BRONZE 60 HSA HMO 4500/40% W/ CHILD DENTAL + INFERTILITY

HSA-Qualified Deductible HMO Plan

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE	
Individual/Family	$4,500/$9,000[1] (embedded)
OUT-OF-POCKET MAXIMUM	
Individual/Family	$6,500/$13,000[1,2] (embedded)
IN THE MEDICAL OFFICE	
Primary care visits	40% (after deductible)
Urgent care visits	40% (after deductible)
Specialty office visits	40% (after deductible)
Preventive exams, vaccines (immunizations)	$0[3]
Prenatal care	$0[4]
Postpartum care	$0 (after deductible)[5]
Well-child preventive care visits	$0[6]
Allergy injections	40% (after deductible)
Infertility services	50% (IVF not covered)
Physical, occupational, and speech therapy	40% (after deductible)
Most laboratory tests	40% (after deductible)
Most X-rays and diagnostic testing	40% (after deductible)
Most MRI/CT/PET scans	40% (after deductible)
Outpatient surgery (per procedure)	40% (after deductible)
EMERGENCY SERVICES	
Emergency Department visits	40% (after deductible)
Ambulance	40% (after deductible)
PRESCRIPTIONS	
Generic drugs (up to a 100-day supply)	40% (after plan deductible)[7]
Brand-name drugs (up to a 100-day supply)	40% (after plan deductible)[7]
Specialty drugs (up to a 30-day supply)	40% (after plan deductible)[7]
HOSPITAL CARE	
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	40% (after deductible)
Skilled nursing facility care (up to 100 days per benefit period)	40% (after deductible)
MENTAL HEALTH SERVICES	
In the medical office	40% (after deductible)
In the hospital	40% (after deductible)
CHEMICAL DEPENDENCY SERVICES	
In the medical office	40% (after deductible)
In the hospital (detoxification only)	40% (after deductible)
OTHER	
Certain durable medical equipment (DME) (base only)	40% (after deductible)[8]
Certain prosthetic and orthotic devices	$0 (after deductible)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[9]
Pediatric vision exam	$0
Adult optical (eyewear)	Not covered[10]
Adult vision exam (for eye refraction)	$0
Home health care (up to 100 visits per year)	$0 (after deductible)
Hospice care	$0 (after deductible)

[1]This plan has an embedded deductible and out-of-pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual deductible **or out-of-pocket maximum (depending on the benefit)**, or when the family deductible **or out-of-pocket maximum** is satisfied. Individual family members are no longer subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of-pocket maximum is met.
[2]Out-of-pocket maximum is the maximum amount an individual or family will pay for all covered services in a year.
[3]Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam.
[4]Scheduled prenatal visits
[5]First postpartum visit only covered at no charge
[6]Well-child visits through age 23 months
[7]Prescription drugs are covered in accordance with our formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copays. For information on our formulary, including the drugs on the specialty tier, go to kp.org/formulary or call our Member Service Contact Center.
[8]Please refer to the *Evidence of Coverage* for information on what is included in your DME benefit. Coverage is limited.
[9]Under age 19
[10]Kaiser Permanente members are entitled to a 20% discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be combined with any other Health Plan vision benefit. The discounts will not apply to any sale, promotion, or packaged eyewear program; for any contact lens extended purchase agreement; or to low-vision aids or devices. Visit kp2020.org for Kaiser Permanente optical locations.

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