KAISER PERMANENTE®

# PACE Benefit Comparison

| | HMO 10 | HMO 15 | HMO 25 |
|---|---|---|---|
| **Annual Deductible: Self Only / Indv / Family** | **None / None / None** | **None / None / None** | **None / None / None** |
| **Maximum Out-Of-Pocket: Self Only / Indv / Family** | **$1,500 / $1,500 / $3,000** | **$1,500 / $1,500 / $3,000** | **$1,500 / $1,500 / $3,000** |
| **Maximum Lifetime Benefit** | **None / None** | **None / None** | **None / None** |
| | | | |
| **Hospital Inpatient** (all services rendered while hospitalized) | **No charge** | **No charge** | **$250 per admit** |
| **Outpatient** (specialty, routine, eye/hearing exams, and urgent care) | **$10 per visit / $10 spec** | **$15 per visit / $15 spec** | **$25 per visit / $25 spec** |
| Well-child preventive care visits (23 months or younger) | No charge | No charge | No charge |
| Scheduled prenatal care and first postpartum visit | No charge | No charge | No charge |
| Outpatient surgery | $10 per procedure | $15 per procedure | $25 per procedure |
| Allergy Injections / Immunizations | No charge | No charge | No charge |
| X-rays and Lab tests | No charge | No charge | No charge |
| Ambulance services | No charge | No charge | No charge |
| Emergency department visits | $100 per visit | $100 per visit | $100 per visit |
| **Outpatient Prescription Drugs (pharmacy and mail order)** | **$10 gen / $20 brand / 20% spec, $20 gen / $40 brand MOI** | **$10 gen / $20 brand / 20% spec, $20 gen / $40 brand MOI** | **$10 gen / $20 brand / 20% spec, $20 gen / $40 brand MOI** |
| Days supply | 30 days, 30 days spec, 100 days MOI | 30 days, 30 days spec, 100 days | 30 days, 30 days spec, 100 days |
| **Mental Health Services** | | | |
| Inpatient psychiatric care / days per calendar year | No charge | No charge | $250 per admit |
| Outpatient individual therapy visits | $10 per visit | $15 per visit | $25 per visit |
| Outpatient group therapy visits | $5 per visit | $7 per visit | $12 per visit |
| **Chemical Dependency Services** | | | |
| Inpatient detoxification | No charge | No charge | $250 per admit |
| Outpatient individual therapy visits | $10 per visit | $15 per visit | $25 per visit |
| Outpatient group therapy visits | $5 per visit | $5 per visit | $5 per visit |
| Transitional Residential Recovery Services | No charge | No charge | No charge |
| **Infertility Services** | | | |
| Covered services related to the diagnosis and treatment of infertility | 50% per visit | 50% per visit | 50% per visit |
| **Additional Benefits** | | | |
| Supplemental Durable Medical Equipment | No charge | No charge | No charge |
| Skilled Nursing | No charge | No charge | No charge |
| Optical eyewear (frames, lenses, contact lenses) | Not covered | Not covered | Not covered |
| Hearing aids | Not covered | Not covered | Not covered |
| Chiropractic | Not covered | Not covered | Not covered |
| Dental | Not covered | Not covered | Not covered |

KAISER PERMANENTE®

# PACE Benefit Comparison

| | HMO 40 | DHMO 90 | DHMO 80 |
|---|---|---|---|
| **Annual Deductible: Self Only / Indv / Family** | **None / None / None** | **$500 / $500 / $1,000** | **$500 / $500 / $1,000** |
| **Maximum Out-Of-Pocket: Self Only / Indv / Family** | **$1,500 / $1,500 / $3,000** | **$3,000 / $3,000 / $6,000** | **$3,000 / $3,000 / $6,000** |
| **Maximum Lifetime Benefit** | **None / None** | **None / None** | **None / None** |
| | | *** Benefit applies to deductible** | *** Benefit applies to deductible** |
| **Hospital Inpatient** (all services rendered while hospitalized) | **$500 per admit** | **10% per admit *** | **20% per admit *** |
| **Outpatient** (specialty, routine, eye/hearing exams, and urgent care) | **$40 per visit / $40 spec** | **$20 per visit / $20 spec** | **$20 per visit / $20 spec** |
| Well-child preventive care visits (23 months or younger) | No charge | No charge | No charge |
| Scheduled prenatal care and first postpartum visit | No charge | No charge | No charge |
| Outpatient surgery | $40 per procedure | 10% per procedure * | 20% per procedure * |
| Allergy Injections / Immunizations | $3 per visit | No charge | No charge * |
| X-rays and Lab tests | No charge | $10 per encounter | $10 per encounter * |
| Ambulance services | No charge | $150 per trip | $150 per trip * |
| Emergency department visits | $100 per visit | 10% per visit * | 20% per visit * |
| **Outpatient Prescription Drugs (pharmacy and mail order)** | **$10 gen / $20 brand / 20% spec, $20 gen / $40 brand MOI** | **$10 gen / $30 brand / $30 spec, $20 gen / $60 brand MOI** | **$10 gen / $30 brand / $30 spec** |
| Days supply / Deductible | 30 days, 30 days spec, 100 days MOI | 30 days, 30 days spec, 100 days | 100 days, 30 days spec / $100 |
| **Mental Health Services** | | | |
| Inpatient psychiatric care / days per calendar year | $500 per admit | 10% per admit * | 20% per admit * |
| Outpatient individual therapy visits | $40 per visit | $20 per visit | $20 per visit |
| Outpatient group therapy visits | $20 per visit | $10 per visit | $10 per visit |
| **Chemical Dependency Services** | | | |
| Inpatient detoxification | $500 per admit | 10% per admit * | 20% per admit * |
| Outpatient individual therapy visits | $40 per visit | $20 per visit | $20 per visit |
| Outpatient group therapy visits | $5 per visit | $5 per visit | $5 per visit |
| Transitional Residential Recovery Services | No charge | 10% per admit * | 20% per admit * |
| **Infertility Services** | | | |
| Covered services related to the diagnosis and treatment of infertility | 50% per visit | 50% per visit | 50% per visit |
| **Additional Benefits** | | | |
| Supplemental Durable Medical Equipment | No charge | 20% per item | 20% per item |
| Skilled Nursing | No charge | 10% per admit | 20% per admit * |
| Optical eyewear (frames, lenses, contact lenses) | Not covered | Not covered | Not covered |
| Hearing aids | Not covered | Not covered | Not covered |
| Chiropractic | Not covered | Not covered | Not covered |
| Dental | Not covered | Not covered | Not covered |