

# \$30 GRANDFATHERED (NONMETAL)

## COPAY HMO PLAN

FEATURES	MEMBER PAYS
<b>PLAN DEDUCTIBLE</b>	\$0
<b>OUT-OF-POCKET MAXIMUM</b>	Individual – \$3,000 <sup>1</sup> Family – \$6,000 <sup>1</sup>
<b>IN THE MEDICAL OFFICE</b>	
Primary care visits	\$30
Urgent care visits	\$30
Specialty office visits	\$30
Preventive exams, vaccines (immunizations)	\$0 <sup>2</sup>
Prenatal care	\$0 <sup>3</sup>
Postpartum care	\$0 <sup>3</sup>
Well-child preventive care visits	\$0 <sup>4</sup>
Allergy injections	\$5 per visit
Infertility services	Not covered <sup>5</sup>
Physical, occupational, and speech therapy	\$30
Most laboratory tests	\$10
Most X-rays and diagnostic testing	\$10
Most MRI/CT/PET scans	\$50
Outpatient surgery (per procedure)	\$200
<b>EMERGENCY SERVICES</b>	
Emergency Department visits (waived if admitted directly to hospital)	\$100
Ambulance	\$75
<b>PRESCRIPTIONS</b>	
Generic drugs (up to a 100-day supply)	\$10 <sup>6</sup>
Brand-name drugs (up to a 100-day supply)	\$35 (after \$250 pharmacy deductible) <sup>6</sup>
Specialty drugs (up to a 30-day supply)	\$35 (after \$250 pharmacy deductible) <sup>6</sup>
<b>HOSPITAL CARE</b>	
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	\$400 per day
Skilled nursing facility care (up to 100 days per benefit period)	\$0
<b>MENTAL HEALTH SERVICES</b>	
In the medical office	\$30 individual \$15 group
In the hospital	\$400 per day
<b>CHEMICAL DEPENDENCY SERVICES</b>	
In the medical office	\$30 individual \$5 group
In the hospital (detoxification only)	\$400 per day
<b>OTHER</b>	
Televisits	\$0
Chiropractic and acupuncture	\$30 per visit for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (base only)	50% <sup>7</sup>
Certain prosthetic and orthotic devices	\$0
Pediatric optical (eyewear)	Not covered <sup>8</sup>
Pediatric vision exam	\$0
Adult optical (eyewear)	Not covered <sup>8</sup>
Adult vision exam (for eye refraction)	\$0
Home health care (up to 100 visits per year)	\$0
Hospice care	\$0

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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](https://account.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>Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam.

<sup>3</sup>Scheduled prenatal visits and the first postpartum visit

<sup>4</sup>Well-child visits through age 23 months

<sup>5</sup>Enhanced fertility coverage is available at additional cost, please contact your broker or Kaiser Permanente Representative for details.

<sup>6</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>7</sup>Refer to the *Evidence of Coverage* for information on what's included in your DME benefit.

<sup>8</sup>Kaiser Permanente members are entitled to a discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers.

These discounts can't be combined with any other Health Plan vision benefit. The discounts won't 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](https://kp2020.org) for Kaiser Permanente optical locations.

**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*.