

KAISER PLAN BENEFITS

Available to Ventura County Residents Only

	Kaiser HMO <u>Low Option</u>	Kaiser HMO <u>High Option</u>
Medical Plan		
Annual Deductible	None	None
Lifetime Maximum	None	None
Annual Co-Pay Maximum*	\$1,500 individual, \$3,000 family	\$1,500 individual, \$3,000 family
Hospital Care		
Inpatient*	\$500 per admission*	\$100 per admission
Outpatient*	\$20 copay per procedure/visit*	\$15 copay per procedure/visit*
Emergency Room	\$100 copay, no coverage for non-emergency	\$50 copay, no coverage for non-emergency
Copay waived if admitted		
Urgent Care	\$20 copay	\$15 copay
Skilled Nursing*	No copay for up to 100 days per benefit period*	No copay for up to 100 days per benefit period
Physician Care		
Office Visits (includes specialists)	\$20 copay	\$15 copay
Hospital Visits (physician svcs)	No charge	No charge
Periodic Health Evaluation	\$20 copay per visit	\$15 copay per visit
X-Ray & Lab Services	No charge	No charge
Outpatient Rehabilitation Therapy	\$20 copay per visit	\$15 copay per visit
Immunizations*	No copay*	No copay*
Home Health Care Services (Visit limitations where applicable are combined for network and non-network services)*	No copay per home visit when prescribed by a Plan MD (services limited to inside the Service Area); limit of three 2-hour visits per day, 100 visits per year*	No copay per home visit when prescribed by a Plan MD (services limited to inside the Service Area); limit of three 2-hour visits per day, 100 visits per year*
Chiropractic*	Not covered	Not covered*
Prosthetics / Orthotics*	No charge when deemed medically necessary and prescribed by a Plan MD*	No charge when deemed medically necessary and prescribed by a Plan MD*

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Durable Medical Equipment* (unlimited benefits based on medical necessity)	No charge per covered item. Must be in accordance with DME formulary guidelines*	No charge per covered item. Must be in accordance with DME formulary guidelines*
Acupuncture*	\$20 copay per visit. Covered as alternative to standard treatment as determined by a Plan MD; primarily a component of a multidisciplinary chronic pain management program*	\$15 copay per visit. Covered as alternative to standard treatment as determined by a Plan MD; primarily a component of a multidisciplinary chronic pain management program*
Mental Health		
Severe Disorders – Inpatient*	\$500 copay per admission, 30 day limit but waived for specified disorders*	\$100 copay per admission, 30 day limit but waived for specified disorders*
Severe Disorders – Outpatient*	Individual: \$20; Group: \$10 copay per visit, 2 visit limit but waived for specified disorders*	Individual: \$15; Group: \$7 copay per visit 2 visit limit but waived for specified disorders*
Non-Severe Disorders – Inpatient*	\$500 copay per admission, up to 30 days per calendar year but waived for specified disorders*	\$100 copay per admission, up to 30 days per calendar year but waived for specified disorders*
Non-Severe Disorders – Outpatient*	Individual: \$20; Group: \$10 copay per visit, up to 20 visits per calendar year but waived for specified disorders*	Individual: \$15; Group: \$7 copay per visit, up to 20 visits per calendar year but waived for specified disorders*
Chem. Dependency Rehab – Outpatient*	Individual: \$20; Group: \$5 copay per visit, No outpatient visit limit*	Individual: \$15; Group: \$5 copay per visit, No outpatient visit limit*
Detoxification – Inpatient (Detoxification only)*	\$500 copay per admission; Transitional Residential Recovery Service (TRRS) in a non-medical setting; \$100 copay per admission, up to 60 days per calendar year, but no more than 120 days in any 5 consecutive calendar year period*	\$100 copay per admission; Transitional Residential Recovery Service (TRRS) in a non-medical setting; \$100 copay per admission, up to 60 days per calendar year, but no more than 120 days in any 5 consecutive calendar year period*

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Prescription Drugs		
Retail Generic / Brand*	\$10 generic / \$35 brand copay per prescription, no non-formulary coverage. Up to 30-day supply, when medically necessary, prescribed by a Plan MD and obtained at Plan pharmacies*	\$10 generic / \$35 brand copay per prescription, no non-formulary coverage. Up to 30-day supply, when medically necessary, prescribed by a Plan MD and obtained at Plan pharmacies*
Mail Order Generic / Brand*	\$20 generic / \$70 brand copay per prescription, up to 100 day supply, when medically necessary, prescribed by a Plan MD and obtained through Plan mail order*	\$20 generic / \$70 brand copay per prescription, up to 100 day supply, when medically necessary, prescribed by a Plan MD and obtained through Plan mail order*
Vision		
Screening (Routine Preventive performed by PCP, excludes refractions)	\$20 copay per exam	\$15 copay per exam
Eyewear (Lens, Frame)	Not covered	Not covered

*Services marked with an asterisk are different than current Blue Shield Low and High Option HMO benefit levels