KAISER PERMANENTE COPAYMENT PLANS

Effective: 11/01/2020 - 10/31/2021

PLAN HIGHLIGHTS

FEATURES	$5 PLAN MEMBER PAYS	$15 PLAN MEMBER PAYS	$20 PLAN MEMBER PAYS	MOST POPULAR COPAYMENT PLAN $30 PLAN MEMBER PAYS	$50 PLAN MEMBER PAYS
CALENDAR - YEAR DEDUCTIBLE	$0	$0	$0	$0	$0
PHARMACY CALENDAR-YEAR DEDUCTIBLE	N/A	N/A	N/A	$250 for brand prescription	$250 for brand prescription
ANNUAL OUT-OF-POCKET MAXIMUM[1] Individual/Family	$1,500 / $3,000	$2,500 / $5,000	$2,500 / $5,000	$3,000 / $6,000	$3,500 / $7,000
IN THE MEDICAL OFFICE					
Office visits	$5	$15	$20	$30	$50
Preventive exams	$0	$0	$0	$0	$0
Maternity / Prenatal care[2]	$0	$0	$0	$0	$0
Well-child preventive care visits[3]	$0	$0	$0	$0	$0
Vaccines (immunizations)	$0	$0	$0	$0	$0
Allergy injections	$0	$5	$5	$5	$5
Infertility services	50%	50%	Not covered	Not covered	Not covered
Occupational, physical, and speech therapy	$5	$15	$20	$30	$50
Most labs and imaging	$10	$10	$10	$10	$10
MRI / CT / PET	$50	$50	$50	$50	$50
Outpatient surgery	$5 per procedure	$100 per procedure	$150 per procedure	$200 per procedure	$250 per procedure
EMERGENCY SERVICES					
Emergency Department visits (waived if admitted directly to hospital)	$100	$100	$100	$100	$150
Ambulance	$75	$75	$75	$75	$300
PRESCRIPTIONS[4]	(up to a 100-day supply)	(up to a 30-day supply)	(up to a 30-day supply)	(up to a 100-day supply)	(up to a 100-day supply)
Generic[5]	$5	$10	$10	$10	$10
Brand - name	$15[5]	$25[5]	$30[5]	$35 (after pharmacy deductible)	$35 (after pharmacy deductible)
HOSPITAL CARE					
Physicians' services, room and board, tests, medications, supplies, therapies	$0	$200 per day	$300 per day	$400 per day	$500 per day
Skilled nursing facility care (up to 100 days per benefit period)	$0	$0	$0	$0	$0
MENTAL HEALTH SERVICES					
In the medical office	$5 individual $2 group	$15 individual $7 group	$20 individual $10 group	$30 individual $15 group	$50 individual $25 group
In the hospital	$0	$200 per day	$300 per day	$400 per day	$500 per day
CHEMICAL DEPENDENCY SERVICES					
In the medical office	$5 individual	$15 individual	$20 individual	$30 individual	$50 individual
In the hospital (detoxification only)	$0	$200 per day	$300 per day	$400 per day	$500 per day
OTHER					
Certain durable medical equipment (DME)	20%[6]	20%[6]	20%[6]	50% Coinsurance	50% Coinsurance
Certain prosthetics, orthotics, and devices	$0[8]	$0[8]	$0[8]	$0	$0
Optical (eyewear)	$150 allowance[9]	$150 allowance[9]	Not covered[10]	Not covered[10]	Not covered[10]
Vision exam	$0	$0	$0	$0	$0
Home health care (up to 100 two-hour visits per calendar year)	$0	$0	$0	$0	$0
Hospice care	$0	$0	$0	$0	$0

*Always refer to your plans Evidence of Coverage for complete description of benefits. 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.

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

[2]Scheduled prenatal visits and the first postpartum visit

[3]Well-child visits through age 23 months

[4]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.

[5]The deductible does not apply to this service

[6]The maximum allowable amount for DME is $2,000

[7]Please refer to the Evidence of Coverage for more information on DME, prosthetics, orthotics, and devices. Most DME for home use, prosthetics, orthotics, and devices are not covered.

[8]There is no maximum amount for prosthetics, orthotics, and devices

[9]Allowance toward the cost of eyeglass lenses, frames, and contact lenses fitting and dispensing every 24 months

[10]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 coordinated 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 for Kaiser Permanente optical locations.

KAISER PERMANENTE

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PLAN HIGHLIGHTS

MOST POPULAR

DEDUCTIBLE HMO PLANS

FEATURES	$30/$1,000 PLAN MEMBER PAYS	$30/$1,500 PLAN MEMBER PAYS	$40/$2,000 PLAN MEMBER PAYS
CALENDAR - YEAR DEDUCTIBLE[1] Individual/Family	$1,000/$2,000	$1,500/$3,000	$2,000/$4,000
PHARMACY CALENDAR-YEAR DEDUCTIBLE	N/A	N/A	N/A
ANNUAL OUT-OF-POCKET MAXIMUM[1,2] Individual / Family	$3,500/$7,000	$3,500/$7,000	$4,500/$9,000
IN THE MEDICAL OFFICE			
Office visits[3]	$30	$30	$40
Preventive exams[3]	$0	$0	$0
Maternity / Prenatal care[3,4]	$0	$0	$0
Well-child preventive care visits[3,5]	$0	$0	$0
Vaccines (immunizations)[3]	$0	$0	$0
Allergy injections	$5 (after deductible)	$5 (after deductible)	$5 (after deductible)
Infertility services	Not covered	Not covered	Not covered
Occupational, physical, and speech therapy	$30 (after deductible)	$30 (after deductible)	$40 (after deductible)
Most labs and imaging	$10 (after deductible)	$10 (after deductible)	$10 (after deductible)
MRI / CT / PET	$50 (after deductible)	$50 (after deductible)	$50 (after deductible)
Outpatient surgery	$250 per procedure (after deductible)	$250 per procedure (after deductible)	30% (after deductible)
EMERGENCY SERVICES			
Emergency Department visits (waived if admitted directly to hospital)	$100 (after deductible)	$100 (after deductible)	30% (after deductible)
Ambulance	$75 (after deductible)	$75 (after deductible)	$100 (after deductible)
PRESCRIPTIONS[3,6]	(up to a 30-day supply)	(up to a 30-day supply)	(up to a 30-day supply)
Generic	$10	$10	$10
Brand - name	$30	$30	$35
HOSPITAL CARE			
Physicians' services, room and board, tests, medications, supplies, therapies	$500 per day (after deductible)	$500 per day (after deductible)	30% per admission (after deductible)
Skilled nursing facility care (up to 60 days per benefit period)	$50 per day (after deductible)	$50 per day (after deductible)	30% per admission (after deductible)
MENTAL HEALTH SERVICES			
In the medical office[3]	$30 (for individual therapy) $15 (for group therapy)	$30 (for individual therapy) $15 (for group therapy)	$40 (for individual therapy) $20 (for group therapy)
In the hospital	$500 per day (after deductible)	$500 per day (after deductible)	30% per admission (after deductible)
CHEMICAL DEPENDENCY SERVICES			
In the medical office[3]	$30 (for individual therapy)	$30 (for individual therapy)	$40 (for individual therapy)
In the hospital (detoxification only)	$500 per day (after deductible)	$500 per day (after deductible)	30% per admission (after deductible)
OTHER			
Certain durable medical equipment (DME)[7]	30%	30%	30%
Certain prosthetics, orthotics, and devices[7]	$0	$0	$0
Optical (eyewear)[8]	Not covered	Not covered	Not covered
Vision exam[3]	$0	$0	$0
Home health care[3] (up to 100 two-hour visits per calendar year)	$0	$0	$0
Hospice care[3]	$0	$0	$0

*Always refer to your plans Evidence of Coverage for complete description of benefits. 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.

[1]This is an embedded plan. For a family of two or more, an individual deductible is part of the family deductible. Each family member becomes eligible for copayments or coinsurance either after meeting his or her individual deductible or after the family collectively meets the family deductible. The same methodology applies to the out-of-pocket maximum.

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

[3]For this service the deductible doesn't apply.

[4]Scheduled prenatal visits and the first postpartum visit

[5]Well-child visits through age 23 months

[6]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.

[7]Please refer to the Evidence of Coverage for more information on DME, prosthetics, orthotics, and devices. Most DME for home use, prosthetics, orthotics, and devices are not covered.

[8]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 coordinated 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 for Kaiser Permanente optical locations.

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HSA QUALIFIED DEDUCTIBLE PLAN HIGHLIGHTS

MOST POPULAR DEDUCTIBLE PLAN W/HSA

FEATURES	$0/$2,000 PLAN W/HSA MEMBER PAYS	$0/$2,800 PLAN W/HSA MEMBER PAYS	$30/$3,000 PLAN W/HSA MEMBER PAYS
CALENDAR - YEAR DEDUCTIBLE Individual / Family	$2,000/$4,000[1]	$2,800/$5,450[2]	$3,000/$6,000[2]
PHARMACY CALENDAR-YEAR DEDUCTIBLE	N/A	N/A	N/A
ANNUAL OUT-OF-POCKET MAXIMUM[3] Individual / Family	$3,500/$7,000[1]	$4,500/$9,000[2]	$5,950/$11,900[2]
IN THE MEDICAL OFFICE			
Office visits	$0 (after deductible)	$0 (after deductible)	$30 (after deductible)
Preventive exams[4]	$0	$0	$0
Maternity / Prenatal care[4,5]	$0	$0	$0
Well-child preventive care visits[4,6]	$0	$0	$0
Vaccines (immunizations)[4]	$0	$0	$0
Allergy injections	$0 (after deductible)	$0 (after deductible)	$5 (after deductible)
Infertility services	Not covered	Not covered	Not covered
Occupational, physical, and speech therapy	$0 (after deductible)	$0 (after deductible)	$30 (after deductible)
Most labs and imaging	$0 (after deductible)	$0 (after deductible)	$10 (after deductible)
MRI / CT / PET	$50 (after deductible)	$50 (after deductible)	$50 (after deductible)
Outpatient surgery	$150 per procedure (after deductible)	$250 per procedure (after deductible)	30% (after deductible)
EMERGENCY SERVICES			
Emergency Department visits (waived if admitted directly to hospital)	$100 (after deductible)	$100 (after deductible)	30% (after deductible)
Ambulance	$100 (after deductible)	$100 (after deductible)	$100 (after deductible)
PRESCRIPTIONS[7]	(up to a 30-day supply)	(up to a 30-day supply)	(up to a 30-day supply)
Generic	$10 (after deductible)	$10 (after deductible)	$10 (after deductible)
Brand - name	$30 (after deductible)	$30 (after deductible)	$30 (after deductible)
HOSPITAL CARE			
Physicians' services, room and board, tests, medications, supplies, therapies	$300 per day (after deductible)	$450 per day (after deductible)	30% per admission (after deductible)
Skilled nursing facility care (up to 100 days per benefit period)	$0 per admission (after deductible)	$0 per admission (after deductible)	30% per admission (after deductible)
MENTAL HEALTH SERVICES			
In the medical office	$0 (after deductible for individual therapy) $0 (after deductible for group therapy)	$0 (after deductible for individual therapy) $0 (after deductible for group therapy)	$30 (after deductible for individual therapy) $15 (after deductible for group therapy)
In the hospital	$300 per day (after deductible)	$450 per day (after deductible)	30% per admission (after deductible)
CHEMICAL DEPENDENCY SERVICES			
In the medical office	$0 (after deductible for individual therapy)	$0 (after deductible for individual therapy)	$30 (after deductible for individual therapy)
In the hospital (detoxification only)	$300 per day (after deductible)	$450 per day (after deductible)	30% per admission (after deductible)
OTHER			
Certain durable medical equipment (DME)[8]	$0 (after deductible)	$0 (after deductible)	20% (after deductible)
Certain prosthetics, orthotics, and devices[8]	$0 (after deductible)	$0 (after deductible)	$0 (after deductible)
Optical (eyewear)[9]	Not covered	Not covered	Not covered
Vision exam	$0 (after deductible)	$0 (after deductible)	$30 (after deductible)
Home health care (up to 100 two-hour visits per calendar year)	$0 (after deductible)	$0 (after deductible)	$0 (after deductible)
Hospice care	$0 (after deductible)	$0 (after deductible)	$0 (after deductible)

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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.

[1]This is an aggregate plan. For a family of two or more, the family deductible applies to the whole family. Once the family deductible is met (by one family member or combination of family members), the family becomes eligible for copayments or coinsurance. The same methodology applies to the out-of-pocket maximum.

[2]This is an embedded plan. For a family of two or more, an individual deductible is part of the family deductible. Each family member becomes eligible for copayments or coinsurance either after meeting his or her individual deductible or after the family collectively meets the family deductible. The same methodology applies to the out-of-pocket maximum.

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

[4]The deductible does not apply to this service.

[5]Scheduled prenatal visits

[6]Well-child visits through age 23 months

[7]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.

[8]Please refer to the Evidence of Coverage for more information on DME, prosthetics, orthotics, and devices. Most DME for home use, prosthetics, orthotics, and devices are not covered.

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PLAN HIGHLIGHTS

DEDUCTIBLE HMO PLANS WITH HRA

FEATURES	$30/$1,500 PLAN W/HRA MEMBER PAYS	$30/$2,500 PLAN W/HRA MEMBER PAYS
CALENDAR - YEAR DEDUCTIBLE[1] Individual / Family	$1,500/$3,000	$2,500/$5,000
PHARMACY CALENDAR-YEAR DEDUCTIBLE	N/A	N/A
ANNUAL OUT-OF-POCKET MAXIMUM[1,2] Individual / Family	$3,500/$7,000	$5,000/$10,000
IN THE MEDICAL OFFICE		
Office visits	$30 (after deductible)	$30 (after deductible)
Preventive exams[3]	$0	$0
Maternity / Prenatal care[3,4]	$0	$0
Well-child preventive care visits[3,5]	$0	$0
Vaccines (immunizations)[3]	$0	$0
Allergy injections	$0 (after deductible)	$0 (after deductible)
Infertility services	Not covered	Not covered
Occupational, physical, and speech therapy	$30 (after deductible)	$30 (after deductible)
Most labs and imaging	$10 (after deductible)	$10 (after deductible)
MRI / CT / PET	$50 (after deductible)	$50 (after deductible)
Outpatient surgery	20% (after deductible)	20% (after deductible)
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	20% (after deductible)	20% (after deductible)
Ambulance	$150 (after deductible)	$150 (after deductible)
PRESCRIPTIONS[3,6]	(up to a 30-day supply)	(up to a 30-day supply)
Generic	$10	$10
Brand - name	$30	$30
HOSPITAL CARE		
Physicians' services, room and board, tests, medications, supplies, therapies	20% per admission (after deductible)	20% per admission (after deductible)
Skilled nursing facility care	20% per admission (after deductible) (up to 100 days per benefit period)	20% per admission (after deductible) (up to 100 days per benefit period)
MENTAL HEALTH SERVICES		
In the medical office	$30 (after deductible for individual therapy) $15 (after deductible for group therapy)	$30 (after deductible for individual therapy) $15 (after deductible for group therapy)
In the hospital	20% per admission (after deductible)	20% per admission (after deductible)
CHEMICAL DEPENDENCY SERVICES		
In the medical office	$30 (after deductible for individual therapy)	$30 (after deductible for individual therapy)
In the hospital (detoxification only)	20% per admission (after deductible)	20% per admission (after deductible)
OTHER		
Certain durable medical equipment (DME)[7]	30%	30%
Certain prosthetics, orthotics, and devices[7]	$0	$0
Optical (eyewear)[8]	Not covered	Not covered
Vision exam[3]	$0	$0
Home health care[3] (up to 100 two-hour visits per calendar year)	$0	$0
Hospice care[3]	$0	$0

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Employer is required to establish and fund an HRA account. However, there is no minimum funding requirement.

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

[3]The deductible does not apply to this service.

[4]Scheduled prenatal visits and the first postpartum visit

[5]Well-child visits through age 23 months

[6]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.

[7]Please refer to the Evidence of Coverage for more information on DME, prosthetics, orthotics, and devices. Most DME for home use, prosthetics, orthotics, and devices are not covered.

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