

Benefits at a Glance	Health Maintenance Organization (HMO) Managed by Kaiser Permanente
In-Network Only	
Physician Network Area	Metropolitan Washington D.C., including Northern Virginia and Baltimore areas; includes the City of Fredericksburg, Spotsylvania and Stafford Counties and portions of Caroline, Culpeper, Fauquier, Hanover, Louisa, Orange and Westmoreland Counties. Physician network Area may differ slightly from Service Area, contact Member Services Department for the plan.
Plan Contact Information	Customer Service: 301-468-6000 Website: www.kaiserpermanente.org
Primary Care Physician (PCP)	Yes – required
Referrals for Specialty Care	Yes – required
Annual Deductible	\$0
Yearly Out-of-Pocket Limit	\$3500 individual / \$9400 family
Office Visits (PCP or Specialist)	Covered in full after \$10 copay. No charge for children up to age 5.
Preventive Care <ul style="list-style-type: none"> • Children and Adults 	Covered in full. Refer to benefits page on FairfaxNet for list of services.
Inpatient Hospital Care/ Doctor's Services	Covered in full.
Laboratory & X-Ray	Covered in full.
Prescription Deductible	\$0
Prescription Out-of-Pocket Max	\$0
Prescription Drugs	<i>Kaiser pharmacy (up to 30 day supply):</i> \$10 copay for generic \$20 copay for brand formulary \$35 copy for brand non-formulary <i>Community Pharmacy (Up to 30 day supply):</i> \$20 copay for generic \$40 copay for brand formulary \$55 copay for brand non-formulary <i>Mail Order (up to 90 day supply):</i> \$16 copay generic \$36 copay brand formulary \$66 copay brand non-formulary
Maternity Care	Covered in full after \$10 copay on first pre-natal visit.
Emergency Treatment	Covered in full after \$150 copay per visit. Waived if admitted for treatment other than observation.
Urgent Care	\$10 copay per visit
Mental Health Services and Substance Abuse Treatment	<i>Inpatient</i> – Covered in full when medically necessary. <i>Outpatient</i> - \$10 individual visit copay; \$5 group visit copay.
Infertility Coverage	Coverage for in-vitro fertilization (IVF) for up to 3 completed attempts per lifetime; covered at 50% of allowable charges. \$100,000 Benefit Maximum.
TMJ, surgical and non-surgical	Not covered.
Hearing Aids	Covered in full up to maximum

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<ul style="list-style-type: none"> • One hearing aid/ear/ every 36 months, \$1,000 maximum. 	
Wigs	Not covered.
Dental Care (additional coverage available through Delta Dental plan – separate premium required)	Discounts on services.
Routine Vision Care	In addition to Davis Vision benefits, eye refraction exam/ ophthalmology visits: \$10 copay; eyewear/contact lens discounts also available.