

Deductible 50/5000 NM

Medical calendar-year deductible

Individual plan (subscriber only) \$5,000

Family plan (any one member/all members) No dependent coverage

Annual out-of-pocket maximum

Individual plan (subscriber only) \$7,500

Family plan (any one member/all members) No dependent coverage

Lifetime benefit maximum

Individual \$5 million

Benefits

You Pay

Professional services (plan provider office visits)

Primary and specialty care visits (includes routine and urgent care appointments) \$50 per visit

Routine preventive physical exams (includes vision and hearing exams) \$50 per visit

Well-child visits from 0 to 23 months \$30 per visit

Family planning visits \$50 per visit

Scheduled prenatal care Not covered

Maternity coverage

Maternity care Not covered

Hospitalization services

Room and board, surgery, anesthesia, X-rays, lab tests, and medications 30% coinsurance (after deductible)

Emergency health coverage

Emergency Department visits (charge waived if admitted directly to the hospital) \$150 per visit (after deductible)

Ambulance services

Emergency ambulance services \$150 per trip (after deductible)

Prescriptions

Plan pharmacy (up to a 30-day supply) Not covered

Mail-order (up to a 100-day supply) Not covered

Outpatient services

Outpatient surgery 30% coinsurance (after deductible)

Allergy injection visits \$5 per visit (after deductible)

Vaccines (immunizations) No charge

Most x-rays and lab tests \$10 per encounter (after deductible)

MRI, CT, and PET \$50 per procedure (after deductible)

Note: Deductible does not apply to preventive screenings as described in the *Certificate of Insurance*.

Mental health services

Inpatient psychiatric care (up to 30 days)	30% coinsurance (after deductible)
Outpatient individual psychiatric visits	\$40 per visit
Outpatient group psychiatric visits	\$25 per visit
Outpatient individual/group visits per calendar year	Up to a total of 20 visits

Note: Visit and day limits do not apply to severe mental illness and serious emotional disturbances of children as described in the *Certificate of Insurance*.

Chemical dependency services

Inpatient detoxification	30% coinsurance (after deductible)
Outpatient individual therapy visits	\$50 per visit
Outpatient group therapy visits	\$5 per visit
Transitional residential recovery services (up to 60 days, not to exceed 120 days in any five-year period)	\$100 per admission (after deductible)

Home health services

Home health care (up to 100 two-hour visits)	No charge
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Health education

Individual visits	\$50 per visit
Group visits	No charge

Other

Skilled Nursing Facility care (up to 100 days per benefit period)	30% coinsurance (after deductible)
Hospice care	No charge

1 These plans are offered by Kaiser Permanente Insurance Company, a subsidiary of Kaiser Foundation Health Plan, Inc.

2 KPIC deductible plans offer a copay for preventive care and certain other services from the first day of coverage. You will have to pay all other health care expenses out of pocket until you meet your deductible.

3 This plan does not offer maternity coverage.

4 This plan does not offer prescription coverage.