CHOOSE A PLAN

COPAYMENT PLANS

What copayment plans offer and how they work

IN THIS BROCHURE

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KAISER PERMANENTE®

Choose the plan that's best for ***you***

With copayment plans, you pay specific costs (or copayments) for certain covered services, so you know your out-of-pocket costs for doctor visits and prescriptions in advance. And since you don't have to meet a deductible, you can pay copayments for covered services from the first day of coverage.

Meet the Bishops

Deb and James Bishop are self-employed and have two children: Seth, 4, and Lauren, 14 months.[1] Because the children tend to visit their pediatrician frequently, the Bishops choose the $30/$40 Copay Option Plan.

Here's how they use their plan over the year:

- **Preventive care:** Deb, James, and Seth get checkups. They pay no charge because checkups are preventive care services. There's also no charge for immunizations.
- **Primary care office visits:** Seth and Lauren visit the pediatrician for various colds throughout the year. These visits are no charge because the children are under age 5. James sees his primary care physician for a stomach problem and pays a $30 copay. His doctor orders a lab test and an X-ray to help diagnose the problem.
- **Prescription drugs:** James' physician prescribes a medication. James pays a $10 copay for the generic drug.

Since this Kaiser Permanente medical facility has doctors' offices, lab, X-ray, and pharmacy under one roof, James simply walks down the hall to get his lab and X-ray done and his prescription filled. Plus, James' doctor orders his lab test, X-ray, and prescription online, so the lab and X-ray offices are ready for James when he walks in. And his prescription is waiting for him at the pharmacy.

[1] This example is for illustrative purposes only. Individual situations will vary depending on the specifics of the health care plan.

Have a question? We're here to help. Call **1-800-494-5314**, 8 a.m. to 8 p.m., Monday–Friday; 9 a.m. to 5 p.m., Saturday.

Benefit highlights

	$10/$20 Copay Option Plan	$20/$30 Copay Option Plan	$30/$40 Copay Option Plan	$40/$50 Copay Option Plan
Features				
Annual deductible	None			
Annual out-of-pocket maximum (individual/family)	$3,500/$7,000			
Lifetime maximum	None			
Benefits				
Preventive care				
Immunizations	No charge			
Routine physical exam	No charge			
Well-child exam	No charge			
Well-woman exam, mammogram, and Pap smear	No charge			
Adult preventive care screening	No charge			
Outpatient services (per visit or procedure)				
Primary care office visit (waived for children under age 5)	$10 copay	$20 copay	$30 copay	$40 copay
Specialty care office visit	$20 copay	$30 copay	$40 copay	$50 copay
Outpatient surgery	$100 copay			$500 copay
Diagnostic labs and X-rays	$20 copay	$30 copay	$40 copay	$50 copay
MRI, CT, and PET	$100 copay			
Inpatient hospital care				
Hospital care and professional visits	$500 copay per admission	$400 copay per day (up to $1,200 per admission)	$500 copay per day (up to $1,500 per admission)	25% of allowable charges
Maternity coverage				
Prenatal care/One postpartum visit	No charge			
Delivery and inpatient well-baby care	$500 copay per admission	$400 copay per day (up to $1,200 per admission)	$500 copay per day (up to $1,500 per admission)	25% of allowable charges
Emergency and urgent care				
Emergency Department visit (waived if admitted)	$75 copay			$100 copay
Urgent care visit	$20 copay	$30 copay	$40 copay	$50 copay
Ambulance service	$50 copay			$100 copay
Prescription drugs	**(30-day supply filled at a Kaiser Permanente pharmacy)**			
Pharmacy deductible	None	$100	$150	
Annual prescription drug maximum	$2,000	$1,500	$1,000	
Generic drug	$10 copay			
Preferred brand/Nonpreferred brand drug	$25 copay/$40 copay	$30 copay/$45 copay		
Other				
Dental services	$30 preventive visits and certain other services at discounted rates. See the *Preventive Dental Care* brochure for details.			

These are only highlights of plan coverage and are not inclusive. For specific benefit information, reference the *Guide to Your 2010 Benefits and Services* (*KFHP-NG-KPIF-DC* for District of Columbia residents, *KFHP-NG-KPIF-VA* for Virginia residents, and *KFHP-NG-KPIF-MD* for Maryland residents), which you will receive upon acceptance. Please call Member Services at (301) 468-6000 or 1-800-777-7902 for additional assistance.

For a list of exclusions and limitations associated with the benefits shown, please see the last 2 pages of this brochure.

KAISER PERMANENTE FOR INDIVIDUALS AND FAMILIES EXCLUSIONS AND LIMITATIONS

The following list contains exclusions and limitations associated with the benefits shown in the following documents: plan overview, copayment plans, deductible plans, and HSA-qualified deductible plans.

Preventive care

Limitations:

While the following services may be provided during the course of a preventive care visit, the following services are not considered preventive care: monitoring of chronic disease; diagnosis, followup, services provided to treat a specific disease, and non-routine gynecological visits.

Emergency services

Limitations:

The member or someone on the member's behalf must notify us as soon as possible, but no later than 48 hours or the next business day, whichever is later, of the hospital admission unless it was not reasonably possible to notify us. Follow-up care at a non-plan hospital must be authorized by the Health Plan.

Urgent Care services

Limitations:

We do not cover services outside our Service Area for conditions that, before leaving the Service Area, you should have known might require services while outside our Service Area, unless we determine that you were temporarily outside our Service Area because of extreme personal emergency.

Ambulance services

Exclusions:

Transportation by any type of transportation other than a licensed ambulance.

Vision care

Exclusions:

- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
- Eye exercises.
- Orthoptic (eye training) therapy.
- Sunglasses without corrective lenses unless medically necessary.
- Contact lens services other than the initial fitting and purchase of contact lenses as provided in this section.
- Non-corrective contact lenses.
- Replacement of lost or broken lenses or frames.

HSA-qualified deductible (1250, 1750, 2500 deductible levels) and deductible (4500, 8000 deductible levels) plan exclusions:

- Exclusions noted above plus,
- Eyeglass lenses and eyeglass frames, and
- All services related to contact lenses, including examinations, fitting and dispensing, and follow-up visits, except as otherwise noted.

Prescription drugs (up to 30-day supply, if applicable)

Exclusions:

Drugs, supplies, and supplements exclusions:

- Drugs, supplies, and supplements that can be self-administered or do not require administration or observation by medical personnel.
- Drugs for which a prescription is not required by law, except if the drug is approved under our preferred drug list guidelines.
- Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes.
- Replacement prescriptions necessitated by theft or loss.
- Prescribed drugs and accessories that are necessary for services that are excluded under this agreement.
- Drugs to shorten the duration of the common cold.
- Special packaging (e.g., blister pack, unit dose, or unit-of-use packaging) that is different from the Health Plan's standard packaging for prescription medications.
- Alternative formulations or delivery methods that are (1) different from the Health Plan's standard formulation or delivery method for prescription drugs and (2) deemed not medically necessary.
- Diabetic equipment and supplies, which are covered under Section 3 of this agreement.
- Drugs for treatment of sexual dysfunction disorder.

Limitations:

Benefits are subject to the following limitations:

- For drugs prescribed by dentists, coverage is limited to antibiotics and pain relief drugs that are included on our preferred drug list and purchased at a plan pharmacy.
- In the event of a civil emergency or the shortage of one or more prescription drugs, we may limit availability in consultation with the Health Plan's emergency management department.

Dental services

Exclusions:

The following services are not covered under your dental plan:

- Services provided by dentists or other practitioners of healing arts not associated with the Health Plan and/or dental administrator except upon referral arranged by a participating dental provider and authorized by us, or when required in a covered emergency.
- Services for injuries or conditions which are covered under worker's compensation and/or employer's liability laws.
- Services that are provided without cost to members by any federal, state, municipal, county, or other subdivision's program (with the exception of Medicaid).
- Services that, in the opinion of the attending dentist, are not necessary for the patient's dental health.
- Cosmetic or aesthetic dentistry.

- Oral surgery requiring the setting of fractures or dislocations, except as may be otherwise covered in your medical plan as described in Section 3 of the agreement.
- Drugs obtainable with or without a prescription, except as may be otherwise covered in your medical plan as described in Section 3 of the agreement.
- Hospitalization for any dental procedure.
- Treatment required for conditions resulting from major disaster, epidemic, or war, including declared or undeclared war or acts of war.
- Replacement due to loss or theft of prosthetic appliance.
- Services that cannot be performed because of the general health of the patient.
- Implantation and related restorative procedures.
- Services not listed as covered dental services in the list of covered dental services provided by dental administrator.
- Services provided by a non-participating dental provider or not pre-authorized by dental administrator (with the exception of out-of-area emergency dental services).
- Services related to the treatment of TMD (temporomandibular disorder).
- Elective surgery including, but not limited to, extraction of nonpathologic, asymptomatic impacted teeth.
- Dental expenses incurred in connection with any dental procedure that was started prior to your effective date of coverage under this dental plan and agreement. Examples include orthodontic work in progress, teeth prepared for crowns, and root canal therapy in progress.
- Lab fees for excisions and biopsies, except as may be otherwise covered in your medical plan described in the agreement.
- Treatment of malignancies, neoplasm, or congenital malformations, except as may be otherwise covered in your medical plan as described in the agreement.
- Experimental procedures, implantations, or pharmacological regimens.

Limitations:

Covered dental services are subject to the following limitations:

- Replacement of a bridge, crown, or denture within five (5) years after the date it was originally installed.
- Replacement of a filling within two (2) years after original date of placement.
- Coverage for periodic oral exams, prophylaxes (cleanings), and fluoride applications is limited to once every six (6) months.
- Crown and bridge fees apply to treatment involving five (5) or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider's usual, customary, and reasonable (UCR) fee, minus 25 percent.
- Full mouth X-rays or panoramic film is limited to one set every three (3) years.
- Retreatment of root canal within two (2) years of the original treatment.
- Coverage for sealants is limited to the first and second permanent molars for children under the age of 16 once every 24 months.
- Coverage for periodontal surgery of any type, including any associated material is covered once every 36 months per quadrant or surgical site.
- Coverage for root planing or scaling is limited to once every 24 months per quadrant.
- Full mouth debridement is limited to once every 36 months.
- Periodontal maintenance after active therapy is limited to twice per 12 months within 24 months after definitive periodontal therapy.
- Coverage for relining of dentures is limited to once every 12 months.

To request a full list of Exclusions and Limitations please call member services at **301-468-6000** or **1-800-777-7902** (TTY **301-879-6380**), Monday through Friday, 7:30 a.m.–5:30 p.m.

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Or call **1-800-494-5314**

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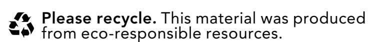
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