

## Plan Facts

Kaiser Med Plus Mid-Atl HMO	
Web site	<a href="http://kaiserpermanente.org">kaiserpermanente.org</a>
Member services	1-800-777-7902; out of service area; 1-301-468-6000 in service area
Find a network provider	<a href="#">Find a Doctor or Hospital</a>
Binding arbitration	No

## Cost

Kaiser Med Plus Mid-Atl HMO	
<b>Health Reimbursement Arrangement--Account Information</b>	
Eligible expenses for reimbursement	Not applicable
<b>General Medical Expenses</b>	
Deductible: Individual/Family	\$0 Individual; \$0 Family
Primary doctor office visit	\$10 copay
Specialist office visit	\$10 copay
Out-of-pocket maximum: Individual/Family	\$3,500 Individual; \$0 Family
Lifetime coverage limit	Limit does not apply
<b>Inpatient Hospital Care</b>	
Hospital copay	100% covered
Hospital semi-private room	100% covered
Inpatient lab and X-ray	100% covered
Inpatient physician and surgeon services	100% covered
<b>Outpatient Care</b>	
Outpatient surgery	\$10 copay
Outpatient laboratory services	100% covered
Outpatient X-ray	100% covered
Emergency room (not followed by admission)	\$50 copay
Urgent care clinic visit	\$10 copay
<b>Prescription Drug Expenses</b>	
Prescription drug vendor	Same as medical plan
Prescription drug Web site	Same as medical plan
Prescription drug member services	Same as medical plan
Annual prescription deductible	Not applicable
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
Retail nonformulary brand	\$5 copay; Kaiser pharmacy; \$10 copay at participating pharmacies; up to 60 day supply; must be medically necessary
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
Oral contraceptives	Retail and mail order available; applicable prescription drug copay applies

## Coverage

Kaiser Med Plus Mid-Atl HMO	
<b>Adult Preventive Care</b>	
Physical exam	\$10 copay
Well-woman exam (includes pap)	\$10 copay
Mammogram	\$10 copay
Cancer screenings	\$10 copay
Cardiovascular screenings	\$10 copay
<b>Family Planning</b>	
Fertility drugs	50% covered
Fertility services	\$10 copay; must be medically necessary; exclusions and limitations apply; check with Plan for details
Artificial insemination	\$10 copay
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
Male vasectomy	\$10 copay
<b>Maternity Care</b>	
Office visit: Pre/postnatal	\$10 copay
In-hospital delivery services	100% covered
Newborn nursery services	100% covered; Medicare guidelines apply; check with Plan for details
Prenatal care management	Yes
<b>Well-Baby/Well-Child Preventive Care</b>	
Well-child 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
<b>Mental Health Care</b>	
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
<b>Substance Abuse Care</b>	
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
<b>Dental Care</b>	

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
<b>Vision Care</b>	
Routine vision exams	Coverage for Medicare covered services only
Regular lenses and frames	Coverage for Medicare covered services only
Contact lenses	Coverage for Medicare covered services only
<b>Other Services</b>	
Ambulance services	100% covered
Allergy tests and treatments	\$10 copay
Durable medical equipment	100% covered; Medicare guidelines apply; check with Plan for details
<b>Hearing Care</b>	
Hearing evaluations	\$10 copay
Hearing aids	Not covered
<b>Medical Therapy</b>	
Acupuncture	Not covered
Chiropractic	\$10 copay; Medicare guidelines apply; check with Plan for details
Outpatient physical therapy	\$10 copay; preauthorization required
Outpatient speech therapy	\$10 copay; preauthorization required
Outpatient occupational therapy	\$10 copay; preauthorization required
<b>Care at Alternate Sites</b>	
Noncustodial home health care	100% covered; PCP referral required; Medicare guidelines apply; check with Plan for details
Prescribed care in noncustodial skilled nursing facility	100% covered; limited to 100 days per benefit period
Hospice care	100% covered

## Access

	Kaiser Med Plus Mid-Atl HMO
Out-of-area dependent coverage	No
Out-of-area participant coverage	No

## Ease of Use

	Kaiser Med Plus Mid-Atl HMO
Need to file claims	No; except for non-routine, out-of-network, or emergency care
Number of PCP changes allowed/year	Not available
Ability to self-refer to OB/GYN	Yes
Ability to self-refer to specialists	No

## Care Management: Education and Assistance

	Kaiser Med Plus Mid-Atl HMO
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Asthma care management	Yes
Cancer care management	Yes
Diabetes care management	Yes
Heart disease care management	Yes
Hypertension care management	Yes
Smoking cessation program	Yes
Weight control program	Yes