KAISER PERMANENTE®

Group Name:
Effective Date:
Account Manager:

	2026	2027
Plan Name		**DHMO 02**
Plan Type	**HMO**	**DHMO**
Network	**Signature**	**Signature**
Individual Deductible	None	$250
Family Deductible	None	$500
Individual Out Of Pocket Maximum	$1,000.00	$2,000
Family Out Of Pocket Maximum	$2,000.00	$4,000
Coinsurance	Plan Pays 100%	Plan Pays 90%
Primary Care	$10 Copay	$10 Copay
Specialty Care	$20 Copay	$25 Copay
Urgent Care	$20 Copay	$25 Copay
Telemedicine	Plan Pays 100%	Plan Pays 100%
Mental Health/Chemical Dependency, Individual Therapy	$10 Copay	$10 Copay
Occupational/Physical/Speech Therapy	$20 Copay, 30 visits per contract year per injury, incident, or condition per each therapy	$25 Copay, 30 visits per contract year per injury, incident, or condition per each therapy
Inpatient Hospital	Plan Pays 100%	$150 copay After Deductible
Outpatient Surgery	$20 copay	$150 copay After Deductible
Emergency Room	$150 Copay	$250 Copay
Ambulance	$0 Copay	$100 Copay
X-Ray, Imaging, & Lab Tests	Plan Pays 100%	$15 Copay
Specialty Imaging (MRI, CT, PET, Nuclear Med)	Plan Pays 100%	$100 copay After Deductible
Eye Exams & Treatments (Optometry/Ophthalmology)	$10/$20 Copay	$10/$25 Copay
Vision Hardware	$75 Frames & Lens or $25 Contact Lens Discount at KP per 12 months	$75 Frames & Lens or $25 Contact Lens Discount at KP per 12 months
Durable Medical Equipment	20% coinsurance	Plan Pays 20% After Deductible
External Prosthetics (Artificial Limbs)	20% coinsurance	Plan Pays 100%
Orthotics	20% coinsurance	Plan Pays 20% After Deductible
Advanced Infertility Rider	Plan Pays 50%, $100,000 ben max/life, 3 attempts/live birth	Plan Pays 50% After Deductible, $100,000 ben max/life, 3 attempts/live birth
Chiropractic Rider	$20 Copay/Visit, 20 Visits/contract year	$25 Copay/Visit, 20 Visits/contract year
Acupuncture Rider	Not Covered	Not Covered
Hearing Aid Rider	$0 copay, 1 hearing aid/ear/36 months	$0 Coinsurance, 1 hearing aid/ear/36 months
Wellness Rider	Not Covered	Not Covered
Dental	No Selection	No Selection
Prescription Drugs (Most Generic / Most Preferred Brand / Non-Preferred Brand)	KP $7/15/30, Network $20/35/50; 30d 1 copay, 90d 2 copay, Mail Order 90d 2 copay	KP $25/40/65, Network $35/60/85; 30d 1 copay, 90d 2 copay, Mail Order 90d 2 copay

This is a summary description. Kaiser Permanente shall not be bound by the exclusions and limitations listed herein, but rather the benefits, services, exclusions and limitations listed in your Evidence of Coverage.