

# KAISER PERMANENTE \$15 COPAYMENT HMO PLAN

FEATURES	MEMBER PAYS
<b>CALENDAR-YEAR DEDUCTIBLE</b>	\$0
<b>PHARMACY CALENDAR-YEAR DEDUCTIBLE</b>	N/A
<b>ANNUAL OUT-OF-POCKET MAXIMUM<sup>1</sup></b> Individual/Family	\$2,500/\$5,000
<b>IN THE MEDICAL OFFICE</b> Office visits Preventive exams Maternity/Prenatal care <sup>2</sup> Well-child preventive care visits <sup>3</sup> Vaccines (immunizations) Allergy injections Infertility services Occupational, physical, and speech therapy Most labs and imaging MRI/CT/PET Outpatient surgery	\$15 \$0 \$0 \$0 \$0 \$5 50% \$15 \$10 \$50 \$100 per procedure
<b>EMERGENCY SERVICES</b> Emergency Department visits (waived if admitted directly to hospital) Ambulance	\$100 \$75
<b>PRESCRIPTIONS<sup>4</sup></b> Generic <sup>5</sup> Brand-name <sup>5</sup>	(up to a 30-day supply) \$10 \$25
<b>HOSPITAL CARE</b> Physicians' services, room and board, tests, medications, supplies, therapies Skilled nursing facility care (up to 100 days per benefit period)	\$200 per day \$0
<b>MENTAL HEALTH SERVICES</b> In the medical office  In the hospital	\$15 individual \$7 group \$200 per day
<b>CHEMICAL DEPENDENCY SERVICES</b> In the medical office In the hospital (detoxification only)	\$15 individual \$200 per day
<b>OTHER</b> Certain durable medical equipment (DME) <sup>6</sup> Certain prosthetic and orthotic devices Optical (eyewear) <sup>7</sup> Vision exam Home health care (up to 100 two-hour visits per calendar year) Hospice care	20% \$0 \$150 allowance \$0 \$0 \$0

Kaiser Permanente plans do not include a pre-existing condition clause.

Preventive services on this plan are available at no cost share. For a complete list of preventive services, please refer to the *Evidence of Coverage* or [businessnet.kp.org](http://businessnet.kp.org).

<sup>1</sup>Out-of-pocket maximum is the maximum amount an individual or family will pay for certain services in a calendar year.

<sup>2</sup>Scheduled prenatal visits and the first postpartum visit

<sup>3</sup>Well-child visits through age 23 months

<sup>4</sup>Prescription drugs are covered in accordance with our formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copayments; please refer to the *Evidence of Coverage* for detailed information about prescription drug copayments.

<sup>5</sup>The deductible does not apply to this service.

<sup>6</sup>The maximum allowable amount for DME is \$2,000.

<sup>7</sup>Allowance toward the cost of eyeglass lenses, frames, and contact lenses fitting and dispensing every 24 months