KAISER PERMANENTE $0/$2,000 HSA-QUALIFIED DEDUCTIBLE HMO PLAN

FEATURES	MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE[1]	
Individual/Family	$2,000/$4,000
PHARMACY CALENDAR-YEAR DEDUCTIBLE	N/A
ANNUAL OUT-OF-POCKET MAXIMUM[1,2]	
Individual/Family	$3,500/$7,000
IN THE MEDICAL OFFICE	
Office visits	$0 (after deductible)
Preventive exams[3]	$0
Maternity/Prenatal care[3,4]	$0
Well-child preventive care visits[3,5]	$0
Vaccines (immunizations)[3]	$0
Allergy injections	$0 (after deductible)
Infertility services	Not covered[6]
Occupational, physical, and speech therapy	$0 (after deductible)
Most labs and imaging	$0 (after deductible)
MRI/CT/PET	$50 (after deductible)
Outpatient surgery	$150 per procedure (after deductible)
EMERGENCY SERVICES	
Emergency Department visits (waived if admitted directly to hospital)	$100 (after deductible)
Ambulance	$100 (after deductible)
PRESCRIPTIONS[7]	(up to a 30-day supply)
Generic	$10 (after deductible)
Brand-name	$30 (after deductible)
HOSPITAL CARE	
Physicians' services, room and board, tests, medications, supplies, therapies	$300 per day (after deductible)
Skilled nursing facility care (up to 100 days per benefit period)	$0 per admission (after deductible)
MENTAL HEALTH SERVICES	
In the medical office	$0 (after deductible for individual therapy) $0 (after deductible for group therapy)
In the hospital	$300 per day (after deductible)
CHEMICAL DEPENDENCY SERVICES	
In the medical office	$0 (after deductible for individual therapy)
In the hospital (detoxification only)	$300 per day (after deductible)
OTHER	
Certain durable medical equipment (DME)[8]	$0 (after deductible)
Certain prosthetic and orthotic devices	$0 (after deductible)
Optical (eyewear)[9]	Not covered
Vision exam	$0 (after deductible)
Home health care (up to 100 two-hour visits per calendar year)	$0 (after deductible)
Hospice care	$0 (after deductible)

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.

[1]This is an aggregate plan. For a family of two or more, the family deductible applies to the whole family. Once the family deductible is met (by one family member or combination of family members), the family becomes eligible for copayments or coinsurance. The same methodology applies to the out-of-pocket maximum.

[2]Out-of-pocket maximum is the maximum amount an individual or family will pay for certain services in a calendar year.

[3]The deductible does not apply to this service.

[4]Scheduled prenatal visits and the first postpartum visit

[5]Well-child visits through age 23 months

[6]Infertility benefits can be added to this plan for an additional cost. For more information, contact your broker or Kaiser Permanente representative.

[7]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.

[8]Please refer to the *Evidence of Coverage* for information on what is included in your DME benefit. Coverage is limited.

[9]Kaiser Permanente members are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be combined with any other Health Plan vision benefit. The discounts will not apply to any sale, promotion, or packaged eyewear program, for any contact lens extended purchase agreement, or to low-vision aids or devices. Visit kp2020.org for Kaiser Permanente optical locations.

Small Business
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