KAISER PERMANENTE®

loanDepot	California
	Proposed 01/01/2023 Plan Type: $500 DHMO
Annual Deductible	
Individual / Family	$500 Individual / $1,000 Family (Embedded)
Maximum Out-Of-Pocket	
Individual / Family	$2,000 Individual / $4,000 Family (Embedded)
Maximum Lifetime Benefit	Unlimited
Grandfathered Status	Non-Grandfathered
Hospital Inpatient	
Services rendered while hospitalized	$200 per admission after Plan Deductible
Maternity Inpatient	$200 per admission after Plan Deductible
Outpatient	
Primary Care	$30 per visit (Plan Deductible does not apply)
Urgent Care	$30 per visit (Plan Deductible does not apply)
Specialist	$40 per visit (Plan Deductible does not apply)
Well-child & Preventive Care visits	No Charge (Plan Deductible does not apply)
Routine prenatal care	No Charge (Plan Deductible does not apply)
Outpatient surgery	$100 per procedure after Plan Deductible
Therapies (PT/OT/ST)	$30 per visit (Plan Deductible does not apply) (Unlimited Visits)
X-rays and Lab tests	X-ray No Charge (Plan Deductible does not apply); Lab No Charge (Plan Deductible does not apply)
Advanced Imaging (CT / MRI / PET)	$100 per encounter (Plan Deductible does not apply)
Ambulance services	$100 per trip (Plan Deductible does not apply)
Emergency department visits	$150 per visit after Plan Deductible waived if admitted
Outpatient Prescription Drugs	
Generic Drugs	$10 Copay Retail (Plan Deductible does not apply), $20 Copay Mail Order (Plan Deductible does not apply)
Brand Drugs	$25 Copay Retail (Plan Deductible does not apply), $50 Copay Mail Order (Plan Deductible does not apply)
Non-preferred Brand Drugs	$25 Copay Retail (Plan Deductible does not apply), $50 Copay Mail Order (Plan Deductible does not apply)
Specialty Drugs	$250 Copay (Plan Deductible does not apply)
Pharmacy 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
Mental Health Services	
Inpatient psychiatric care	$200 per admission after Plan Deductible
Outpatient individual therapy visits	$30 per visit (Plan Deductible does not apply)
Outpatient group therapy visits	$15 per visit (Plan Deductible does not apply)
Substance Use Services	
Inpatient detoxification	$200 per admission after Plan Deductible
Outpatient individual therapy visits	$30 per visit (Plan Deductible does not apply)
Outpatient group therapy visits	$15 per visit (Plan Deductible does not apply)
Infertility Services	
Covered services related to the treatment of infertility	Not Covered
Additional Benefits	
Durable Medical Equipment	20% Coinsurance (Plan Deductible does not apply)
Skilled Nursing Facility	$200 per day after Plan Deductible limited to 120 days per benefit period
Home Health	$30 per visit (Plan Deductible does not apply) limited to 100 visits per year
Hospice Care	No Charge (Plan Deductible does not apply)
Vision Exam	No Charge (Plan Deductible does not apply)
Riders	
Vision Hardware	Not Included
Hearing aids	$2000 allowance / 1 device per ear / every 36 months (Plan Deductible does not apply)
Chiropractic	$30 per visit / limited to 30 visits per year (Plan Deductible does not apply)
Acupuncture	$30 per visit / limited to 30 visits per year (Plan Deductible does not apply)
Bariatric surgery	$200 per admission after Plan Deductible
Dental	Not Included