at 100%, no deductible (Through age 23 months) Covered at 100%, no deductible. Limit 1 visit per year		
<b>Mental health</b>	Inpatient Outpatient	Covered at 90% after deductible Covered at 90% after deductible		
<b>Substance abuse</b>	Inpatient detoxification Inpatient rehabilitation Outpatient detoxification Outpatient rehabilitation	Covered at 90% after deductible Covered at 90% after deductible Covered at 90% after deductible Covered at 90% after deductible		
<b>Other professional care</b>	Outpatient physical/speech/occupational therapy Chiropractic care Infertility	Covered at 90% after deductible \$15 copay per visit. Limit 20 visits per year Diagnosis/Treatment: Covered at 50% for approved treatment; Artificial insemination: Covered at 50% except for donor semen and donor eggs and services related to their procurement and storage; In Vitro Fertilization: Not covered. Contact Plan for details		
<b>Out-of-network coverage</b>	Out-of-network non-emergency care	Not covered		
<b>Key facts</b>	NCQA status: PCP referral required for specialist: Lifetime maximum benefit: Provider network:	Excellent Yes NA See website for details	Domestic partner coverage available: Domestic partner children coverage avail.:  	Yes Yes  

\* Indicates a benefit change

The information contained in this summary is for comparative purposes and does not include all benefits, limitations, and exclusions.