Kaiser Permanente - 4J
2018-19 Benefit Plan Summary
Plan 2

	Kaiser Permanente HMO Plan 2	
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	**In-Network Member Pays**	**Out-of-Network Member Pays**
Deductible per person	$800	NA
Maximum deductible per family	$2,400	NA
Out-of-pocket (OOP) maximum per person [3]	$4,000	NA
Out-of-pocket (OOP) maximum per family [3]	$12,000	NA
Maximum cost share per person	NA	NA
Maximum cost share per family	NA	NA
Preventive Care Services		
Wellness Visit (Moda plans: ages 21 and over, must use Medical Home)	$0[1]	NA
Routine adult, well-child and women's exams; annual obesity screening & immunizations. See Plan Handbook for add'l Preventive Care Services.	$0[1]	Not Covered
Incentive Care Services (for asthma, heart conditions, cholesterol, high blood pressure, diabetes)		
Moda Medical Home incentive care	NA	NA
Incentive office visits and home visits	NA	NA
Office Services		
Moda Medical Home primary care services	NA	NA
Primary care office visits	$25[1]	Not Covered
Specialist office visits	$35[1]	Not Covered
Urgent Care	$40[1]	See Plan Handbook
Mental Health Services		
Mental health office visits	$25[1]	Not Covered
Mental health inpatient and residential services	20%	Not Covered
Chemical dependency services (inpatient, outpatient or residential)	$0[1]	Not Covered
Outpatient Services		
Outpatient surgery/facility care	20%	Not Covered
Outpatient Rehabilitation (physical, occupational & speech therapy) Kaiser Plans: Maximum 20 visits per therapy per Plan Year, Moda Plans: 30 sessions per plan year / 60 for spinal or head injury	$35[1] per visit	Not Covered
Tests (outpatient)		
Preventive tests	$0[1]	Not Covered
Laboratory	$25[1] per visit	Not Covered
X-ray, imaging, and special diagnostic procedures	$25[1] per visit	Not Covered
CT, MRI, PET scans	$25[1] per visit	Not Covered
Alternative Care Services ($2,000 combined maximum)		
Acupuncture, Chiropractic & Naturopathic Services, labs, diagnostics, etc. *Cost of supplies & procedures performed in Alternative Care Provider's office applies to Alternative Care Benefit Maximum*	$25[1] per service	Not Covered
Maternity Care		
Outpatient Materntity Care	$0[1]	Not Covered
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20%	Not Covered
Hospital Services		
Inpatient care/surgery	20%	See Plan Handbook
Skilled nursing facility care (Kaiser Plans: 100 days per plan year, Moda Plans: 60 days per plan year)	20%	NA
Additional Cost Tier		
Moda Plans Only: $100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	NA	NA
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement [4], knee & shoulder arthroscopy, uncomplicated hernia repair	NA	NA
Emergency Services		
Emergency room (copay waived if admitted)	20%	
Ambulance	$100[1]	
Other Covered Services		
Hearing Aids: $4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10%[1]	Not Covered
Durable Medical Equipment (DME)	20%[1]	Not Covered
Bariatric Surgery (Roux-en-Y and gastric sleeve)	$500 + 20%	Not Covered
Pharmacy Services		
Out-of-pocket Maximum	$1100	
Retail		
Value (Moda Plans Only)	NA	NA
Generic (Kaiser plans) / Select generic (Moda Plans)	$5 per 30-day supply	See Plan Handbook
Preferred Brand	$25 per 30-day supply	See Plan Handbook
Non-preferred brand[5]	$45 per 30-day supply if criteria met	See Plan Handbook
Mail		
Value (Moda Plans Only)	NA	NA
Generic (Kaiser plans) / Select generic (Moda Plans)	$10 per 90-day supply	See Plan Handbook
Preferred Brand	$50 per 90-day supply	See Plan Handbook
Non-preferred brand[5]	$90 per 90-day supply if criteria met	See Plan Handbook
Specialty		
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $100 per 30 day supply	See Plan Handbook
Non-preferred brand[5]	25% up to $100 per 30 day supply	See Plan Handbook

NA - Not applicable

** If enrolled in a Moda CCM plan using the Synergy or Summit Network, you must select a Medical Home (primary care clinic) for each individual on the plan. Primary care must be performed at the designated Medical Home in order to receive the "In-Network" benefit; if these services are performed outside the individual's selected Medical Home, they will be paid at the "Out-of-Network" benefit level.

[1] Deductible waived.

[2] Individual deductible and out-of-pocket maximum apply to single coverage only. Family deductible and out-of-pocket maximum apply when two or more individuals are covered on the plan. This plan also includes an embedded per member out-of-pocket max, which is set at the individual OOP amount. Under this plan, deductible must be met before benefits will be paid (except where 1 indicates deductible waived).

[3] For PPO plans, OOP max includes medical copayments and coinsurance. Pharmacy copays and coinsurance and ACT copayments will continue accruing towards Maximum Cost Share. For CCM plans, OOP max includes medical copayments, coinsurance, as well as pharmacy copays and coinsurance. ACT copayments will continue accruing towards Maximum Cost Share limit.)

[4] Benefit is subject to a reference price limitation. This is not applicable to CCM Plans.

[5] A formulary exception must be approved for non-preferred brand prescription medication.

This document is for comparison purposes only and is not intended to fully describe the benefits of each plan. Refer to your member handbook for more details of benefit coverage. In the case of a conflict between this comparison and your member handbook, the member handbook will prevail.