KAISER PERMANENTE®

Natus Medical Incorporated	Northern California 606090 Proposed 01/01/2022 Plan Type: HMO	Southern California 234217 Proposed 01/01/2022 Plan Type: HMO	Washington 23779 Proposed 01/01/2022 Plan Type: HMO
Annual Deductible			
Individual / Family	Not Applicable	Not Applicable	Not Applicable
Maximum Out-Of-Pocket			
Individual / Family	$3,500 Individual / $3,500 Individual Family Member / $7,000 Family (Embedded)	$3,500 Individual / $3,500 Individual Family Member / $7,000 Family (Embedded)	$3,500 Individual / $3,500 Individual Family Member / $7,000 Family (Embedded)
Maximum Lifetime Benefit	Unlimited	Unlimited	Unlimited
Grandfathered Status	Non-Grandfathered	Non-Grandfathered	Non-Grandfathered
Hospital Inpatient			
Services rendered while hospitalized	$500 per day	$500 per day	$500 per day for up to 5 days per admission
Maternity Inpatient	$500 per day	$500 per day	$500 per day for up to 5 days per admission
Outpatient			
Primary Care	$30 per visit	$30 per visit	$25 per visit
Urgent Care	$30 per visit	$30 per visit	$25 per visit
Specialist	$50 per visit	$50 per visit	$50 per visit
Well-child & Preventive Care visits	No Charge	No Charge	No Charge
Routine prenatal care	No Charge	No Charge	No Charge
Outpatient surgery	$250 per procedure	$250 per procedure	$250 per procedure
Therapies (PT/OT/ST)	$30 per visit	$30 per visit	$50 per visit limited to 60 combined visits
X-rays and Lab tests	X-ray $10 per encounter; Lab $10 per encounter	X-ray $10 per encounter; Lab $10 per encounter	X-ray No Charge; Lab No Charge
Advanced Imaging (CT / MRI / PET)	$100 per encounter	$100 per encounter	No Charge
Ambulance services	$150 per trip	$150 per trip	20% Coinsurance
Emergency department visits	$150 per visit waived if admitted	$150 per visit waived if admitted	$150 per visit waived if admitted
Outpatient Prescription Drugs			
Generic Drugs	$15 Copay Retail, $30 Copay Mail Order	$15 Copay Retail, $30 Copay Mail Order	$10 Copay Retail, $20 Copay Mail Order
Brand Drugs	$35 Copay Retail, $70 Copay Mail Order	$35 Copay Retail, $70 Copay Mail Order	$35 Copay Retail, $70 Copay Mail Order
Non-preferred Brand Drugs	Applicable cost shares apply	Applicable cost shares apply	$70 Copay Retail, $140 Copay Mail Order
Specialty Drugs	30% Coinsurance	30% Coinsurance	Applicable cost shares apply
Pharmacy Deductible	This Plan does not have a drug deductible	This Plan does not have a drug 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 100-day supply	Retail Plan Pharmacy: up to a 30-day supply, Mail Order Plan Pharmacy: up to a 100-day 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	$500 per day	$500 per day	$500 per day for up to 5 days per admission
Outpatient individual therapy visits	$30 per visit	$30 per visit	$25 per visit
Substance Use Services			
Inpatient detoxification	$500 per day	$500 per day	$500 per day for up to 5 days per admission
Outpatient individual therapy visits	$30 per visit	$30 per visit	$25 per visit
Infertility Services			
Covered services related to the diagnosis and treatment of infertility	50% Coinsurance	50% Coinsurance	50% Coinsurance diagnostic services & drugs
Additional Benefits			
Durable Medical Equipment	50% Coinsurance	50% Coinsurance	50% Coinsurance
Skilled Nursing Facility	No Charge limited to 100 days per benefit period	No Charge limited to 100 days per benefit period	No Charge limited to 100 days per year
Vision Exam	Based on provider type	Based on provider type	Based on provider type
Riders			
Vision Hardware	Not Included	Not Included	Not Included
Hearing aids	Not Included	Not Included	Not Included
Chiropractic	$15 per visit limited to 20 visits; $50 allowance per year	$15 per visit limited to 20 visits; $50 allowance per year	$25 per visit limited to 20 visits per year
Dental	Not Included	Not Included	Not Included

The information presented in this chart is a summary only. For a complete understanding of benefits, please read this chart in conjunction with the Evidence of Coverage (EOC). The EOC contains a detailed explanation of benefits, exclusions and limitations.