

\$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% ⁵
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 ⁶
Brand-name drugs (up to a 100-day supply)	\$15 ⁶
Specialty drugs (up to a 30-day supply)	\$15 ⁶
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% ⁷
Certain prosthetic and orthotic devices	\$0
Pediatric optical (eyewear)	\$150 allowance ⁸
Pediatric vision exam	\$0
Adult optical (eyewear)	\$150 allowance ⁸
Adult vision exam (for eye refraction)	\$0
Home health care (up to 100 visits per year)	\$0
Hospice care	\$0

(continued)

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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.

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

²Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam.

³Scheduled prenatal visits and the first postpartum visit

⁴Well-child visits through age 23 months

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

⁶Prescription 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.

⁷Both 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.

⁸Allowance 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*.