$5 GRANDFATHERED (NONMETAL)

COPAY HMO PLAN

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE	$0
OUT-OF-POCKET MAXIMUM	Individual – $1,500[1] Family –$3,000[1]
IN THE MEDICAL OFFICE Primary care visits	$5
Urgent care visits	$5
Specialty office visits	$5
Preventive exams, vaccines (immunizations)	$0[2]
Prenatal care	$0[3]
Postpartum care	$0[3]
Well-child preventive care visits	$0[4]
Allergy injections	$0
Infertility services	50%
Physical, occupational, and speech therapy	$5
Most laboratory tests	$10
Most X-rays and diagnostic testing	$10
Most MRI/CT/PET scans	$50
Outpatient surgery (per procedure)	$5
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital)	$100
Ambulance	$75
PRESCRIPTIONS Generic drugs (up to a 100-day supply)	$5[5]
Brand-name drugs (up to a 100-day supply)	$15[5]
Specialty drugs (up to a 30-day supply)	$15[5]
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$0
Skilled nursing facility care (up to 100 days per benefit period)	$0
MENTAL HEALTH SERVICES In the medical office	$5 individual $2 group
In the hospital	$0
CHEMICAL DEPENDENCY SERVICES In the medical office	$5 individual $2 group
In the hospital (detoxification only)	$0
OTHER Televisits	$0
Chiropractic and acupuncture	$5 per visit for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (Supplemental and base)	20%[6]
Certain prosthetic and orthotic devices	$0
Pediatric optical (eyewear)	$150 allowance[7]
Pediatric vision exam	$0
Adult optical (eyewear)	$150 allowance[7]
Adult vision exam (for eye refraction)	$0
Home health care (up to 100 visits per year)	$0
Hospice care	$0

(continues)

KAISER PERMANENTE®

(continued)

Kaiser Permanente plans don't 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 **account.kp.org**.

[1]Out-of-pocket maximum is the maximum amount an individual or family will pay for certain services in a calendar year.
[2]Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam.
[3]Scheduled prenatal visits and the first postpartum visit
[4]Well-child visits through age 23 months
[5]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.
[6]Both base and supplemental DME are covered. Supplemental DME is limited to a combined maximum benefit of $2,000 per year for services. Refer to the *Evidence of Coverage* for information on what's included in your DME benefit.
[7]Allowance toward the cost of eyeglass lenses, frames, and contact lenses fitting and dispensing every 24 months

This is a summary of benefits only and is subject to change. The KFHP *Evidence of Coverage* and the KPIC *Certificate of Insurance* contain a complete explanation of benefits, exclusions, and limitations. The information provided isn't intended to describe all the benefits included in each plan, nor is it designed to serve as the *Evidence of Coverage* or *Certificate of Insurance*.