

Feature	Kaiser of Southern CA HMO - Pre-65
Provider	Kaiser Permanente 1-800-464-4000 www.kaiserpermanente.org
Cost Sharing	
Annual Deductible	\$0 Individual; \$0 Family
Out-of-pocket maximum	\$1,500 Individual; \$3,000 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; limitations apply; check with Plan for details
Out-of-area dependent coverage	Yes; check with Plan for details
Out-of-area participant coverage	Yes; check with Plan for details
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	100% covered
Pediatric exams	\$10 copay
Immunizations (child)	100% covered
Colorectal screening	\$10 copay
Cancer screenings	100% covered
Cardiovascular screenings	100% covered
Allergy tests and treatments	100% covered; injections; \$10 copay testing
Outpatient Care	
Outpatient surgery	\$10 copay
Outpatient laboratory services	100% covered
Outpatient physical therapy	\$10 copay; must be medically necessary; preauthorization required
Outpatient X-ray	100% covered
Outpatient occupational therapy	\$10 copay; limitations apply; check with Plan for details
Outpatient speech therapy	\$10 copay; must be medically necessary; preauthorization required
Outpatient cardiac rehabilitation	\$10 copay; must be medically necessary; preauthorization required
Family Planning/Maternity Care	
Office visit: pre/postnatal	\$10 copay
In-hospital delivery services	100% covered; preauthorization required
Newborn nursery services	100% covered

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Fertility services	100% covered; inpatient; \$10 copay outpatient; preauthorization required for inpatient admission for treatment of infertility
In vitro fertilization	Not covered
Artificial insemination	\$10 copay; limited to intrauterine insemination only
Female tubal ligation	100% covered; inpatient; \$10 copay outpatient; after appropriate counseling
Male vasectomy	100% covered; inpatient; \$10 copay outpatient; after appropriate counseling
Hearing	
Hearing evaluations	\$10 copay
Hearing aids	Not covered
Vision	
Routine vision exams	\$10 copay; PCP screening or eye refraction exam; limited to one exam per benefit plan year
Regular lenses and frames	Not covered
Contact lenses	Not covered
Dental	
Dental implants	Not covered
Accidental injury to teeth	Applicable copays apply; must be medically necessary; check with Plan for details
Surgical removal of tumors, cysts and impacted teeth	100% covered; inpatient; \$10 copay outpatient; must be medically necessary; removal of impacted teeth not covered
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	\$50 copay
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; up to 100 day supply; Kaiser pharmacies only
Retail formulary brand	\$15 copay; up to 100 day supply; Kaiser pharmacies only
Retail nonformulary brand	\$15 copay; up to 100 day supply; must be medically necessary and prescribed by Plan physician; Kaiser pharmacies only; includes inhaled insulin
Mail Order	

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Mail order generic	\$5 copay; up to 100 day supply; Kaiser pharmacies only
Mail order formulary brand	\$15 copay; up to 100 day supply; Kaiser pharmacies only
Mail order nonformulary brand	\$15 copay; up to 100 day supply; must be medically necessary and prescribed by Plan physician; Kaiser mail order only; includes inhaled insulin
	Other
Oral contraceptives	Retail and mail order available; applicable prescription drug copay applies
Fertility drugs	Applicable prescription drug copay applies; check with Plan for details
Retail injectable drugs	100% cov; inpatient; drugs requiring administration or observation included in office visit; \$10 copay for 100 day supply of self-administered drugs
	Mental Health
Mental Health: Combined with substance abuse	No
Mental Health: Outpatient coverage	\$5 copay; group visit; \$10 copay individual visit; limited to 20 visits per calendar year
Mental Health: Inpatient coverage	100% covered; limited to 45 days per calendar year; no day limit for serious mental illness
	Substance Abuse
Detox: Outpatient coverage	\$5 copay; group visit; \$10 copay individual visit; no PCP referral required
Detox: Inpatient coverage	100% covered
Rehab: Outpatient coverage	\$5 copay; group visit; \$10 copay individual visit
Rehab: Inpatient coverage	\$100 copay; non-medical setting; limited to 60 days per calendar year; limited to 120 days in a five year period
	Alternative Care
Chiropractic	Not covered
Acupuncture	\$10 copay; limitations apply; check with Plan for details
	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; limited to three visits per day and 100 visits per year in-area; preauthorization required
Hospice care	100% covered
Prescribed care in noncustodial skilled nursing facility	100% covered; limited to 100 days per benefit plan year at designated facilities
Durable medical equipment	80% covered; DME formulary applies
Prosthetic devices	100% covered; must be medically necessary and prescribed by Plan physician