

# KAISER PERMANENTE \$20 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	\$20 \$0 \$0 \$0 \$0 \$5 Not covered <sup>4</sup> \$20 \$10 \$50 \$150 per procedure
<b>EMERGENCY SERVICES</b> Emergency Department visits (waived if admitted directly to hospital) Ambulance	\$100 \$75
<b>PRESCRIPTIONS<sup>5</sup></b> Generic <sup>6</sup> Brand-name <sup>6</sup>	(up to a 30-day supply) \$10 \$30
<b>HOSPITAL CARE</b> Physicians' services, room and board, tests, medications, supplies, therapies Skilled nursing facility care (up to 100 days per benefit period)	\$300 per day \$0
<b>MENTAL HEALTH SERVICES</b> In the medical office  In the hospital	\$20 individual \$10 group \$300 per day
<b>CHEMICAL DEPENDENCY SERVICES</b> In the medical office In the hospital (detoxification only)	\$20 individual \$300 per day
<b>OTHER</b> Certain durable medical equipment (DME) <sup>7</sup> Certain prosthetic and orthotic devices Optical (eyewear) <sup>8</sup> Vision exam Home health care (up to 100 two-hour visits per calendar year) Hospice care	20% \$0 Not covered \$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>Infertility benefits can be added to this plan for an additional cost. For more information, contact your broker or Kaiser Permanente representative.

<sup>5</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>6</sup>The deductible does not apply to this service.

<sup>7</sup>The maximum allowable amount for DME is \$2,000.

<sup>8</sup>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](http://kp2020.org) for Kaiser Permanente optical locations.