KAISER PERMANENTE®

Benefit Summary

Customer/Group Name: City of Sacramento

Customer/Group #: 15155

Kaiser Permanente Multi-Site HMO $20/$2000 Plan* 01/01/2024

Out-of-Pocket Maximum(s) and Deductible(s)

For covered services that apply to the Plan out-of-pocket maximum, you may not pay any more copays, coinsurance, or deductibles for the rest of the year once you have reached the amounts listed below.

Amounts Per Year	**Self-Only Coverage** (Individual)	**Family Coverage** Entire family of 2 or more members
Plan deductible	None	None
Plan out-of-pocket maximum	$2,000	$4,000

Professional Services	**You Pay**
Primary care office visit[1]	$20 copay
Specialty care office visit	$30 copay (CA, CO, GA, MAS, NW, WA); $20 copay (HI)
Telemedicine / Virtual care (phone/video)	$0 copay
Routine prenatal care exams	$0 copay
Outpatient rehabilitation services (visit limits vary by region)[2,3]	$30 copay (GA, MAS, NW, WA); $20 copay (CA, CO, HI)
Preventive Services	**You Pay**
Preventive examinations (including immunizations, well-child, women's health care)	$0 copay
Outpatient Services	**You Pay**
Outpatient surgery in a hospital or ambulatory surgical facility	$125 copay (CA, CO, GA, MAS, NW, WA); $75 copay (HI)
Laboratory services	$10 copay
Diagnostic X-rays[2]	$10 copay (CA, GA, HI, MAS, NW, WA); $0 copay (CO)
Specialty imaging (MRI, CT, and PET scans)	$100 copay (CA, CO, GA, MAS, NW, WA); 10% coinsurance (HI)
Hospital Inpatient Services	**You Pay**
Inpatient hospital services	$250 copay per admission
Delivery and inpatient maternity care	$250 copay per admission
Emergency Health Coverage	**You Pay**
Urgent care[4,5]	$30 copay (CO, GA, MAS, NW); $20 copay (CA, HI)
Emergency Department visits Note: This copay does not apply if you are admitted directly to the hospital as an inpatient for covered services (see "Inpatient hospital services" for inpatient copay)	$200 copay (CA, CO, GA, MAS, NW, WA); $100 copay (HI)
Ambulance services	$125 copay (CA, CO, GA, MAS, NW, WA); 20% coinsurance (HI)
Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Prescription drugs: Generic Maintenance (HI only)	$3 copay for up to a 30-day supply
Prescription drugs: Generic	$15 copay for up to a 30-day supply
Prescription drugs: Preferred brand	$30 copay (CA, CO, GA, MAS, NW, WA); $45 copay (HI) for up to a 30-day supply
Prescription drugs: Non-preferred brand[6]	$60 copay (CA, CO, GA, MAS, NW, WA); $45 copay (HI) for up to a 30-day supply
Prescription drugs: Specialty	20% (not to exceed $250) (CA, CO, GA, NW, WA); 20% (not to exceed $150) (MAS); $200 copay (HI) for up to a 30-day supply

Prescription Drug Coverage	You Pay
Mail order[6,7]	$6 copay generic maintenance (HI) / $30 copay generic / $60 copay (CA, CO, GA, MAS, NW, WA); $90 copay (HI) preferred brand / $120 copay (CA, CO, GA, MAS, NW, WA) $90 copay (HI) non-preferred brand for a 90-day supply
Durable Medical Equipment	**You Pay**
Durable medical equipment[3,8]	20% coinsurance
Mental Health & Substance Use Services	**You Pay**
Inpatient hospital and residential services	$250 copay per admission
Individual outpatient services[1]	$20 copay
Group outpatient services[1]	$10 copay (CA, CO, GA, MAS, NW); $20 copay (HI); $0 copay (WA)
Home Health Services	**You Pay**
Home health care (visit limits vary by region)[9]	$0 copay
Vision Exam Services	**You Pay**
Adult routine eye exam (age 19 or older)[10]	Based on the provider type
Pediatric routine eye exam (under age 19)[10]	Based on the provider type
Other	**You Pay**
Skilled nursing facility care[11]	$250 copay (CA, CO, GA, HI, MAS, NW); $0 copay (WA) per admission
Hospice care	$0 copay
Bariatric surgery	$250 copay (CA, CO, HI, MAS, NW, WA); $125 copay (GA)
Infertility: Covered services diagnosis & treatment[3,12]	50% coinsurance (CA, GA, MAS, NW, WA); $30 copay (CO); $20 copay (HI)
Infertility drugs	50% coinsurance (CA, GA, MAS, NW, WA); Standard Rx copay (HI); Applicable Rx Cost Share (CO)
Chiropractic care[3]	Benefit coverage varies by region
Acupuncture[3]	Benefit coverage varies by region
Adult hearing aid(s)[3]	$1,000 allowance per aid per ear (CA, CO, GA, MAS, NW-OR); $3,000 allowance per aid per ear (NW-WA, WA); 20% up to two hearing aids, one for each hearing impaired ear (HI) every 36 months
Pediatric hearing aid(s)[3,13]	Mandated benefit coverage varies by region

Kaiser Permanente Multi-Site Plan (KPMP) benefits may not deviate from the standard plan design.

This is a summary of the most frequently asked about benefits. This chart does not explain benefits, copays, coinsurance, deductibles, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and copay, coinsurance, or deductible amounts. For a complete explanation, please refer to the *Evidence of Coverage*.

(1) NW(OR): Visits 1–3 at $5 (not subject to deductible); visit limits cross-accumulate between primary care office visit, self-referred naturopathy, mental health (MH) individual and group visits, MH intensive outpatient/partial hospitalization, substance use disorder (SUD) individual and group visits, SUD day treatment services, telemedicine primary care visits. Visit 4+ at cost share. Telemedicine will remain at no charge. **(2)** Includes physical, occupational & speech therapy; CA: unlimited visits; CO: 30 visits per therapy per year; GA: Unlimited visits with no benefit maximum for ABA members through age 20 and 30 visits/therapy for non-ABA members; HI: unlimited visits; MAS: 30 visits per injury, incident, or condition per year; NW: 20 visits per therapy per year; WA: Unlimited visits for ABA members and 90 combined visits for non-ABA members. **(3)** For a complete explanation, please refer to the *Evidence of Coverage.* **(4)** WA: The cost share is based on the provider type. **(5)** HI: Urgent care services outside of the service area cost share – 20% coinsurance. **(6)** In California, nonformulary drugs are subject to a formulary exception process. Members pay the same cost share as for formulary drugs, when approved through the formulary exception process. **(7)** CA: 100-day supply for mail order. **(8)** HI: Diabetic supplies cost share – 50% coinsurance. **(9)** CA, CO, GA, MAS: 120 visits per year; HI, WA: unlimited visits; NW: 130 visits per year. **(10)** CA: $0 copay; CO: PCP copay. **(11)** Skilled nursing facility visit limits – CA, CO, GA, MAS, NW, WA: 100-day limit; HI: 120-day limit. **(12)** CO: IVF is covered at the outpatient surgery cost share. HI: Standard benefits apply - Initial infertility consultation and diagnosis covered at standard office visit & other benefit cost shares (e.g., labs, tests). IVF - 20% up to one treatment cycle per lifetime with KP. MAS: IVF is covered at 50% coinsurance. For a complete coverage explanation, please refer to the *Evidence of Coverage*. **(13)** CO: PCP copay for children up to age 18 with no limit on allowance; every 5 years as medically necessary. GA: DME copay for children up to age 19; $3,000 per aid per ear every 48 months. MAS(MD): No charge for children until end of month they turn 19; One aid per ear every 36 months. MAS(VA): No charge for children until end of month they turn 19; up to $1,500 per ear/aid every 24 months. NW(OR): DME copay for dependents up to the end of the month in which dependent turns 26; One aid per ear every 36 months. NW(WA), WA: $3,000 allowance per aid per ear every 36 months.

*Kaiser Foundation Health Plan of the Northwest (KFHP-NW) is licensed as a Health Care Service Contractor in Oregon and Washington.