KAISER PERMANENTE®

Mid-Atlantic States, Inc.

Current

American Airlines

Effective Dates: 01/01/2018-12/31/2018

DHMO Sig Plan 5 (Virginia)

Group Number(s): 3381

General Information	
Website	Kp.org
Member Services Number	301-468-6000
Member Services Weekday Hours	Monday – Friday 7:30 am – 5:30 pm
Member Services Weekend Hours	Closed
Annual Deductible: Individual/Family	$250 / $500
Annual Out-of-Pocket Max: Individual/Family	$3,000 / $6,000
Office Visits (Outpatient)	
Primary Care	$20 copay (Copayments waived for children under age 5)
Specialty Care	$40 copay
Preventive Care	No charge
Scheduled Prenatal Visits, 1st Postpartum Visit	No charge
Well-Baby Care	No charge
Vision Exam - Optometrist	$20 copay
Vision Exam - Ophthalmologist	$40 copay (referral required)
Physical, Occupational, Speech Therapy	$40 copay 90 days per condition
Outpatient/Ambulatory Surgery	20% coinsurance
Lab and X-Ray	
Laboratory	20% coinsurance (after deductible)
X-Ray	20% coinsurance (after deductible)
MRI/CT/PET/Nuclear Medicine	20% coinsurance (after deductible)
Emergency Care	
Ambulance (Ground or Air)	20% coinsurance(after deductible)
Emergency Room	20% coinsurance (after deductible)
Urgent Care	$40 copay
Hospital Care (Inpatient)	
Inpatient	20% coinsurance (after deductible)
Delivery and Inpatient Baby Care	20% coinsurance (after deductible)

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, cost sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and cost sharing. For a complete explanation, please refer to the applicable EOC, or to the Disclosure Form for California, or to the Member Handbook for Hawaii.

`	
Mental Health Outpatient (Individual)	$20 copay
Mental Health Outpatient (Group)	$10 copay
Mental Health Inpatient	20% coinsurance (after deductible)
Chemical Dependency Outpatient (Individual)	$20 copay
Chemical Dependency Outpatient (Group)	$10 copay
Chemical Dependency Inpatient	20% coinsurance (after deductible)
Prescription Drugs	
Pharmacy/Retail: Generic	$15 (Plan Pharmacy) / $25 (Participating Network Pharmacy)
Pharmacy/Retail: Brand	$25 (Plan Pharmacy) / $45 (Participating Network Pharmacy)
Pharmacy/Retail: Brand Non-Formulary	$40 (Plan Pharmacy) / $60 (Participating Network Pharmacy)
Pharmacy/Retail: Day Supply	Up to a 30-day supply for 1 copays; up to a 90-day supply for 3 copays
Mail Order - Generic	$15
Mail Order – Brand Formulary	$25
Mail Order – Brand Non- Formulary	$40
Mail Order - Day Supply	Up to a 90-day supply for 2 copays
Other	
Skilled Nursing Facility (SNF)	20% coinsurance up to 100 day/cont yr (after deductible)
Infertility Services	50% of allowable charge
Hospice Care	20% coinsurance (after deductible)
Home Health Care	20% coinsurance (after deductible)
Durable Medical Equipment (DME) w/Orthotics and Prosthetics	20% coinsurance (after deductible)
Chiropractic Care	$15 copay, limit 20 visits
Notes	

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, cost sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and cost sharing. For a complete explanation, please refer to the applicable EOC, or to the Disclosure Form for California, or to the Member Handbook for Hawaii.

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, cost sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and cost sharing. For a complete explanation, please refer to the applicable EOC, or to the Disclosure Form for California, or to the Member Handbook for Hawaii.