

# Now Plus plans with prescription coverage

Benefit Category	Now Premier Plus	Now 500 Plus
Annual Deductible (individual/family)	None	\$500 / \$1,500
Out-of-Pocket Maximum (coinsurance) (individual/family)	None	\$2,000 / \$6,000
Lifetime Benefit Maximum <sup>1</sup>	Unlimited	\$6 million
<b>Benefits</b>		
<b>Office Services</b> <ul style="list-style-type: none"> <li>■ Primary Care</li> <li>■ Specialty Care</li> <li>■ Preventive Screenings<sup>2</sup></li> </ul>	\$30 per visit \$50 per visit Plan pays 100%	\$40 per visit \$60 per visit Plan pays 100%
<b>Pharmacy Services – 30 day supply</b> <ul style="list-style-type: none"> <li>■ Prescription Drugs – Generic (Kaiser Permanente pharmacy/network pharmacy)</li> <li>■ Prescription Drugs – Brand (Kaiser Permanente pharmacy/network pharmacy)</li> <li>■ Pharmacy Deductible (brand drugs only) (individual/family)</li> </ul>	\$15 / \$21 \$40 / \$46 \$200 / \$600	\$15 / \$21 \$40 / \$46 \$300 / \$600
<b>Outpatient Services</b> (Kaiser Permanente Medical Center/non-Kaiser Permanente facility) <ul style="list-style-type: none"> <li>■ Laboratory Services</li> <li>■ Radiology Services</li> <li>■ High Tech Radiology Services (MRI, CT, PET, others)</li> <li>■ Outpatient Surgery Facility</li> </ul>	\$0 / \$100 \$0 / \$100 \$50 / \$100 \$100	Plan pays 100% / 70% Plan pays 100% / 70% Plan pays 70% Plan pays 70%
<b>Inpatient Services</b> <ul style="list-style-type: none"> <li>■ Hospital (facility charge)</li> <li>■ Physician and Other Professional Charges</li> </ul>	\$500 Plan pays 100%	Plan pays 70% Plan pays 70%
<b>Maternity Services</b> <ul style="list-style-type: none"> <li>■ Maternity (obstetrician/midwife)<sup>3</sup></li> <li>■ Maternity (hospital delivery)<sup>3</sup></li> </ul>	\$1,000 \$2,000	\$1,500 \$3,000
<b>Emergency Services</b> <ul style="list-style-type: none"> <li>■ Emergency Room Visit (per visit; copay waived if admitted)</li> <li>■ Ambulance (per trip)</li> </ul>	\$150 \$150	\$250 \$250
<b>Other Services</b> <ul style="list-style-type: none"> <li>■ Physical/Occupational Therapy (20 visits per year combined)</li> </ul>	\$50	Plan pays 70%

**Note:** Benefits with a copay are not subject to the deductible. Benefits with coinsurance are subject to the deductible.

<sup>1</sup> Some benefits may have limitations.

<sup>2</sup> Office visit copay may apply. Well-child visit: no charge up to age 2

<sup>3</sup> Maternity charges for members are for Ob/Gyn and/or midwife services (pre/post-natal and delivery) and for inpatient facility charge. Other charges may apply for other professional services.

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 1000 Plus	Now 2000 Plus	Now 4000 Plus	Now 6000 Plus	Now 10000 Plus
\$1,000 / \$3,000	\$2,000 / \$6,000	\$4,000 / \$12,000	\$6,000 / \$18,000	\$10,000 / \$30,000
\$2,000 / \$6,000	\$5,000 / \$9,000	\$5,000 / \$9,000	\$5,000 / \$9,000	\$5,000 / \$9,000
\$6 million	\$6 million	\$6 million	\$6 million	\$6 million
\$40 per visit \$60 per visit Plan pays 100%	\$40 per visit \$60 per visit Plan pays 100%	\$40 per visit \$60 per visit Plan pays 100%	\$40 per visit \$60 per visit Plan pays 100%	\$40 per visit \$60 per visit Plan pays 100%
\$15 / \$21 \$40 / \$46 \$300 / \$600	\$15 / \$21 \$40 / \$46 \$300 / \$600	\$15 / \$21 \$40 / \$46 \$300 / \$600	\$15 / \$21 \$40 / \$46 \$300 / \$600	\$15 / \$21 \$40 / \$46 \$300 / \$600
Plan pays 100% / 70% Plan pays 100% / 70% Plan pays 70% Plan pays 70%	Plan pays 100% / 70% Plan pays 100% / 70% Plan pays 70% Plan pays 70%	Plan pays 100% / 70% Plan pays 100% / 70% Plan pays 70% Plan pays 70%	Plan pays 100% / 70% Plan pays 100% / 70% Plan pays 70% Plan pays 70%	Plan pays 100% / 70% Plan pays 100% / 70% Plan pays 70% Plan pays 70%
Plan pays 70% Plan pays 70%	Plan pays 70% Plan pays 70%	Plan pays 70% Plan pays 70%	Plan pays 70% Plan pays 70%	Plan pays 70% Plan pays 70%
\$1,500 \$3,000	\$1,500 \$3,000	\$1,500 \$3,000	\$1,500 \$3,000	\$1,500 \$3,000
\$250 \$250	\$250 \$250	\$250 \$250	\$250 \$250	\$250 \$250
Plan pays 70%	Plan pays 70%	Plan pays 70%	Plan pays 70%	Plan pays 70%

# Now plans without prescription 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.

Benefit Category	Now 2000	Now 4000	Now 6000	Now 10000
<b>Annual Deductible (individual/family)</b>	\$2,000 / \$6,000	\$4,000 / \$12,000	\$6,000 / \$18,000	\$10,000 / \$30,000
<b>Out-of-Pocket Maximum (coinsurance) (individual/family)</b>	\$5,000 / \$9,000	\$5,000 / \$9,000	\$5,000 / \$9,000	\$5,000 / \$9,000
<b>Lifetime Benefit Maximum<sup>1</sup></b>	\$6 million	\$6 million	\$6 million	\$6 million
<b>Benefits</b>				
<b>Office Services</b>				
■ Primary Care	\$40 per visit	\$40 per visit	\$40 per visit	\$40 per visit
■ Specialty Care	\$60 per visit	\$60 per visit	\$60 per visit	\$60 per visit
■ Preventive Screenings <sup>2</sup>	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
<b>Pharmacy Services – 30 day supply</b>				
■ Prescription drugs (generic/brand)	No coverage <sup>3</sup>	No coverage <sup>3</sup>	No coverage <sup>3</sup>	No coverage <sup>3</sup>
■ Pharmacy Deductible	No coverage	No coverage	No coverage	No coverage
<b>Outpatient Services (Kaiser Permanente Medical Center/ non-Kaiser Permanente facility)</b>				
■ Laboratory Services	Plan pays 100% / 70%	Plan pays 100% / 70%	Plan pays 100% / 70%	Plan pays 100% / 70%
■ Radiology Services	Plan pays 100% / 70%	Plan pays 100% / 70%	Plan pays 100% / 70%	Plan pays 100% / 70%
■ High Tech Radiology Services (MRI, CT, PET, others)	Plan pays 70%	Plan pays 70%	Plan pays 70%	Plan pays 70%
■ Outpatient Surgery Facility	Plan pays 70%	Plan pays 70%	Plan pays 70%	Plan pays 70%
<b>Inpatient Services</b>				
■ Hospital (facility charge)	Plan pays 70%	Plan pays 70%	Plan pays 70%	Plan pays 70%
■ Physician and Other Professional Charges	Plan pays 70%	Plan pays 70%	Plan pays 70%	Plan pays 70%
<b>Maternity Services</b>				
■ Maternity (obstetrician/midwife) <sup>4</sup>	\$1,500	\$1,500	\$1,500	\$1,500
■ Maternity (hospital delivery) <sup>4</sup>	\$3,000	\$3,000	\$3,000	\$3,000
<b>Emergency Services</b>				
■ Emergency Room Visit (per visit; copay waived if admitted)	\$250	\$250	\$250	\$250
■ Ambulance (per trip)	\$250	\$250	\$250	\$250
<b>Other Services</b>				
■ Physical/Occupational Therapy (20 visits per year combined)	Plan pays 70%	Plan pays 70%	Plan pays 70%	Plan pays 70%

**Note: Benefits with a copay are not subject to the deductible. Benefits with coinsurance are subject to the deductible.**

<sup>1</sup> Some benefits may have limitations. <sup>2</sup>Office visit copay may apply. Well-child visit: no charge up to age 2

<sup>3</sup> Some exceptions may apply as set out in the *Evidence of Coverage* or as required by law.

<sup>4</sup> Maternity charges for members are for Ob/Gyn and/or midwife services (pre/post-natal and delivery) and for inpatient facility charge. Other charges may apply for other professional services.