Active Employees and Pre-65 Retirees (Non-Medicare Only)	Kaiser Permanente HMO - Northern & Southern California*
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Plan Changes are in Orange	**2023 In-Network**
General Information	
Lifetime Maximum Benefit	None
Annual Maximum Benefit	None
Coinsurance Percentage	100% after applicable copay
Precertification Requirements	None
Precertification Penalty	None
Health Savings Account (HSA)	N/A
Health Reimbursement Account (HRA)	N/A
R & C	N/A
Deductibles	
Individual Annual Deductible	None
Family Annual Deductible	None
Applies to Out-of-Pocket Maximum	N/A
Prescription benefits are covered under medical deductible	N/A
Out-of-Pocket Mx per Plan Year	
Individual Out-of-Pocket Maximum Per Year	$3,000
Family Out-of-Pocket Maximum Per Year	$6,000
Outpatient Services	
Primary Care Physician Visits	$20 per visit
Specialist Visit	$35 per visit
Lab tests and X-ray	No charge. $20 office visit copay may apply.
Specialized Imaging	$100 Copay
Outpatient Surgery	Outpatient Surgery Center: $100 per procedure; PCP Office: $20 per procedure
Allergy Testing	$35 per visit
Allergy Injections	No charge; office visit copay may apply
Preventive Care	
Well Child Care Office Visit	100% covered
Well Child Age limit	23 months
Adult Routine Physical Exams	100% covered
Adult Immunizations	No charge; office visit copay may apply
Routine Mammogram	No charge
Pap Smear	100% covered
Prostate Screening (PSA)	100% covered
Colon Cancer Screenings	100% covered
Cardiovascular screenings	100% covered
Hearing Evaluations	Preventive: 100% covered; PCP Diagnostic: $20 copay; Specialist Diagnostic: $35 copay
Inpatient Hospital	
Deductible per Confinement	None
Deductible per Day	None
Hospital Services	No charge
Physicians and Surgeons' Services	No charge
Emergency Services	
Emergency Room Treatment	$75 per visit; waived if admitted
Non-emergency or non-urgent use of ER	Not covered
Ambulance	No charge
Urgent Care Facility Services	$20 per visit
Physician Office Visit	Included in $75 ER copay
After Hours	$20 per Urgent Care visit; $75 per ER visit
Maternity Care	
Physician Office Visit	No charge
Maternity Care - Inpatient Delivery	No charge

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Midwife delivery services	No charge; at facilities where available
Mental Health	
Deductible per Confinement	None
Deductible per Day	None
Mental Health Inpatient	No charge
Mental Health-Inpatient Plan Maximums	None
Mental Health Outpatient	$20 per individual visit
Mental Health - Group Therapy	$10 per group visit
Mental Health-Outpatient Plan Maximums	None
Severe Mental Illness	No charge for inpatient; $20 per individual outpatient visit; $10 per group outpatient visit; no day or visit limits
Substance Abuse	
Deductible per Confinement	None
Deductible per Day	None
Detoxification	No charge
Substance Abuse - Inpatient Treatment	No charge for Transitional Residential Recovery Services (TRRS) in a non-medical setting
Substance Abuse-Inpatient Plan Maximums	Limited to detox only Transitional Residential Recovery Services provided at no charge and with no day limits, in compliance with MHPA, as long as medically necessary and prescribed by a Plan physician
Substance Abuse-Outpatient	$20 per individual visit; $5 per group visit
Substance Abuse-Outpatient Plan Maximums	Unlimited
Rehabilitation Therapy	
Inpatient Rehabilitation	No charge
Outpatient Physical, Occupational, and Speech Therapy	$20 copay per visit. Benefits limited to medically necessary therapy authorized by a Plan physician.
Alternative Care	
Chiropractic Care	$15 per visit, up to 30 visits per calendar year with American Specialty Health Plans rider
Acupuncture	$35 per visit when approved by a Plan physician, generally as a component of a multidisciplinary pain management program for the treatment of chronic pain
Acupressure	Not covered
Massage Therapy	Not covered
Other Services	
Private-Duty Nursing Care	No charge when medically necessary and authorized by a Plan physician for inpatient care
Durable Medical Equipment	No charge when prescribed by a Plan physician in accordance with Formulary guidelines
Prosthetic and Orthotic Appliances	No charge when prescribed by a Plan physician in accordance with Formulary guidelines
Smoking Cessation	Covered health education classes are at no charge. Smoking cessation drugs are covered the same as other drugs when members participate in a behavioral health class.
Weight control program	Covered health education classes are at no charge
Bariatric surgery	If determined medically necessary by a Plan physician, and program requirements are met, covered at $35 per visit, no charge for inpatient hospitalization
TMJ	Inpatient: 100% covered; Outpatient: PCP $20 copay per encounter; Surgery Center or Specialist: $35 copay per encounter. Must be deemed medically necessary (i.e. etiology must be medical, not dental).
Podiatry Services	$35 per visit when medically necessary

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Home Health Care	No charge when prescribed by a Plan physician; limited to 2 hours/visit, 3 visits/day, 100 visits per year
Skilled Nursing Facility Care	No charge, up to 100 days per benefit period
Hospice Care	No charge when authorized by a Plan physician for a terminal diagnosis with life expectancy of less than one year
Hearing Aids	Not covered
Family Planning	
Tubal ligation	No charge; after appropriate counseling
Vasectomy	$100 copay (outpatient); No charge (inpatient); after appropriate counseling
Contraceptive Drugs	100% covered
Contraceptive Devices	100% covered
Infertility Testing	$35 per visit; no charge for lab
Infertility Treatments - Office Visit	$35 per visit
Infertility Treatments - Surgery	Specialist office: $35 per procedure; Outpatient Surgery Center: $100 per procedure; Inpatient: No charge
In Vitro Fertilization	Not covered
Infertility Treatments - Lifetime Maximum	Treatment for involuntary infertility is covered as authorized by a Plan physician
Vision Care	
Eye Examination	Preventive: 100% covered; PCP Diagnostic: $20 copay; Specialist Diagnostic: $35 copay
Lenses	Not covered
Frames	Not covered
Contact lenses- necessary	When prescribed by a Plan physician, no charge for contact lenses to treat aniridia (missing iris), up to two lenses per eye every 12 months. When prescribed by a Plan physician for aphakia (absence of the crystalline lens of the eye), no charge for up to 6 lenses per eye every 12 months, through age 9
Contact lenses-elective	Not covered
Lasik Eye Surgery	Not covered
Organ and Tissue Transplants	
Organ Transplant -Inpatient	No charge for inpatient
Organs covered	Heart, lung, heart/lung, liver, kidney, small bowel, pancreas, simultaneous pancreas/kidney and liver/kidney, cornea, and bone marrow, when transplant is determined to be medically necessary
Transplant Travel	Covered when pre-authorized by the Plan physician and related to the provision of covered services, in accordance with Plan policies
Transplant donor expenses	Certain medical and hospital expenses are covered if approved by Health Plan and the expenses are directly related to the transplant
Lifetime Maximum	None
Prescription Drug Coverage	
Annual Prescription Deductible - Family	None
Annual Prescription Deductible - Individual	None
Out-of-Pocket Maximums - Individual	N/A
Out-of-Pocket Maximums - Family	N/A
Annual Maximum Benefit	Unlimited
Lifetime Maximum Benefit	Unlimited
Generic Substitution	Determined by patient's Plan physician
Retail Refill Penalty	None
Prescription Drug Retail	

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Plan Changes are in Orange	**2023 In-Network**
Retail - Generic	$10 per prescription, up to a 30-day supply All prescriptions must be medically necessary, prescribed by a Plan physician, and obtained from a Plan pharmacy of from Plan mail order to be covered
Retail - Brand Formulary	$25 per prescription; up to 30-day supply; when medically necessary, prescribed by a Plan physician, and filled at Plan pharmacies
Retail - Brand Non-Formulary	$25 per prescription; up to 30-day supply; when medically necessary, prescribed by a Plan physician, and filled at Plan pharmacies
Single Source Brand	$25 per prescription; up to 30-day supply; when medically necessary, prescribed by a Plan physician, and filled at Plan pharmacies
Multi Source Brand	$25 per prescription; up to 30-day supply; when medically necessary, prescribed by a Plan physician, and filled at Plan pharmacies
Injectable Medications	$10 per generic/$25 per brand prescription, up to a 30-day supply
Prescription Drug Mail Order	
Mail-Order - Generic	$10 for up to a 30-day supply, or $20 for a 31 to 100-day supply
Mail-Order - Brand Formulary	$25 for up to 30-day supply; $50 for a 31- day up to a 100-day supply; when medically necessary, prescribed by a Plan physician and filled at Plan mail order
Mail-Order - Brand Non-Formulary	$25 for up to 30-day supply; $50 for a 31 -day up to a 100-day supply; when medically necessary, prescribed by a Plan physician and filled at Plan mail order
Single Source Brand	$25 for up to 30-day supply; $50 for a 31 -day up to a 100-day supply; when medically necessary, prescribed by a Plan physician and filled at Plan mail order
Multi Source Brand	$25 for up to 30-day supply; $50 for a 31 -day up to a 100-day supply; when medically necessary, prescribed by a Plan physician and filled at Plan mail order
Injectable Medications	$10 Generic/$25 brand for up to a 30-day supply, or $20 generic/$50 brand for a 31- to 100-day supply
Day Supply	Up to 100
Other Services - Prescription Drugs	
Over the Counter	Not covered
Prenatal Vitamins	Not covered
Diabetic Supplies	Insulin: $10 copay for up to 100-day supply; Testing supplies: 100% covered up to 100-day supply in accordance with DME base formulary guidelines
Lifestyle Drugs	Drugs for the treatment of sexual dysfunction are covered at 50% of charges with a maximum dosage limit of 8 doses for 30-day supply or 27 doses for 100-day supply
Contraceptives - Injectable	Covered at no charge when dispensed in Plan Medical Offices
Fertility Drugs	Covered at applicable prescription copay
Smoking Cessation	Covered at applicable prescription copay if prescribed by a Plan physician and patient is concurrently participating in a Plan-approved behavioral modification program
Cosmetic Medications	Not covered
Nutritional Supplements	Not covered