

Kaiser Medicare Plus Mid-Atlantic HMO - Post-65	Kaiser Medicare Plus Mid-Atlantic HMO - Post-65
Provider	Kaiser Permanente 1-800-777-7902; out of service area 1-301-468-6000 in service area www.kaiserpermanente.org
Cost Sharing	
Annual Deductible	\$0 Individual; \$0 Family
Out-of-pocket maximum	\$3,500 Individual; \$0 Family
Lifetime coverage limit	Limit does not apply
Policies/Requirements	
Need to file claims	No; except for non-routine, out-of-network, or emergency care
Domestic partner benefits	Yes
Access	
Ability to self-refer to OB/GYN	Yes
Ability to self-refer to specialists	Yes
Out-of-area dependent coverage	No
Out-of-area participant coverage	No
Spending Account	
HRA -- You only	Not applicable
HRA -- You and spouse	Not applicable
HRA -- You and child	Not applicable
HRA -- You and family	Not applicable
Eligible expenses for reimbursement	Not applicable
Outpatient Services	
Primary doctor office visit	\$10 copay
Specialist doctor office visit	\$10 copay
Preventive Care	
Annual physical exam	\$10 copay
Well-woman exam (includes pap)	\$10 copay
Mammogram	\$10 copay
Pediatric exams	\$10 copay; Medicare guidelines apply; check with Plan for details
Immunizations (child)	100% covered for pneumonia; \$10 copay for hepatitis B; Medicare guidelines apply; check with Plan for details
Colorectal screening	\$10 copay
Cancer screenings	\$10 copay
Cardiovascular screenings	\$10 copay
Allergy tests and treatments	\$10 copay
Outpatient Care	
Outpatient surgery	\$10 copay
Outpatient laboratory services	100% covered
Outpatient physical therapy	\$10 copay; preauthorization required
Outpatient X-ray	100% covered
Outpatient occupational therapy	\$10 copay; preauthorization required
Outpatient speech therapy	\$10 copay; preauthorization required
Outpatient cardiac rehabilitation	\$10 copay; preauthorization required
Family Planning/Maternity Care	
Office visit: pre/postnatal	\$10 copay

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In-hospital delivery services	100% covered
Newborn nursery services	100% covered; Medicare guidelines apply; check with Plan for details
Fertility services	\$10 copay; must be medically necessary; exclusions and limitations apply; check with Plan for details
In vitro fertilization	\$10 copay; limited to three attempts per live birth; not to exceed maximum benefit of \$100,000; applicable hospital and office visit copays apply
Artificial insemination	\$10 copay
Female tubal ligation	\$10 copay
Male vasectomy	\$10 copay
	Hearing
Hearing evaluations	\$10 copay
Hearing aids	Not covered
	Vision
Routine vision exams	\$10 copay; eye refraction exam
Regular lenses and frames	25% discount available; check with Plan for details
Contact lenses	15% discount on initial fitting; check with Plan for details
	Dental
Dental implants	Check with Plan for details
Accidental injury to teeth	Coverage limited to \$2,000; check with Plan for details
Surgical removal of tumors, cysts and impacted teeth	Coverage based on place of service; preauthorization required; check with Plan for details
	Inpatient Services
Hospital copay	100% covered; preauthorization required
Hospital semi-private room	100% covered; preauthorization required
Inpatient lab and X-ray	100% covered; preauthorization required
Inpatient surgery	100% covered; preauthorization required
Inpatient physician and surgeon services	100% covered; preauthorization required
	Emergency Care
Emergency room (not followed by admission)	\$50 copay
Urgent care clinic visit	\$10 copay
Ambulance services	100% covered
	Prescription Drug Coverage
Annual prescription deductible	Not applicable
Prescription drug website	Same as medical plan
Prescription drug member services	Same as medical plan
Prescription drug vendor	Same as medical plan
Annual Rx out-of-pocket maximum	Not applicable
	Retail
Retail generic	\$5 copay; Kaiser pharmacy; \$10 copay at participating pharmacies; up to 60 day supply
Retail formulary brand	\$5 copay; Kaiser pharmacy; \$10 copay at participating pharmacies; up to 60 day supply; must be medically necessary

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Retail nonformulary brand	\$5 copay; Kaiser pharmacy; \$10 copay at participating pharmacies; up to 60 day supply; must be medically necessary
	Mail Order
Mail order generic	\$3 copay; up to 90 day supply at Kaiser mail order pharmacy
Mail order formulary brand	\$3 copay; up to 90 day supply at Kaiser mail order pharmacy; must be medically necessary
Mail order nonformulary brand	\$3 copay; up to 90 day supply at Kaiser mail order pharmacy; must be medically necessary
	Other
Oral contraceptives	Retail and mail order available; applicable prescription drug copay applies
Fertility drugs	50% covered
Retail injectable drugs	Coverage based on place of service; applicable prescription drug copay or office visit copay applies; check with Plan for details
	Mental Health
Mental Health: Combined with substance abuse	No
Mental Health: Outpatient coverage	\$10 copay
Mental Health: Inpatient coverage	100% covered; limited to 190 days per lifetime
	Substance Abuse
Detox: Outpatient coverage	\$10 copay
Detox: Inpatient coverage	100% covered; limited to 190 days per lifetime
Rehab: Outpatient coverage	\$10 copay
Rehab: Inpatient coverage	100% covered; limited to 190 days per lifetime
	Alternative Care
Chiropractic	\$10 copay; Medicare guidelines apply; check with Plan for details
Acupuncture	Not covered
	Care Management Programs
Heart disease care management	Yes
Hypertension care management	Yes
Diabetes care management	Yes
Asthma care management	Yes
Prenatal care management	Yes
Cancer care management	Yes
Smoking cessation program	Yes
Weight control program	Yes
	Other
Noncustodial home health care	100% covered; PCP referral required; Medicare guidelines apply; check with Plan for details
Hospice care	100% covered
Prescribed care in noncustodial skilled nursing facility	100% covered; limited to 100 days per benefit plan year
Durable medical equipment	100% covered; Medicare guidelines apply; check with Plan for details
Prosthetic devices	100% covered