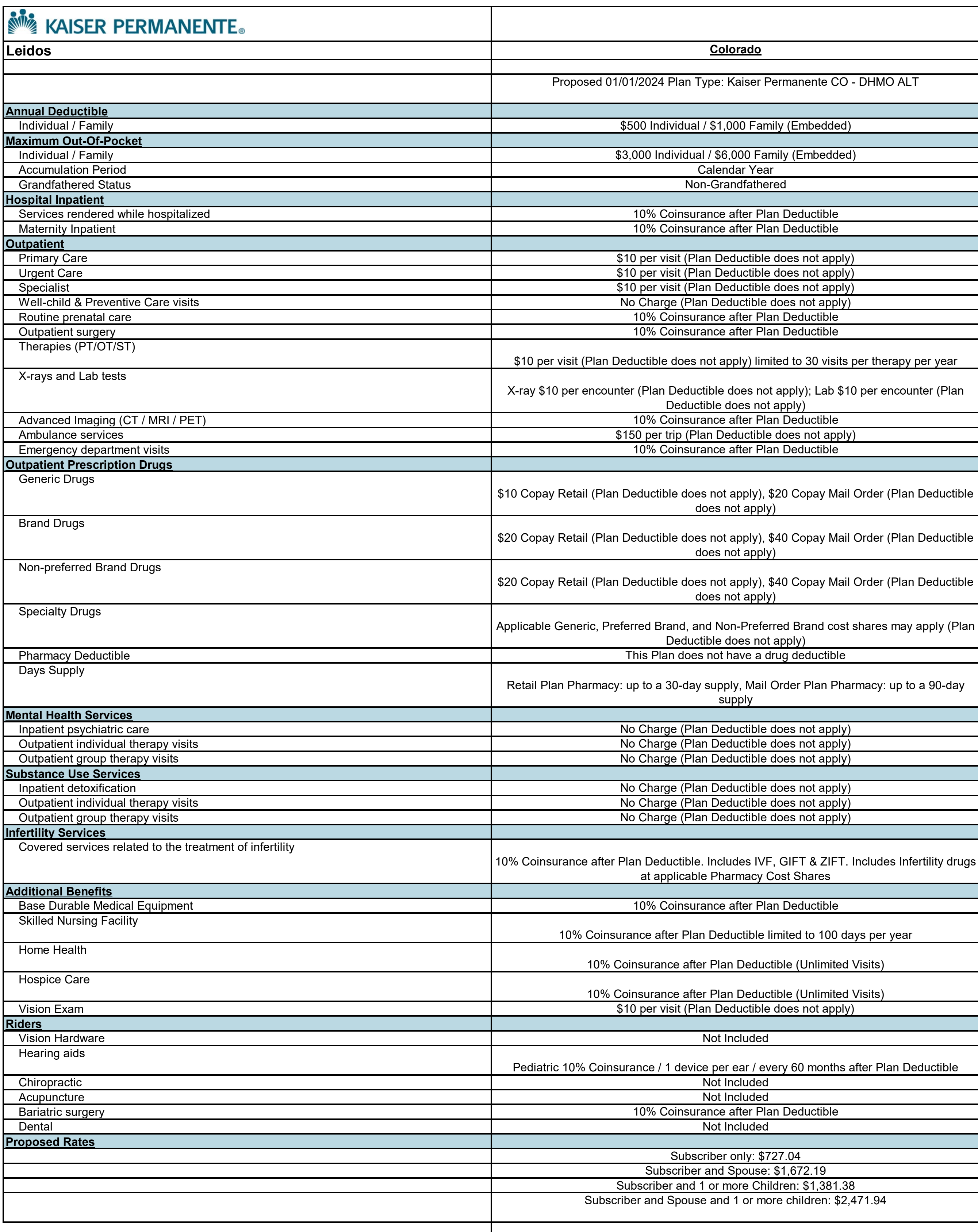

KAISER PERMANENTE®

| Leidos | Colorado |
|---|---|
| | |
| | Proposed 01/01/2024 Plan Type: Kaiser Permanente CO - DHMO ALT |
| **Annual Deductible** | |
| Individual / Family | $500 Individual / $1,000 Family (Embedded) |
| **Maximum Out-Of-Pocket** | |
| Individual / Family | $3,000 Individual / $6,000 Family (Embedded) |
| Accumulation Period | Calendar Year |
| Grandfathered Status | Non-Grandfathered |
| **Hospital Inpatient** | |
| Services rendered while hospitalized | 10% Coinsurance after Plan Deductible |
| Maternity Inpatient | 10% Coinsurance after Plan Deductible |
| **Outpatient** | |
| Primary Care | $10 per visit (Plan Deductible does not apply) |
| Urgent Care | $10 per visit (Plan Deductible does not apply) |
| Specialist | $10 per visit (Plan Deductible does not apply) |
| Well-child & Preventive Care visits | No Charge (Plan Deductible does not apply) |
| Routine prenatal care | 10% Coinsurance after Plan Deductible |
| Outpatient surgery | 10% Coinsurance after Plan Deductible |
| Therapies (PT/OT/ST) | $10 per visit (Plan Deductible does not apply) limited to 30 visits per therapy per year |
| X-rays and Lab tests | X-ray $10 per encounter (Plan Deductible does not apply); Lab $10 per encounter (Plan Deductible does not apply) |
| Advanced Imaging (CT / MRI / PET) | 10% Coinsurance after Plan Deductible |
| Ambulance services | $150 per trip (Plan Deductible does not apply) |
| Emergency department visits | 10% Coinsurance after Plan Deductible |
| **Outpatient Prescription Drugs** | |
| Generic Drugs | $10 Copay Retail (Plan Deductible does not apply), $20 Copay Mail Order (Plan Deductible does not apply) |
| Brand Drugs | $20 Copay Retail (Plan Deductible does not apply), $40 Copay Mail Order (Plan Deductible does not apply) |
| Non-preferred Brand Drugs | $20 Copay Retail (Plan Deductible does not apply), $40 Copay Mail Order (Plan Deductible does not apply) |
| Specialty Drugs | Applicable Generic, Preferred Brand, and Non-Preferred Brand cost shares may apply (Plan Deductible does not apply) |
| Pharmacy Deductible | This Plan does not have a drug deductible |
| Days Supply | Retail Plan Pharmacy: up to a 30-day supply, Mail Order Plan Pharmacy: up to a 90-day supply |
| **Mental Health Services** | |
| Inpatient psychiatric care | No Charge (Plan Deductible does not apply) |
| Outpatient individual therapy visits | No Charge (Plan Deductible does not apply) |
| Outpatient group therapy visits | No Charge (Plan Deductible does not apply) |
| **Substance Use Services** | |
| Inpatient detoxification | No Charge (Plan Deductible does not apply) |
| Outpatient individual therapy visits | No Charge (Plan Deductible does not apply) |
| Outpatient group therapy visits | No Charge (Plan Deductible does not apply) |
| **Infertility Services** | |
| Covered services related to the treatment of infertility | 10% Coinsurance after Plan Deductible. Includes IVF, GIFT & ZIFT. Includes Infertility drugs at applicable Pharmacy Cost Shares |
| **Additional Benefits** | |
| Base Durable Medical Equipment | 10% Coinsurance after Plan Deductible |
| Skilled Nursing Facility | 10% Coinsurance after Plan Deductible limited to 100 days per year |
| Home Health | 10% Coinsurance after Plan Deductible (Unlimited Visits) |
| Hospice Care | 10% Coinsurance after Plan Deductible (Unlimited Visits) |
| Vision Exam | $10 per visit (Plan Deductible does not apply) |
| **Riders** | |
| Vision Hardware | Not Included |
| Hearing aids | Pediatric 10% Coinsurance / 1 device per ear / every 60 months after Plan Deductible |
| Chiropractic | Not Included |
| Acupuncture | Not Included |
| Bariatric surgery | 10% Coinsurance after Plan Deductible |
| Dental | Not Included |
| **Proposed Rates** | |
| | Subscriber only: $727.04 |
| | Subscriber and Spouse: $1,672.19 |
| | Subscriber and 1 or more Children: $1,381.38 |
| | Subscriber and Spouse and 1 or more children: $2,471.94 |
| | |

This is a summary of the most frequently asked-about benefits. For a complete explanation, please refer to the EOC.