

KAISER PERMANENTE SUMMARY OF COVERAGE

Benefit Highlights

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call our Member Service Call Center.

Annual Out-of-Pocket Maximum for Certain Services

For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:

For self-only enrollment (a Family of one Member).....	\$1,500 per calendar year
For any one Member in a Family of two or more Members	\$1,500 per calendar year
For an entire Family of two or more Members	\$3,000 per calendar year

Deductible or Lifetime Maximum

None

Professional Services (Plan Provider office visits)

You Pay

Most primary and specialty care consultations, exams, and treatment.....	\$5 per visit
Routine physical maintenance exams.....	No charge
Well-child preventive exams (through age 23 months).....	No charge
Family planning counseling	No charge
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge
Eye exams for refraction	No charge
Hearing exams.....	No charge
Urgent care consultations, exams, and treatment	\$5 per visit
Physical, occupational, and speech therapy.....	\$5 per visit

Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures	\$5 per procedure
Allergy injections (including allergy serum).....	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests.....	No charge
Health education:	
Covered individual health education counseling.....	No charge
Covered health education programs.....	No charge

Hospitalization Services

You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs .	No charge
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Emergency Health Coverage

You Pay

Emergency Department visits	\$35 per visit
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Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).

Ambulance Services

You Pay

Ambulance Services	No charge
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Prescription Drug Coverage

You Pay

Most covered outpatient items in accord with our drug formulary guidelines at Plan Pharmacies or through our mail-order service	\$5 for up to a 100-day supply
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Durable Medical Equipment

You Pay

The durable medical equipment for home use listed in the "Benefits and Cost Sharing" section in accord with our durable medical equipment formulary guidelines (most durable medical equipment is not covered)..	No charge
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Mental Health Services

You Pay

Inpatient psychiatric hospitalization.....	No charge
Individual outpatient mental health evaluation and treatment.....	\$5 per visit
Group outpatient mental health treatment	\$2 per visit

Chemical Dependency Services	You Pay
Inpatient detoxification.....	No charge
Individual outpatient chemical dependency evaluation and treatment	\$5 per visit
Group outpatient chemical dependency treatment	\$2 per visit
Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge
Other	You Pay
Skilled Nursing Facility care (up to 100 days per benefit period).....	No charge
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the "Benefits and Cost Sharing" section (most external prosthetic and orthotic devices are not covered)	No charge
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the "Benefits and Cost Sharing" and "Exclusions, Limitations, Coordination of Benefits, and Reductions" sections.